AMERICAN PSYCHOSOMATIC SOCIETY

Dedicated to the Integration of Biological, Psychological and Social Factors in Medicine

VOL. 19, NO. 3 NEWSLETTER FOR APS MEMBERS Winter 2008/2009

President's Letter

Matthew F. Muldoon, MD, MPH

This time like all times is a very good one if we but know what to do with it. — Ralph Waldo Emerson

As my term as president approaches completion, I find myself thinking of the broad challenges faced by the American Psychosomatic Society and its leaders, and of the progress we have made to see the way forward. In general the business of managing the APS calls us to capitalize on the expertise and ingenuity of our members vis-à-vis advances in medical research and contemporary issues in health and healthcare. Much of our effort is expended executing the day-to-day operations of the organization. However, I also recognize the central importance our professional identity, vision and goals hold for the Society's future.

Development of our goals requires reflection on the composition, achievements and shortcomings of the APS. Twenty years ago, we had 600 members of whom 65% were psychiatrists who mostly trained in the heyday of psychoanalysis. In contrast, today's 850 members are more diverse and share a greater breadth of expertise, research methodologies and clinical practices. The APS' annual meetings invariably invigorate our minds and our friendships, and the Society's journal publishes quality biobehavioral studies on a broad array of topics; all very beneficial achievements. Nonetheless, the Society has not grown in size in recent years, and our place among and impact upon the broader world of medical research and clinical practice remain limited. The Society's finances are not immune to the current economic crisis, but neither are we crippled. Thus, the quote from Emerson is particularly apt: "This time like all times is a very good one if we but know what to do with it."

This past June, we held a 10-year strategic planning retreat and are now actively digesting the ideas and goals suggested by its 30 attendees. In particular, one suggestion concerned the need to define our professional identity and examine how to project that to groups we interact with and wish to influence. While the APS began as a division of psychiatry studying the psychodynamic and psychophysiologic bases of physical symptoms, the Society has evolved well beyond that orientation. Our members now examine health and the full spectrum of diseases from their genetic determinants through societal sequelae.

That being the case, what is our current professional identity? Although focused on the social, psychological and behavioral factors which influence health, the Society does not eschew reductionist, biomedical techniques. Perhaps we could be described as a scientific body that embraces contemporary biomedical modeling enriched by the incorporation of psychosocial constructs. Is this accurate, or is the APS something else again? How should we portray ourselves to other research organizations, academic institutions, the media, the government and the general public? These are difficult, but ultimately crucial questions for the future of the APS. Spawned by the June retreat, a working group is beginning to examine these questions, and your input is needed as well. Please plan to attend our Townhall meeting on the APS identity in Chicago and don't hesitate to contact Shari Waldstein, our president-elect and working group chair at waldstei@umbc.edu.

Here is a summary of several other initiatives proposed in June:

1. Broaden member participation and enhance leadership development by increasing the roles of Council and general members in the nominations process, by removing barriers to voting, by publicizing our committee work and goals and inviting members to get involved in relation to their interests and skills, and by recognizing key contributions of individual members. Please refer to the article on page 6 describing revisions to our nominations and elections procedures.
2. Strengthen budgetary management by the adoption of additional, prudent budgetary guidelines and by the reinvigoration of fund-raising efforts.
3. Consider approaches to increase funding of psychosomatic or biobehavioral medicine research.
4. Consider approaches to foster high-impact, clinically-applicable research by our members.
5. Consider approaches to foster translation and implementation of our principals and research within healthcare.

These last three proposed initiatives are being studied by three other working groups who will report back to council during 2009. The APS is additionally engaged in strategic activities to increase membership as well as medical student exposure to the principals of psychosomatic or biobehavioral medicine. We seek to increase liaison activities with organizations sharing our goals and will continue to emphasize professional education and career development for our members.

In summary, we are actively examining ways to improve our governance while concurrently developing strategies to grow our society, enhance member benefits, and boost our impact on medical research and healthcare. These efforts call upon the vision and leadership of not just the Council and committee chairs, but also the entire membership. We increasingly need the contributions of members to define what can be an ambitious and attainable agenda, advancing our field in a manner that, over time, benefits everyone.

