

The Wisconsin Psychiatrist

Summer
2008
Vol.48 No.2

QUARTERLY PUBLICATION OF THE WISCONSIN PSYCHIATRIC ASSOCIATION: NORTHERN, SOUTHERN AND MILWAUKEE CHAPTERS

WPA 2008 Spring Meeting Features Resnick and Goodwin

By Jerry Halverson, M.D., Program Chair

The Wisconsin Psychiatric Association's Spring 2008 Scientific Meeting was held April 18-19 at the Intercontinental Hotel, in Milwaukee. The scientific program was split into two clinically relevant topics on two days: Risk assessment, Friday and bipolar disorder, Saturday. By all measures it was a successful meeting; it stimulated great interest, it was well attended and it was well reviewed.

Friday's focus was on risk assessment with the centerpiece speaker being Phillip Resnick, MD, renowned forensic psychiatrist from Cleveland, Ohio. The meeting was kicked off with a morning packed with clinically relevant information and practical advice about violence and risk management as well as teaching us how to ferret out the malingerers in our clinical load. His first presentation was on violence risk assessment and he effectively used case presentations and examples to engage the audience in the discussion.

He went over risk factors and gave risk assessment tips based on his rich experience of dealing with some of the most violent and risky patients. He followed with a presentation on suicide risk assessment. He, again, related case examples and discussed practical tips for assessing dangerousness based on his experience, this time as an expert witness for the prosecution, oftentimes against a psychiatrist in a malpractice claim. His handouts were worth the price of admission alone! Dr. Resnick then finished the morning with a discussion of the evaluation of malingered psychosis. He used cases and videos to illustrate his points and to test the audience's acumen. The morning was all that it was billed- very fast paced and filled with clinical nuggets. This was more a discussion than a lecture!

The business meeting was held during the luncheon. The WPA President Carl Chan, MD gave an update on the "state of the association" and discussed current hot issues in the WPA and the APA. The WPA also gave an award to Kathy Molenitsky to thank her for her many years of service after her recent retirement.



From Left to Right
WPA President Carl Chan, MD
Conference Speaker Phillip Resnick, MD
WPA Conference Chair Jerry Halverson, MD

Friday afternoon was devoted to an in-depth discussion of the Jeffrey Dahmer case, nearly 20 years later and what we learned from it as far as risk assessment and whether we could prevent this in the future. The panel was "introduced" with a presentation from each member of the panel, each painting a different part of the picture. We started off with Neil Purtell, a retired FBI agent who was one of the first to interview Dahmer. His presentation laid the ground work for the rest of the panel with many of the "facts" and new information and new hypotheses. He discussed not only the crimes that we know about, but gave some interesting insights into Dahmer's military days and a possible connection with the Adam Walsh murder in Florida. Mr. Purtell was followed by Ken Smail, PhD.

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Mr. Nathan Comp of Madison Special Friend of Children and Adolescents

by Douglas A. Kramer, M.D., M.S.

On April 18, 2008, the Wisconsin Council of Child & Adolescent Psychiatry presented the AACAP Special Friends of Children Award to Nathan J. Comp at the Annual Meeting of the WPA in Milwaukee. Mr. Comp is a reporter for two Madison newspapers, The Capital Times, the afternoon daily, and the Isthmus, a weekly feature and entertainment alternative.

“We got high so confidently at lunch because we knew we weren’t going to be spotted. It wasn’t like they had drug crime fighters in the halls,” she said. “Unless they could smell it, no one ever looked at us funny. It’s amazing how much we got away with.”

Mr. Comp used interviews with adolescents and parents in his front page article in the afternoon daily, “Drugs are the Real Deal for Middleton Students,” with an entire inside page continuation, on adolescent drug and alcohol abuse. High school students in this community adjacent to Madison were the focus of the article. Interviews with family and friends of two deceased adolescents were highlighted. This group of articles would be excellent for teaching or parent education. Please email me to obtain the web links: dakame1@wisc.edu

Two weeks after his discharge from the hospital last fall, on the eve of Halloween, Billy again tried hanging himself. This time, he bolstered his effort by lacerating his arms. At some point, his will to live

supplanted his desire to die and he woke his mother. He was taken to the emergency room, where he received 27 stitches, and was then readmitted to the psychiatric hospital.

The feature article in the Isthmus by Mr. Comp, “The Kids Aren’t All Right,” looks at the continuum of treatment, or lack thereof, available to children and adolescents before and after an inpatient stay at Meriter’s Child and Adolescent Psychiatric Hospital just outside of Madison. Patient and parent interviews are included. Mr. Comp stressed the multiple barriers to adequate treatment for these most acute patients including inadequate reimbursement by insurers, especially Medicaid, the lack of mental health parity, inpatient facilities like Meriter operating at a loss, and thus being few and far between, and the difficulties with obtaining appropriate care after discharge, in his acceptance remarks. The article includes a very good description of the comprehensive diagnostic services and daily programming that occur in facilities like Meriter.

This article has excellent educational material for health care systems at all levels, as well as for discussions with legislators and government agencies. Search www.thedailypage.com/isthmus, or email me for the url.

Dr. Kramer is the immediate Past President of the Wisconsin Council of Child & Adolescent Psychiatry.

Professionalism and Medicine's Social Contract

By Carlyle H. Chan, M.D.



Congratulations to Jerry Halverson for putting on a tremendous program for the WPA Annual Meeting. Well done, Jerry! Also, kudos is in order for Mollie Rolli and Alice O'Connor

for their organization of the WPA's Legislative Action Day. With the aid of an APA grant, they made possible a wonderful and strategic opportunity to interact with state legislators, become a more forceful voice for the mental health needs of our patients and initiate an annual event. It was also rewarding to see all the resident members from UW and MCW participate.

When I have given recent talks on professionalism, I am struck by my observation that consistently, a very small percentage of my audiences have heard about the Charter on Medical Professionalism and an equally small number of physicians are familiar with the concept of medicine's social contract. This includes residents as well as established physicians. The Medical Professionalism Project was completed in 2002 as a combined effort of the American Board of Internal Medicine Foundation, American College of Physicians Foundation and the European Federation of Internal Medicine. It has since been endorsed by over 200 medical specialty societies world-wide including the American Psychiatric Association.