The APS Newsletter is published by APS with the cooperation of Degnon Associates
Made from recycled content

From the Editor

Mary-Frances O'Connor, PhD

> *For everywhere we look, there is work to be done. The state of the economy calls for action, bold and swift, and we will act—not only to create new jobs, but to lay a new foundation for growth. We will build the roads and bridges, the electric grids and digital lines that feed our commerce and bind us together. We will restore science to its rightful place, and wield technology's wonders to raise health care's quality and lower its cost. We will harness the sun and the winds and the soil to fuel our cars and run our factories. And we will transform our schools and colleges and universities to meet the demands of a new age. All this we can do. And all this we will do.*
>
> President Barack Obama
> January 20, 2009

The ushering in of a new president will have many long-reaching changes, not the least of which will be to the landscape of science and medicine in the United States. Obama is known as an "avid technophile", with a penchant for his Blackberry and an impressive command of the Internet for social mobilization. He has also indicated that he will fight for more funding for the National Institutes of Health (NIH), the National Science Foundation (NSF) and for stem-cell research.

To that end, a bill by House Democrats proposed a $825 billion plan to boost the U.S. economy. It was developed in cooperation with the Obama transition team, and includes $10 billion for research and instrumentation and another $6 billion to modernize academic laboratories. "We need to put scientists to work looking for the next great discovery, creating jobs in cutting-edge technologies, and making smart investments that will help businesses in every community succeed in a global economy" claims the proposal summary.

Included in the NSF proposal: $3 billion, including $2 billion for expanding employment opportunities in fundamental science and engineering to meet environmental challenges and to improve global economic competitiveness, $400 million to build major research facilities that perform cutting edge science, $300 million for major research equipment shared by institutions of higher education and other scientists, $200 million to repair and modernize science and engineering research facilities at the nation's institutions of higher education and other science labs, and $100 million is also included to improve instruction in science, math, and engineering.

Also included is funding for the NIH: $2 billion; including $1.5 billion for expanding good jobs in biomedical research to study diseases such as Alzheimer's, Parkinson's, cancer, and heart disease (NIH is currently able to fund less than 20% of approved applications); and $500 million to implement the repair and improvement strategic plan developed by the NIH for its campuses.

Finally, there is money set aside for university research facilities: $1.5 billion for NIH to renovate university research facilities and help them compete for biomedical research grants.

> *We will restore science to its rightful place, and wield technology's wonders to raise health care's quality and lower its cost.*

One particular interest of President Obama seems to be genomics research. He wants to create an inter-agency task force on genomics research, modernize FDA review of genomics tests, and expand support to genomics researchers, including funding and creating a new mechanism to allow researchers across the country to access and analyze genomics research.

Obama's interest in genomics may also motivate his choice for the new NIH director. The candidate most often named is Francis Collins, former director of the National Human Genome Research Institute. Collins championed the public sharing of genome data and pushed for legislation to protect people against discrimination based on their genes.

We can only hope that the goals of the President will dovetail nicely with the goals of APS, and that we will benefit both from his leadership and from improved funding in this next decade.

Julius B. Richmond, MD, In Memoriam

Dr. Julius B. Richmond, past president of APS (1962), died in July, 2008, at his home at 91. Dr. Richmond was trained in pediatrics and child development and pioneered in introducing psychosocial development into pediatric education, research and services. His collaborative work with Dr. Bettye Caldwell on the development of young children growing up in poverty led to his appointment in 1965 as the first director of the national Head Start program. He also served as assistant director for health affairs of the OEO and directed the Community Health Centers program.

Dr. Richmond was a John D. MacArthur Professor of Health Policy, Emeritus at Harvard University. From 1983 to 1988 he was Director of the Division of Health Policy Research and Education at Harvard University. He served as Professor of Child Psychiatry and Human Development at the Harvard Medical School as well as Chairman of Psychiatry at Children's Hospital and Director of the Judge Baker Children's Center from 1971-77.

From 1977 to 1981 Dr. Richmond served as Surgeon-General and Assistant Secretary of the Department of Health and Human Services. During this time he had responsibility for administering all of the agencies of the US Public Health Service. In 1979 he issued the report, *Healthy People: The Surgeon-General's Report on Health Promotion and Disease Prevention*. This report for the first time established quantitative health goals for the nation for the next decade–a process which has been institutionalized by the US Public Health Service through its recent report, *Healthy People 2010: National Health Promotion and Disease Prevention Objectives*.