The document's preamble states, "Professionalism is the basis of medicine's contract with society. It demands placing the interests of patients above those of the physician, setting and maintaining standards of competence and integrity, and providing expert advice to society on matters of health." It continues, "Essential to this contract is public trust in physicians,

which depends on the integrity of individual physicians and the whole profession."

The concept of a social contract is not new. The American Medical Association referred to it in their 1847 Code of Medical Ethics. Essentially, it is a quid pro quo between the profession of Medicine and society. Society expects medicine to guarantee professional competence, integrity and altruistic service (not just for monetary rewards). In return, medicine is afforded essentially monopoly status. We get to self regulate and earn a good income. For example, although we are licensed by each state, the house of medicine self-governs its medical education through the American Association of Medical Colleges (AAMC), its residency training through the Accreditation Council for Graduate Medical Education (ACGME), its specialty certification through the American Board of Medical Specialties (ABMS), and its continuing education through the Accreditation Council on Continuing Medical Education (ACCME). Our fiduciary relationship is to our patients who trust us to do what is in their best health interests.

What happens if medicine doesn't fulfill its part of the social contract? Society then responds either through legislative action or through prosecutory interventions. For example, Psychiatry was long aware of problems with patient-therapist sexual relations but failed to take any action. States then enacted laws that criminalized the behavior. In Wisconsin it is now a felony and therapists (with the consent of their patients) are required to report such behavior to the state if the topic arises in the course of therapy.

In another example, medicine long ignored the mounting evidence by sleep researchers of the ill effects of sleep deprivation including data on airline pilots and truck drivers. In fact, one surgeon published a

paper reporting that performance of his surgical residents improved after sleep deprivation. It wasn't until U.S. Congressional Representative Conyers introduced federal legislation mandating that duty hours be limited to 80 hours weekly that the ACGME responding with similar regulations (albeit with the possible option of adding an additional 8 hours per week). In Europe weekly work ours are even more restrictive and are not limited to house-staff, but extend to all health care professionals. The Institute of Medicine, under a grant from the U.S. Congress, is holding hearings about similar limitations for the U.S.

Medicine's relationship with the health-care product industry (pharma and device manufacturers) has now come under intense scrutiny. The Department of Justice has successfully prosecuted both industry and individual doctors for violations of anti-kickback and Medicaid fraud statutes related to payments to MDs. The ACCME has just revised and toughened its Standards for Commercial Support for Continuing Medical Education partly as a result of hearings conducted by the U.S. Senate Finance Committee. Members of this same Finance Committee (including Wisconsin Senator Herb Kohl) have introduced the Physician Payment Sunshine Act to require industry to report all payments to doctors greater than \$50. This will extend reporting requirements in Minnesota and six other states to the entire nation.

The Social Contract is not an abstract concept. If we do not take seriously our professional responsibilities, we will face increasing legislation or criminal prosecution. It may behoove all of us to review the Charter on Medical Professionalism.

Perspective: Medical Professionalism in the New Millennium: A Physician Charter, *Annals of Internal Medicine*, February 5, 2002, vol 136:3,243-246

Doctor Heal Thyself

By Alice O'Connor, Public Affairs Councilor

The Wisconsin Medical Society's Board of Directors has voted to discontinue the operations of the Statewide Physician Health Program (SPHP) because of declining physician participation, changes in staffing, and the significant difficulties in finding permanent funding sources to adequately fund the program on a long-term basis. The Society had also attempted to identify and contract with out-of-state vendors to maintain the program but was unable to do so. The end date of the SPHP's operations was October 15, 2007.

This decision leaves the physicians of Wisconsin without a statewide resource for treatment and advocacy that is intended for impaired physicians and run by physicians.

History

The current program had operated under the auspices of the Wisconsin Medical Society. It was funded by WMS dues. The SPHP was costly to operate and as WMS has needed to become more fiscally viable, the program came under scrutiny. Not only was it recognized as being inadequately funded, but it did not meet the needs of the physicians of the state of Wisconsin. The current medical director, David Benzer MD, in recent years, had suggested trying a private model where hospitals would pay for consulting fees, however this was not successful in that there were only 18 enrolled physicians among the 16,000 licensed in the state.

The WMS Board, in 2006, approved the reorganization of the program with the goal of creating a more vibrant, effective physician health program. The Board created a Task Force on Physician Health and Wellness to develop viable alternatives to allow the Society to transfer the duties of the SPHP medical director and all aspects of physician monitoring of current SPHP participants to an interim vendor/program. The Board also charged the Task Force with developing a new physician health and wellness program.

The Task Force considered contracting with an outside vendor of physician health services and distributed a Request for Proposal to contract with a vendor. But in the final analysis, it was felt going with an out of state vendor was not a viable option either. Costs would have escalated in using an outside vendor to perform remote monitoring and other services. The number of participants in the program was small. Nearly half of the then current SPHP participants were already being monitored by the Department of Regulation and Licensing's Impaired Professionals Program. In addition, the Society would continue to have potential liability for the operations of the SPHP.

The Society's Council on Health Care Ethics (Council) met on July 27, 2007. During that meeting, members of the Society staff conveyed information about the status of the SPHP and the Board's decision to have the Council discuss the experience of the SPHP, the needs of Wisconsin physicians, alternative methods of addressing those needs and determine the nature and extent of the Society's future involvement. The Council members discussed the importance of programs that respond to the needs of impaired physicians. Council members also expressed a desire to preserve and utilize the work performed to date by the Task Force and the Managing Committee to assess the needs of physicians and explore alternative methods of addressing those needs.

On September 5th 2007, Mark Grapentine and Ruth Heitz met with staff members of the department of Regulation and Licensing to discuss the SPHP. DRL representatives discussed a willingness to participate in further discussion about developing a state-wide, robust monitoring program if the program would serve needs of all credentialed holders. This conceivably could entail every licensed professional covered by the DRL's authority from cosmetologists to architects to physicians. The DRL has made it clear it is not interested in participating in a program geared only to meeting the needs of impaired physicians. (Department of Regulation and Licensing does have a monitoring program, desig-

nated as the Impaired Professionals Procedure (IPP). Their program is exclusively designed to monitor chemical dependency needs. Web site <http://drl.wi.gov/dept/ipp.htm> or call 608.266.5432.)