Dr. Richmond received the C. Anderson Aldrich Award of the American Academy of Pediatrics, the Gustav O. Lienhard Award and the Walsh McDermott Medal of the Institute of Medicine of the National Academy of Sciences, the John Howland Award of the American Pediatric Society, the Ronald McDonald Award of the Ronald McDonald Children's Charities, the David E. Rogers Award of the AAMC, the John Stearns Award for Lifetime Achievement in Medicine from the New York Academy of Medicine, the Heinz Award for Public Policy, and a number of honorary degrees including those of Yale and Harvard.

He co-authored, with Professor Rashi Fein, a book, *The Health Care Mess: How We Got Into It And What It Will Take To Get Out* (Harvard University Press 2005). It is a history of medical care and education in the United States and presents recommendations for national health policy. His legacy will continue in health policies with a particular emphasis on health promotion and disease prevention, with special emphasis on children and families.

The Public's Trust in Medicine

Jessie Gruman, PhD, President
Center for the Advancement of Health

Medicine is not immune to broad trends that are undermining our trust in other important institutions like government and banks.

Trust has always been central to health care. We must trust doctors and hospitals if we are to benefit from the care they offer. Without trust, who would allow a surgeon to cut open their chest and fiddle with their heart? Without trust, who would take noxious medicines or suffer radiation burns for a disease whose symptoms they cannot detect? Patients don't know how these things work, but regularly entrust their lives to those who say they do and have licenses affirming it. They have little choice.

But public trust in medicine is eroding.

Why? Most of us, happily, are healthy enough to be personally unfamiliar with medical errors, hospital-acquired infections and eccentric health plan limitations. But there's increasing public discussion of them.

Advances in technology promote increased transparency that can tarnish our idealized vision of medicine. For example, new evidence about what treatments are optimal leads to documentation of how infrequently they are delivered appropriately. Similarly, the ability of researchers to examine the data underlying the new claims sensitizes us to incomplete data, inaccurate conclusions and biased researchers. Combining these with an active, 24-hour news cycle and the proliferation of watchdog groups creates an environment constantly questioning whether health care professionals and institutions merit our trust.

"That's the reality," you say. "This is why you have to be a vigilant health care consumer: health care is unreliable. You have to be careful; you have to become an expert; you have to question everything." Or, to cite an otherwise useful rule of thumb, "trust, but verify."

That's asking a lot. Isn't being sick already a full-time job? When I am sick, now I am also increasingly scared because I can't do the due diligence required to feel safe.

Experts argue that big threats jar us into acting rationally. Perhaps. But even Alan Greenspan was shocked to belatedly learn that individuals and institutions often don't act on the basis of their long-term self-interest. And evidence abounds showing that threats provoke behavior change only among some individuals in specific circumstances.

Declining trust can justify a casual attitude toward important recommendations. We may ignore or devalue counsel that we prudently should be relying on because of our difficulty in judging credibility.

On the other hand, the replacement of blind trust with wariness yields a more realistic picture of what it takes to benefit from health care: we must learn when and how to test what we're told and challenge our care.

For example, new evidence about what treatments are optimal leads to documentation of how infrequently they are delivered appropriately.

Ultimately we'll adjust. We will acquire a more accurate sense of what health care can do and what we must do. In the meantime, however, the transition adds extra anxiety. And we aren't sure where to find reliable counsel.

APS Distinguished Scientist and Past Leader, Wayne Katon

Our research program on diabetes and depression represents a unique collaboration between the Department of Psychiatry and Behavioral Sciences at the University of Washington School and the Center for Health Studies at Group Health Cooperative. Group Health is a non-profit health maintenance organization whose electronic records allow access to population-based samples of patients with chronic illnesses. Our research group embarked on a series of NIMH funded studies beginning in 2000 studying the interaction between depression and diabetes. We proposed in this early work that depression was associated with an adverse bidirectional interaction in patients with diabetes. Depression early in life was posited to be associated with a higher risk of several adverse health behaviors including smoking, sedentary lifestyle, development of obesity as well as psychophysiologic changes such as dysregulation of the hypothalamic pituitary axis, and autonomic nervous system and an increase in inflammatory markers. These psychophysiologic changes and adverse health behaviors may lead to increased risk of development of obesity, problems with decreasing insulin sensitivity, and type 2 diabetes. Depression has also been associated with poor adherence to self-care regimens such as diet, exercise and taking medications regularly[1], and when coupled with the adverse psychophysiologic changes described above may lead to an increased risk of complications and mortality from diabetes. Complications from chronic medical illnesses like diabetes and subsequent functional decline may subsequently lead to depression.