Although the SPHP's operations will end, the members of the Society's Board, the SPHP Managing Committee and the staff stated that the WMS remains firmly committed to improving patient care by supporting and strengthening physicians' ability to practice high-quality medicine. The Board approved the following three actions to help the Society provide support to impaired physicians in the future:

- The Task Force on Physician Health and Wellness will evaluate the creation of a group for the purposes of developing a source of referral information about monitoring and treatment programs and community support opportunities.
- The Society staff compiled a resource guide for physicians and others seeking information about program and community services for impaired physicians. The Society included an article in the August 9, 2007 issue of Medigram about community programs and support groups to help the Society expand its resource guide.
- The Society's Council on Health Care Ethics will discuss the experience of the SPHP, the needs of Wisconsin physicians, alternative methods of addressing those needs and determine the nature and extent of the Society's future involvement. The Society, along with other stakeholders, will identify methods to promote advocacy and education for recovering physicians.
- Lastly, the Council, in its meeting of May 16, 2008, did create a subcommittee to develop a proposal for a future program and a strategy for obtaining funding and possible legislative support for change.

Why physicians are different

Many equate impaired professional programs with substance abuse. But clearly physicians issues are much more complex and deserve attention. Physicians work in unique circumstances and arguably require specialized programs. Physicians are reluctant to seek help because of stigma and fear of losing their ability to practice. It makes it difficult for them to come forward and get help before their problems become disabling.

Doctors notoriously tend to prefer to take care of themselves. They have prescribing privileges and they tend not to seek care for themselves. Their occupation also gives them access to potentially habit-forming drugs. This exposure can make return to work problematic because one cannot avoid contact with the drugs to which one has become addicted. Rehabilitation, however, for physicians is quite successful because of monitoring and because physicians are highly educated professionals who are extremely motivated.

According to an article that recently appeared in Newsweek magazine entitled "Doctors Who Kill Themselves" (04/28/08), from 300-400 physicians successfully commit suicide each year. This statistic does not include the number of attempted suicides. The article concludes: "The unsettling truth is that doctors have the highest rate of suicide of any profession." This data alone would suggest that physicians face unprecedented stressors and deserve specialized attention.

In working with physicians over the last 5 years in the Physician Health Program at the Marshfield Clinic, I have come to understand that physicians have many of the same problems that other professionals have, from disruptive behavior, to pornography and family issues, as well as mental health issues. They are likewise quite reluctant to come forward because of their visibility in the community, fear of licensing and credentialing and personality issues of physicians needing to be in control. Personalized care provided in a discreet setting with safeguards for

their private and professional lives makes treatment much more accessible and palatable.

What is needed

Currently aside from the monitoring program offered by the Department of Regulation and Licensing, there is not a statewide program designed to address the needs of impaired physicians. The WMS Task Force did identify several robust, successful physician health and wellness programs in the United States. Such programs offer a comprehensive range of services including advocacy and monitoring and facilitating evaluation and treatment. There are statewide counseling groups and contracting with providers who are experienced in dealing with healthcare professionals. The better programs have interactive websites with education about physician health and wellbeing and wellness initiatives.

The effective programs serve as diversion programs separate from Medical Examining Boards (MEB's) but linked to them so that there is some enforcement leverage for recalcitrant physicians but also can be an alternative to disciplinary action if a physician complies with the goals and restrictions. They can act as advocates for physicians.

The current system in Wisconsin is not user friendly. The Wisconsin MEB is punitive and physicians are unlikely to voluntarily come forward and self report. This creates a very non-therapeutic environment and physicians are not encouraged to get help or report until something drastic occurs. In the past, Dr. Mike Miller indicated that there was a coordinating council committee on physician impairment made up of three members of the MEB and three WMS Physician Health Committee members. Dr. Roland Harrington was one of the founders. The Committee could discuss a case before it went to disciplinary action from a regulatory and rehabilitation perspective in a much more collaborative fashion. There was reorganization in 1967 and all licensing authority was brought under the DRL.

The inadequacies of the present system have not gone unnoticed. There have been public outcries about impaired physicians and the apparent inability of the MEB to address them. Dr. Darrold Treffert, who has served on the MEB, has written very eloquently about the inadequacies of the present system in a letter addressed to the Milwaukee Journal Sentinel on January 28, 2008. He pointed out that:

"The DRL staff are hard working very capable but they also staff the Real Estate, Barbering and Cosmetology, Architects and Engineers and 41 other Boards Councils or committees. When it comes time to set timetables and priorities DRL has made it clear those capable persons do not work for the MEB, they work for DRL and DRL will set priorities, protocols and regulations. DRL also sets the budget and allocated resources. The problem is that their medical expertise is not a dedicated resource to only the MEB but is rather divided among a whole host of unrelated boards"

He recommended an organizational structure that separates out medical licensee's "not as a matter of elitism but as a matter of priorities and resources"

The success of a new program will depend on funding from the state, private entities and individuals. It may need collaboration with multiple stakeholders, which could include all medical personnel from nurses to physician assistants to dentists to psychologists and social workers.

Other states with robust programs have developed a more adequate funding base with funding through licensure fees. Arkansas has a \$32 surcharge to the annual medical license renewal fee which is a small price to pay.

Some states charge physicians to participate in its physician health and wellness program. The amount of the fee varies from program to program depending on the services and the amount of outside support. Again in Arkansas, a physician who participated in the health and wellness program paid fees ranging between \$400 and \$1,200 annually.

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Legislative Update

By Alice O'Connor, Public Affairs Councilor



It's an election year; the biggest question at the State Capitol is who will return as the majority party in the State Assembly. Currently, the Assembly Republicans hold the majority by three votes. It's been many years since Assembly Democrats held the majority, but they believe this is a good year for Democrats. No one expects the State Senate to flip. In other words, the current 18-15 majority enjoyed by Senate Democrats is projected to continue.

The filing deadline for people interested in seeking statewide office is the end of June, with 11 Assembly members and two Senators not seeking re-election. Some legislative districts have as many as nine people running in a primary to be the party's nominee. What this means is at least one-third of the Legislature will be new, regardless of party affiliation. Supporters of mental health need to have an ongoing dialogue with anyone running for office so old and new lawmakers alike are aware of the positive economic aspects for employers who cover employees who seek mental health services.