Our initial study, the Pathways Epidemiologic Study, screened over 7000 patients from 9 Group Health clinics attaining a response rate of approximately 62%. We demonstrated in this early research that the prevalence of major depression in these 4800 patients was 12% and the prevalence of minor depression was 8.5%.[2] Patients with major depression and diabetes compared to those with diabetes alone developed type 2 diabetes 5 to 6 years earlier supporting data suggesting depression is a risk factor for type 2 diabetes.[2] Recent reviews of prospective epidemiologic studies have shown that depression early in life is associated with an increased risk of development of both diabetes[3] and coronary artery disease[4].

Our initial goals were to study the impact of depression on diabetes symptom burden, functional impairment, and health risk behaviors. We published a series of papers demonstrating that patients with comorbid depression and diabetes compared to those with diabetes alone had a 2 to 5 -fold greater risk of reporting all ten diabetes symptoms from a standard diabetes symptom scale even after controlling for socioeconomic status, HbA_{1c}, diabetes complications and other medical comorbidity.[5] An interesting point to emphasize in this study was that patients who had two or more diabetes complications compared to those with 0 to 1 complication also had a higher risk of having nine out of ten of these symptoms, but the increased risk of each symptom was only 25% to 2-fold higher.[5] Patients with HbA_{1c} levels greater than 8.0% compared to those $\leq$8.0% had a significantly higher prevalence of only having four of these symptoms. Thus, depression in patients with comorbid depression and diabetes is actually a better predictor of diabetes symptom burden than physiologic control of diabetes based on blood sugar levels or number of diabetes complications.

We also examined the effect of depression among patients with diabetes compared to those with diabetes alone on the mean number of reduced household work days[6] and the mean number of days of reduced work from paid labor[7]. In both of these papers, we demonstrated that comorbid depression was associated with additive or more than additive number of days of missed work.

In terms of the effect of comorbid depression on health risk behaviors, we found that there was a significantly higher risk among patients with both comorbid minor depression and major depression in patients with diabetes of being smokers, of having BMI greater than 30 kg/m^2, and of having HbA_{1c} above 8%.[2] In each of these analyses a dose response effect was seen i.e. increasing severity of comorbid depression was associated with a higher risk of being smokers, having BMI >30 kg/m^2 and higher HbA_{1c} levels compared to nondepressed diabetic patients. Virtually all patients in our study filled all of their prescriptions at Group Health pharmacies because of low co-pays and we demonstrated that diabetic patients with comorbid depression compared to those with diabetes alone had a higher percentage of nonadherent days over a 1-year period based on refills of prescriptions for oral hypoglycemics, lipid lowering medications and Ace inhibitors.[8] In addition, we examined the effect of comorbid depression on the eight Framingham risk factors for the development of heart disease.[9] This is especially important in patients with diabetes because approximately 50-75% of diabetics die of cardiovascular disease and stroke. We found in our sample of over 4000 patients with diabetes that major depression was associated with an almost 2-fold greater risk of having three or more of these eight Framingham cardiac risk factors.[9]

The above data on adverse health risk behaviors among patients with diabetes and depression, poor adherence to treatment as well as having the higher percentage with multiple Framingham risk factors should place these patients at increased risk of higher medical costs and adverse diabetes outcomes. We have shown that patients with major depression and diabetes compared to those with diabetes alone have approximately 50% to 70% greater total medical costs after controlling for socioeconomic and medical disease severity.[10] We also have now shown in two separate populations of patients with type 2 diabetes that comorbid depression is associated with an increased risk of mortality.[11, 12]

After this initial study, we were awarded a second NIMH epidemiologic grant to complete a five-year follow-up of our initial cohort of over 4000 patients with diabetes. We have been able in this grant to continue testing the hypothesis that posited that there are bidirectional adverse interactions between depression and diabetes. We are currently examining in several analyses the adverse effects of depression on increasing risk of macrovascular and microvascular complications over the five year period as well as the risk associated with depression with poor blood pressure, lipid and glycemic control. Our preliminary analyses have shown that depression increases risk of subsequent macrovascular and microvascular complications. We have also confirmed in these initial analyses the increased risk in mortality associated with major depression. We have also shown that both severity of depressive symptoms, number of diabetic symptoms at

***Katon**, continued on page 5*

***Katon**, continued from page 4*

baseline and incident cardiovascular events and procedures over the 5-year period were the best predictors of major depression at 5-year follow-up.[13] Approximately 80% of patients with major depression at 5-year follow-up met criteria for either minor or major depression at baseline emphasizing the chronicity or high rate of relapse of depression in patients with comorbid depression and diabetes.