Summer and fall months are being used by the Coalition for Fairness to retool strat-

egy so we can pass mental health parity legislation next year. Many of you who have been actively seeking a change in the law for more than 20 years with no success, realize changing the law will require more than discussion about the "fairness" of mental health parity legislation.

If the Democrats end up controlling the Governor's office, State Assembly and State Senate, assume mental health parity legislation will be included in whatever health care reform package moves ahead. However, one should not assume a state law change will automatically generate positive feelings about the value of mental health services. Psychiatrists, advocates, social workers, psychologists, and other patient groups are going to need to keep demonstrating value to a business' bottom line – especially in this economy.

The Coalition on Fairness, a large consortium of different groups who are working for mental health parity legislation, is meeting late July to discuss an updated strategy to pass legislation in the 2009-2011 legislative session.

If you have an interest in participating in any of the following activities, please let me know. Activities will be targeted in specific legislative districts that will include such things as:

- Newspaper editorial board visits;
- Letters to editor (150 words max);

- Opinion page articles (up to 1,000 words);
- Questions about mental health parity inserted into legislative candidate questionnaires of other associations who already routinely ask candidates their views on different issues;
- Attendance at local candidate forums to find out where candidates for statewide office stand on mental health issues;
- Planning for 2009 Advocacy Day, and individual meetings early in the session with lawmakers, once leadership positions and committee assignments are made.
- There are also some of us who feel that the name "Fairness Coalition" needs to be "rebranded" so that our message is more "visually" tied to the economic benefits of mental health services to employees.

Even though the Legislature is not in session, this is an extremely busy time when a lot of ground work is being laid.

For more information, contact Alice O'Connor at aconnor@murphydesmond.com, or (608) 257-7181. Alice is the WPA Government Relations Advisor.

Doctor Heal Thyself

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Conclusion

There is too much at stake to allow this program to die. The Wisconsin Medical Society's Council on Health Care Ethics subcommittee has appointed a subcommittee that was assigned to assess the needs of impaired physicians in Wisconsin, alternative methods of addressing those needs and determine the nature and extent of the

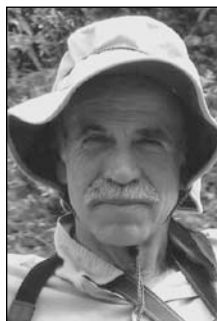
Society's future involvement. I will serve on that committee. Other volunteers of the subcommittee include Norm Jensen, MD, Stephen Webster, MD, John Kelly, MD and Linda Cuning, MD. Doctor Cuning served on the Society's Statewide Physician Managing Committee and the physician health taskforce. Doctor Jensen also served on the physician health taskforce.

Hopefully we can take this cause forward. When physicians and healthcare providers struggle and do not get treatment, there are potential quality of care and patient safety issues and hence a public concern. The question before us is how do we take care of others if we do not take care of ourselves?

The Biological Roots of Child Psychology

Comprehensive Biological Treatment, i.e., CBT

By Douglas A. Kramer, MD, MS



Do I feel guilty about appropriating the acronym CBT to describe a comprehensive biological approach to treating children and adolescents? No, I don't. After all, the struggle over naming rights has a proud history in psychiatry. Bowlby (1988) lamented the "physiological psychiatrists who had improperly kidnapped the label biological psychiatry." The Society for Biological Psychiatry was founded in 1945, largely as a reaction to the psychoanalytic influence in psychiatry, at a time when "biological" with reference to psychiatry primarily referred to the use of insulin shock, electroshock, and leucotomy to relieve the suffering of patients (El-Hai 2005).

Bowlby's writings on the biology of attachment systems began in 1951, well before the pharmacological influence in psychiatry had become established, and were also a reaction to traditional psychoanalytic theory. At the time of the publication of his most known work, the first volume of the series *Attachment and Loss* (Bowlby 1969), I do not think he knew what to call this comprehensive biological approach.

In the acknowledgments to that volume, he mentions his psychoanalytic background and training, but says "my position has come to differ much from theirs..." He then graciously thanks many of the founders of classical ethology, e.g., Julian Huxley, Konrad Lorenz, and Niko Tinbergen, "for continuing my education and for encouragement;" and Robert Hinde "for the time and guidance given me;" and says (p xviii) "in seeking to utilise [sic]

the more recent findings and concepts of ethology..."

I speculate that in 1969 he might have been thinking this psychiatry would be called "ethological psychiatry," as the vast majority of that volume is devoted to ethological research. He was not yet ready to break with psychoanalysis, however, stating that this "theoretical schema" was derived "partly from psychoanalysis and partly from ethology."

When Bowlby (1988) gave the Adolph Meyer Lecture at the American Psychiatric Association Annual Meeting in 1986, the more general term now clearly belonged to the "physiological psychiatrists," so he chose to call this new approach to psychiatric thinking "developmental psychiatry." He again refers, in the very next sentence after the kidnapping charge (p 2), to the foundation of this comprehensive approach being in ethology: "Not only are ethological concepts proving extremely fruitful when applied to our field..."

I believe he used the term "kidnapped" on purpose as the problem wasn't that the modalities to which it applied couldn't be seen as biological, but that "biological" had become too narrowly defined. It was not that it was wrong, just overly narrow, thus "kidnapped"

rather than "stolen." Bowlby's approach to biological psychiatry was clearly broader than what was, and mostly still is, thought of as biological.

I learned more about the role of biology in medical care during my surgical training than I did in my psychiatry residency. Sure, there are certainly surgeons who fit the caricature often broadly applied. The surgeons from whom I learned, however, during my straight surgical internship in

1971-72 in Vermont had an almost sacred respect for the power of the human body to heal itself (Pilcher 2006). They saw themselves simply as servants of an almost majestic healing force inherent in the biology of living beings.

As I have thought about this, I think they were absolutely correct. Whatever repairs, removals, or realignments might be performed by the surgeon, they are totally useless if not for the body conducting its magic and completing the intended process. In general, I think many of us, including myself, forget this as we write prescriptions, check blood levels, recommend hospitalization, or provide counseling or therapy (including cognitive behavior therapy).

It would seem, at least as a working hypothesis, that the brain, and its emergent function, the mind, might have the same inherent healing properties, especially in the age of biological psychiatry. In Comprehensive Biological Treatment (CBT) perhaps the psychiatrist facilitates healing rather than ordains it; a participant in the process rather than the conductor.

What are the elements of CBT? To some extent the definitions are arbitrary, but they do suggest the breadth of a comprehensive biological treatment versus a narrow "physiological" one, to use Bowlby's characterization. I will list seven that seem relevant to every encounter with a patient in medicine including psychiatric medicine:

1. The gene: I suppose the base pairs that comprise genes are the most elemental of biological units, but for medical purposes the gene is the initial unit of biology. All human conditions defined as psychiatric

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CBT

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disorders likely begin with either a normal genetic complement being expressed in an abnormal fashion or, alternatively, a mutant complement being expressed normally.

2. The environment: Not usually thought of as a biological component of an organism, but at the level of gene x environment interplay it is likely that the organism experiences both the genetic influence and the environmental influence as biological (Kramer 2005).
3. The chromatin structure: The chromatin is the specific chromosomal structure within which epigenesis occurs, where the genome and the environment come together, functioning primarily through the processes of cytosine methylation and histone acetylation.
4. Gene expression: The final common pathway of epigenesis is the expression or non-expression of genes in various combinations and sequences during development and throughout the life of the individual. The result is a dynamic biological organism.
5. The phenotypic individual: The lowest biological level subject to natural selection. Natural selection operates at the level of the phenotype, not the genotype. Individuals survive or not, reproduce or not. Components at a lower level of biological organization, at least among sexually reproducing species, can do neither.
6. The family: The primary entity within which attachment systems operate. At the level of the family, kin selection functions in the service of inclusive fitness. In the family, experiences that we refer to as

“environmental” contribute to the process of epigenesis in the context of ongoing child development. The family as a biological entity is also subject to natural selection, and thus is a biological entity capable of being defined as a patient. Intervention at this level may affect the biology of individuals within the family by way of epigenetic processes.

7. The extended family social group: The default social condition among chimpanzees, bonobos, and primitive human groups is a community wherein most individuals are related to each other genetically or through mating and parental care. As hunting, gathering, and surviving enemies and predators occurred at this level of social organization, these human groups were subject to natural selection.

The proposed idea of a Comprehensive Biological Treatment (CBT) acknowledges the various elements of biological functioning in the understanding of human beings, and incorporates multiple biological elements in the treatment of psychiatric disorders. This approach to treatment is consistent with what Bowlby described as “developmental psychiatry,” but which he clearly thought of as “biological psychiatry,” a term already in use for a more narrow group of interventions. He saw this comprehensive biological treatment as based in the science of ethology. Bowlby did his work from his position as Chairman of the Staff Committee of the School of Family Psychiatry and Community Mental Health at the Tavistock Institute of Human Relations.

Niko Tinbergen was as thoughtful and gentle a mentor as one could possibly have. He died in 1988, two years prior to John Bowlby who passed away in 1990.

Albert G. Mackay, M.D., with both his hands and his eyes, taught me to respect the inherent healing capacity of the human body.

Comments on the biology of child psychiatry are always welcome: dakrame1@wisc.edu.

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Prescriptive Authority in the States

A Look at Which States Allow RxP and Which Have Considered It.

By C. Munsey, Reprinted from *Monitor on Psychology*, Volume 39, No. 2 February 2008, Page 60

Hawaii's state legislature was the first to consider a bill granting prescriptive authority to appropriately trained psychologists in 1985. Since then, 21 states or territories have introduced prescriptive authority legislation – a push that will resume in legislatures across the nation this year.

The territory of Guam approved prescriptive authority in 1999. New Mexico was the first state to approve the privilege in 2002, followed by Louisiana in 2004.

Last year, Hawaii came closest to being the third state: Last May, the state's legislature approved a bill that would have allowed appropriately trained and supervised licensed psychologists who practice in federally qualified health centers to prescribe psychotropic medications in collaboration with patients' primary-care physicians. But Gov. Linda Lingle (R) vetoed the measure in July.

Besides Hawaii, bills granting prescriptive authority for appropriately trained psychologists were considered last year in California, Georgia, Illinois, Mississippi, Missouri, Montana, Oregon and Tennessee.

How it works in N.M. and La.

In New Mexico, under regulations implemented in 2005, psychologists undergo a rigorous training period, including 450

hours of instruction, followed by a supervised 400-hour practicum with a minimum of 100 patients and a national exam before they can apply for a two-year conditional prescribing certification.

During the two-year period and after, psychologists are required to maintain a collaborative relationship with patients' primary-care physicians.

As of December, 10 psychologists were prescribing under the conditional two-year certification, and three psychologists had moved beyond the two-year period and been granted unrestricted certifications, according to the New Mexico State Board of Psychologist Examiners.

In Louisiana, psychologists must complete a postdoctoral master's degree in clinical psychopharmacology and pass a national certification exam to be eligible for prescriptive authority.

Called a "medical psychologist" by Louisiana law, the psychologist prescribes in consultation and collaboration with patients' primary or attending physicians and with the concurrence of physicians. As of December, 42 psychologists had been granted prescriptive authority in Louisiana, according to the Louisiana State Board of Examiners of Psychologists.

In 2006, Louisiana amended its law to ensure that medical psychologists could pre-

scribe in state health facilities.

New Mexico's formulary includes all psychotropic medications approved by the federal Food and Drug Administration for the treatment of mental disorders, while Louisiana's formulary includes non-narcotic drugs related to the diagnosis and treatment of mental and emotional disorders.

On the horizon

Since 1985, prescriptive authority bills have also been introduced in Alaska, Connecticut, Florida, Maine, New Hampshire, Oklahoma, Texas, Wyoming and the Virgin Islands.

While it's up to individual state associations to push for prescriptive authority, says Deborah Baker, JD, assistant director for prescriptive privileges for APA's Practice Directorate, APA provides assistance and resources to state associations pursuing prescriptive authority. These resources include the APA Model Legislation for Prescriptive Authority, recommended education and training guidelines, as well as grant funding and consultation on strategy.

Find this article online at:

<http://www.apa.org/monitor/feb08/prescriptive.html>

2008 WPA Spring Meeting

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Dr. Smail was one of the first mental health professionals to assess Dahmer and he spent a great deal of time with him. His presentation went into the psychology of Dahmer, traced his origins and went into some family history. Long time Milwaukee District Attorney E. Michael McCann then gave a very personal and impassioned presentation on some of the legal aspects of the case and some of his personal impressions about this case, one the cases that defined his storied career. For me, his presentation was one of the highlights of the conference. Ken Robbins, MD then gave a short presentation of his thoughts on the case and his experiences interviewing Dahmer and his murderer, Christopher Scarver. The panel was then moderated by Dr. Robbins with Dr. Resnick and the other speakers participating in the panel. The panel's discussion was lively and gave an opportunity for our speakers to interact, confront each other and discuss the case. The audience had excellent and thoughtful questions. It was a great way to finish a long day; it kept most interested until the very end.

After the panel, the WPA held a cheese and cracker reception at the Intercontinental at which Milwaukee Chapter President Jon Berlin and his jazz trio played as members socialized and reflected on the days happenings. Following the reception Friday evening, separate member in training and early career recruitment events were held in downtown Milwaukee. The highlight of the early career program was hearing Fred Goodwin talk about the Scientologists going through his garbage. A good time was had by all.

Saturday morning was dedicated to an update on bipolar disorder. We had Fred Goodwin, MD host of "The Infinite Mind" (<http://www.lcmmedia.com/mindprgm>.



Bipolar Panel Discussion, From Left to Right
Alexander Scharko, MD; Louis Kraus, MD; Frederick Goodwin, MD

htm), ex chief of NIMH and author of the authoritative book on bipolar disorder give us an update on the treatment of bipolar disorder. His first presentation went through the treatment of bipolar disorder and how to fit in the new treatments with the old treatments. His second presentation specifically looked at the controversial construct of bipolar depression and its treatment. He went through the data in both of his presentations and made treatment recommendations based on the evidence. His presentations were very densely packed with terrific information. Many attendees, including myself, had their practices changed after this presentation. Sandwiched between the two Goodwin talks, we were fortunate to have Louis Kraus, MD head of the child program at Rush in Chicago discuss the diagnosis of bipolar disorder in children. He feels that bipolar disorder is real in children, but is

concerned that it may be over diagnosed. His presentation was humorous and also filled with clinically relevant information. The morning ended with a panel on the treatment of bipolar disorder, moderated by WPA member Harold Harsch, MD and including Dr. Goodwin, Kraus and another WPA member, child psychiatrist Alexander Scharko, MD. The program was followed by a women psychiatrist networking program.

Overall, the program delivered what it promised. Big names delivering clinically relevant information in the big city. We expect to continue that trend next year when we bring you an update on Depression and Anxiety with many of the biggest names in the field at the American Club in Kohler!

When the Internet Becomes Too Much

By Reid Goldsborough



One of the top tech trends for 2008 will be Internet addiction, prognosticates J. Walter Thompson, the advertising agency powerhouse. What's old is new again. "Internet ad-

diction has been a concern since the dawn of the Web," acknowledges Ann Mack, the agency's "Director of Trendspotting."

It may not be a new trend, but it remains an important one. Mack points to online discussions, Internet gambling, online porn, and interactive role-playing games. But just about everything about the Internet can snag you in one way or another.

Are you an Internet addict? A surprising number of people are. Between 5 and 10 percent of Web users suffer from some form of Internet dependency, estimates Maressa Hecht Orzack, who has studied computer addiction at McLean Hospital, a psychiatric hospital in Belmont, Mass, affiliated with Harvard University.

There's even a name for it: Internet Addiction Disorder, or IAD. It first made waves in 1995, two years after the Web went graphical with the introduction of the browser Mosaic. Ironically, the disorder was suggested by New York City psychiatrist Ivan Goldberg as a joke, parodying the bevy of new psychiatric conditions that had been recently recognized by the American Psychiatric Association.

But his thoughts struck a chord, with colleagues telling Goldberg that his descriptions were right on target, and Goldberg came to accept IAD as a serious affliction. People were, and are, going overboard, spending too much time online to the detriment of their work, academic, family or social lives.

IAD still hasn't yet been accepted by the American Psychiatric Association as a formal diagnosis, and the term "Internet overuse syndrome" is probably better descriptively. But there are ways to tell if you're so afflicted, according to Goldberg, who maintains a Web site titled "Depression Central" (www.psycom.net/depression.central.html).

You may be "addicted" to the Internet, says Goldberg, if you need to spend more and more time online to achieve the same level of satisfaction and feel anxious when not connected. You might grasp your situation but find it difficult to cut down on your Internet use.

If you're an addict, says Goldberg, you're probably reducing or forgoing important social, occupational or recreational activities in favor of your time online. You may even be experiencing sleep deprivation, facing marital difficulties, losing friendships and neglecting your job or school work to the point of risking being fired or flunking out.

Some experts dispute that IAD is a true addiction, but Kimberly S. Young differs. "It's like other addictions," says Young, director of the Center for Internet Addiction Recovery (www.netaddiction.com) and a professor at St. Bonaventure University. "It has same qualities as compulsive gambling, shopping, even smoking and alcoholism."

Before you can be cured of Internet Addiction, as with other addictions, you have to recognize that you're hooked, according to Young.

Common warning signs, she says, are compulsively checking your e-mail, always anticipating your next Internet session, and others complaining that you're spending too much time or money going online. As with any other addiction, you have to be motivated in order to kick the habit. "You have to really want to change," says Young.

Reestablishing a healthy relationship to the Internet depends to a great extent on your individual circumstances. In some cases, all you may need to do is develop time-management techniques to help you better control yourself, says Goldberg. You could, for instance, set a daily online time limit of an hour a day.

In other cases, you may need to deal with any underlying reasons that cause you to feel compelled to spend so much time online. There may be problems or conflicts you're consciously or subconsciously trying to avoid, which may be dealt with best through therapy.

"Internet addiction can be an attempt to deny or avoid another more serious problem in your life," says Goldberg. "People spend excess time in front of their computer to avoid thinking about such difficulties as what they will do when they graduate from school, the infidelity of their spouse, the drug abuse of their children, and so on."

The key concept here is the surrendering of the will. If you no longer control your relationship to it – whether it's an activity such as Internet use or a pharmaceutical drug – you're in trouble.

The Internet is a fantastic medium, dramatically improving our ability to communicate with one another and find information to help us with our careers or studies. But, as with most things in life, there's a need to keep things in healthy balance.

*Reid Goldsborough is a syndicated columnist and author of the book *Straight Talk About the Information Superhighway*. He can be reached at reidgold@comcast.net or www.reidgoldsbrough.com.*

WPA's First Advocacy Day a Resounding Success

April 23rd the Wisconsin Psychiatric Association held its first legislative advocacy day. 21 Psychiatrists, residents and medical students participated in the event. Our Lobbyist Alice O'Connor organized a fantastic event. We kicked off the day with keynote speech from Representative Sheryl Albers. Representative Albers introduced a mental health parity bill in the house last session and has been a very brave advocate for mental health parity within the Republican Party.

We also heard from Bob Kerney from the APA who briefed attendees about how to approach legislators with our issues. After lunch we all headed up to the capitol to call on legislators. Our agenda was focused on mental health parity and educating legislators about who we are. Many are not familiar with psychiatry and don't recognize our role as physicians. After the capitol visits we reconvened at the Madison Club where Representative Albers joined us again to process the experience. We ended the day with a cocktail reception. Eight legislators or their staff attended.

Attendees, legislators and psychiatrists alike, were pleased with the event. We were all impressed with the positive reception we received during the capitol visits. And the informal social gathering with legislators was fun and a new experience for many folks in attendance. Several UW residents were so inspired by the experience they decided to have an advocacy theme at their resident retreat this year.

We hope to be able to call this the "first annual" psychiatric association advocacy day. We invite you to attend next year's event which is in the planning stages. It is a pleasure to experience our voice being heard on the capitol and far easier to make an impact than we think.



Molli Rolli, MD and WI State Representative Sheryl Albers.



WPA Legislative Advocacy Day Participants.

Graduating Fellows

Graduating General Psychiatry Residents

Justin Schoen has signed on with the Marshfield Clinic with a focus on outpatient work and medical student education. He will start in July 2008.

Adriana Stacey will join Mercy Health System in Janesville for outpatient psychiatric practice in November 2008.

Graduating Geriatric Psychiatry Fellow:

Jeremy Peacock will joined the UW Department of Psychiatry with a clinical practice at our 780 Regent Street site. He will start in July 2008.

In conjunction with the Wisconsin
Psychoanalytic Institute

2008 WPA Fall Meeting
“A Day with Glen Gabbard”

November 15, 2008

Medical College of Wisconsin
Alumni Center

WPA 2009 Annual Meeting

“An update on
Depression and Anxiety”

*Featuring Charles Nemeroff,
Alan Schatzburg and Ned Kalin*

April 17-18, 2009

American Club, Kohler Wisconsin

New “Revenue Streams”

Barbara Hale-Richlen, MD



My wheels turned into the parking lot of the new medical office building that was still under construction. I walked into the expensively tiled hallway to see workmen putting the finishing touches on what will certainly be a beautiful office. Impressed by the professional appearance, I walked down the soon-to-be-busy hallway excited to meet my potential employer.

I was ushered into a cozy waiting room and soon found myself in a plush office. I rose to shake hands with the social worker who owned the group and was introduced to an office manager and a Ph.D. who were also working there. My initial first impressions of a well run mental health practice were soon dashed as the conversation turned to talk of “expanding revenue streams,” and the lack of “money to be made” in mental health. My thoughts of talking about treatment philosophies to see if we were a “good fit” soon turned to thoughts of “how fast can I get out of

here?” During the 45-minute interview, I was exposed to a side of medicine I had not yet seen but always knew was out there – the businessman with no medical training who seeks to capitalize on new technology solely for the purposes of profit.

He quickly dominated the conversation with talk of how he planned to “capture the market on attention-deficit/hyperactivity disorder (ADHD)” within 18 months, and then “franchise” his model out to other businesses. When I pointed out that ADHD was a relatively straight-forward diagnosis to make and treat, he disagreed, stating that it was often misdiagnosed and was really posttraumatic stress disorder (PTSD) or some other disorder. He then launched into his grand plan: SPECT scans of children’s brains to “prove” the diagnosis of ADHD. Several thoughts tumbled through my mind including that he might be pulling my leg.

“Who will pay for this treatment?” was the first question I managed to ask.

“It’s \$3,500 and will be all out of pocket,” he replied.

Incredulously I looked at him and said, “Do you believe there will be people willing to pay that amount of money for something that a Conners form and a good clinical interview could diagnose for one tenth that amount?”

“They certainly will!” he retorted. “They are doing it right now in California and Colorado.”

I asked if he really felt this would be helpful to families and pointed out that there is no evidence to show that SPECT scanning has any diagnostic validity.

“Well, I’d do it if it were my kid! I wouldn’t want to expose them to those drugs for nothing!” he replied rather defensively. “Besides,” he added, “we’ve partnered with a pediatric radiologist and he’s looked at the data and he feels it’s there.”

I listened patiently for a while and then realized that this “interview” had to end. I interrupted to tell them a little about myself. I spoke of my enjoyment treating complex cases involving significant social problems, medical and psychiatric issues that required a dedicated team approach, and added that often those families have little to no money. I pointed out that finding new “revenue streams” was not an interest of mine. I soon found myself back in the waiting room needing to knock on the glass divider to ask the receptionist for my coat.

As I hurried to my car, I thought of all the families that would feel they weren’t giving their child the best treatment possible if they didn’t use this fancy new technology. I’m sure they would be impressed, just like I was initially, with the expensive exterior and the slick marketing. All this helps to lend credibility to what all my years of training have taught me is a sham. For the amount of money they want

for one SPECT scan, a child psychiatrist could diagnose and treat that child for two years, including medication costs.

I knew it would be useless to explain that the ADHD-specific questionnaires and rating scales have been shown to have an odds ratio greater than 3.0, which is equivalent to sensitivity and specificity of greater than 94 percent. In fact, the American Academy of Pediatrics Clinical Practice Guideline for the Diagnosis and Evaluation of Children with ADHD states that, “ADHD-specific rating scales accurately distinguish between children with and without the diagnosis of ADHD” (AAP 2000).

Joseph Biederman, M.D., program director of the Pediatric Pharmacology Research Unit at Massachusetts General Hospital, stressed that SPECT scanning is a valuable research tool but cannot be used diagnostically. “Although brain-imaging studies have documented both structural and functional pathological changes in frontal-subcortical-cerebellar circuits, imaging methods cannot be used as diagnostic methods” (Biederman 2005).

But perhaps utmost in my mind that day were the ethical concerns I had. Principle I of the American Academy of Child and Adolescent Psychiatry Code of Ethics states that professional judgment and the behaviors or actions which arise

from that judgment must be based on scientific knowledge and collective and personal experience (emphasis added). Principle III acknowledges the unique relationship that a child and adolescent psychiatrist has with children, adolescents, and families. The potential influence based on that relationship should be used to foster “optimum development and well-being of children and families.” Principle III further states “any action that involves exploitation of children, parents, or others involved for the physician’s personal gain or aggrandizement, is clearly unethical.” At this point in time, it is hard for me to imagine a child and adoles-

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2008 WPA Fall Meeting “A Day with Glen Gabbard”

By Jerry Halverson, M.D., Program Chair

After a two year hiatus, the WPA is planning a 2008 Fall Meeting! On November 15, 2008 in Milwaukee at the newly remodeled Medical College of Wisconsin Alumni Center in conjunction with the Wisconsin Psychoanalytic Institute, the WPA will be welcoming world renowned clinician-teacher Glen O. Gabbard, MD, for “A Day with Glen Gabbard”. This will be an excellent and unique opportunity to learn from one of the true giants of our field. Dr. Gabbard is a well known analyst and prolific author with recent titles including: the 4th Edition of his “Treatment of Psychiatric Disorders” text as well as the 4th Edition of his classic text “Psychodynamic Psychiatry in Clinical Practice”. He is well known for his expertise on psychotherapeutic interventions and on how to combine psychotherapy and medications for the best effect in many of our most common disorders. He has written extensively on treatments of various personality disorders, both psychotherapeutic and pharmacologic.

Dr. Gabbard is the Brown Foundation Professor of Psychoanalysis at Baylor College of Medicine and the Director of Baylor’s Psychiatry Clinic. Dr. Gabbard has authored or edited 20 books and over 250 papers. He has received many honors and awards, including the American Psychiatric Association Adolf Meyer Award in 2004 and the APA’s Distinguished Service Award in 2002. In addition, he was



the recipient of the Edward A. Strecker Award of the Institute of the Pennsylvania Hospital in 1994, which annually recognizes the outstanding psychiatrist in the country under the age of 50. In 2000 he was awarded the prestigious Sigourney Award for Outstanding Contributions to Psychoanalysis. He is currently the Joint Editor-in-Chief of the International Journal of Psychoanalysis and Associate Editor of the American Journal of Psychiatry. He is a Training and Supervising Analyst at the Houston-Galveston Psychoanalytic Institute. Dr. Gabbard’s textbooks have been translated into Italian, Portuguese, Korean, Japanese, Danish, and Spanish.

He lectures throughout Europe, South America, and Australia, as well as in the United States and Canada.

The exact topics and organization of the day is yet to be determined, but it will be from 8-4 and will likely be comprised of two half-day workshops where our members will be able to get some “hands on” experience and clinically relevant instruction from one of our field’s great teachers. This will be a valuable and unique opportunity to learn “up close” from one of the experts in our field! A block of rooms will be set aside at the conveniently located and recently opened Crowne Plaza Hotel just down the road from the Medical College of Wisconsin Alumni Hall for our member’s convenience. We are excited to bring Dr. Gabbard to Wisconsin! Look for more information in the fall “Wisconsin Psychiatrist” and in your mailbox later in the summer.

For those that are interested, Dr. Gabbard has also committed to the University Of Wisconsin Department Of Psychiatry Grand Rounds on Friday, November 14, 2008 at Noon. His lecture will be titled “Psychotherapeutic Implications of Recent Neurobiological Findings in Personality Disorders.” The Grand Rounds will be held at Wisconsin Psychiatric Institute and Clinics (WISPIC), 6001 Research Park Drive, Madison, WI, 53719.

New “Revenue Streams”

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cent psychiatrist ethically recommending SPECT scans as a diagnostic tool.

I fear that our patients’ families, with already stretched budgets, will be dazzled by fast talk and fancy equipment, and will fall prey to those who want to use the hard earned credibility of the medical profession to fatten their wallets. We need to be aware that these practices are occurring so we can educate our patients as well as our colleagues to not fall prey to this “new revenue stream.”

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Barbara Hale-Richlen, M.D., is chief resident in the Child and Adolescent Psychiatry Fellowship at the Medical College of Wisconsin. She also serves as a resident representative to the Executive Committee of the Wisconsin Council of Child and Adolescent Psychiatry. Dr. Hale-Richlen can be reached at BHale-Ri@mcw.edu.

Calendar of Professional & Clinically-Oriented Events

November 2008

7-8 – Fall 2008 Psychiatric Update
**Unambiguous, Unsurpassable Utterances
from Umbelliferous Ubermen**
UW School of Medicine and Public Health
and Madison Institute of Medicine, Inc.
Monona Terrace® Community and
Convention center, Madison WI

15 – **Gabbard Event: Medical College of
Wisconsin, Milwaukee**

April 2009

3-4 – Spring 2009 Psychiatric Update

17-18 – **WPA 2009 Annual Meeting**
“An update on Depression and Anxiety”
**Featuring Charles Nemeroff, Alan
Schatzburg and Ned Kalin**
American Club, Kohler Wisconsin

October 2009

23-24 – Fall 2009 Psychiatric Update

March 2010

19-20 – Spring 2010 Psychiatric Update

Note to readers and publicists: If you wish to have a professional meeting listed in future issues of the *Wisconsin Psychiatrist*, please send it to the WPA Office, 6737 W. Washington St., Suite 1420, Milwaukee, WI 53214, FAX: 414-276-7704

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