In addition to these studies, we have now completed two large grants in which we tested a depression collaborative care intervention versus usual primary care in patients with comorbid major depression and/or dysthymia with diabetes treated within primary care systems.[14, 15] Both of these trials (Pathways and IMPACT) tested an intervention which included behavioral activation, a depression care manager who provided an initial patient choice of starting with antidepressant medication or problem solving treatment in primary care, a stepped-care algorithm so that if patients were not responding to initial antidepressant medications, they could receive a different antidepressant or be augmented with problem-solving therapy and vice-versa, and a relapse prevention package.[14, 15] The depression care managers were supervised weekly by a psychiatrist who reviewed outcome data from an electronic depression case registry. This multimodal intervention was shown in both studies to not only improve quality of depression care and depression outcomes over the first twelve months when the intervention was being provided compared to usual care but in fact the beneficial effect on depressive symptoms extended for the next one-year period. In addition, patients in the intervention arm were significantly more satisfied with treatment for depression compared to controls and were 30% more likely than usual care patient to state that they were "very much" to "completely" improved.[14, 15] In both of these studies, the HbA_{1c} levels that patients started with were relatively low to begin with (i.e. 7.8 to approximately 8.0%) and the intervention was not associated with decreased HbA_{1c} levels compared to patients in the usual care arm over a 12-month period.

We have now published two papers on the cost effectiveness analyses from these studies and demonstrated in both studies that the increased mental health intervention costs of approximately $500-$700 which were largely in the first year of treatment were offset by greater savings in total medical costs over a two-year period.[16, 17] We have also extended these findings to a five-year period in one of the two studies and have shown the same trends for total medical cost savings in years 3-5 that we demonstrated in the first two years.[18] It appears that enhanced treatment of depression in patients with comorbid depression and diabetes puts patients on a different trajectory of medical costs over the next two to five years compared to usual care patients, potentially leading to cost savings in medical systems.

The above data showing the effectiveness of collaborative care for improving outcomes of depression but no association of improved depression outcomes with HbA_{1c} levels has lead our research group to posit that treating depression is a necessary first-step that is often not sufficient alone to help patients improve self-care activities such as adhering to diet, exercise, cessation of smoking, checking blood glucose levels, and prescription medication. That has led our research group to test a new model of care, TeamCare, in a new NIMH-funded study.

In this new study we screen patients with diabetes and/or coronary artery disease for poor disease control (i.e. $HbA_{1c} \geq 8.5\%$, blood pressure > 140/90, LDLs > 130) and if they have evidence of poor disease control they are then screened for depression. Those with major depression and/or dysthymia and poor disease control are then randomized to an intervention aimed at improving both quality of depression care, improving self-care activities and improving medical disease control. We have trained diabetes nurseeducators to provide this intervention and completed recruitment in October 2008. Results of this study should be available by fall of 2009.

> *It appears that enhanced treatment of depression in patients with comorbid depression and diabetes puts patients on a different trajectory of medical costs ...*

Overall, this series of studies have provided a fascinating lens into the interaction of brain and body and provided us with a unique perspective of the difficulties patients and physicians have in managing the potential adverse bidirectional interactions between these illnesses.

**references available from APS upon request*

APS 67th Annual Scientific Meeting

"Psychosomatic Research and Care Across the Life Course"

Register Now at
www.psychosomatic.org

Meeting Highlights include ~

Plenary Sessions:
* Developmental Processes from Early Life into Adulthood * Mid-life Transitions * Processes of Aging: From Molecules to Organisms to Persons *

Workshops:
* Epidemiological Cohort Research * Statistics: Longitudinal Analyses * Grant Writing *

Paper Session topics:
* Risk and Prognosis * Inflammation * Depression & Heart * Cancer * Behavior and Risk Factors * Asthma * Somatization * HPA Axis * Sleep * Pain * Hypertension * Stress & Heart *

Roundtable Discussion topics:
* Genetics * Early Life Stress * Measuring Symptoms * Hypnosis * Career Development * Women's Health/ Mid-Life Transitions * Dissemination of Evidence-Based Behavioral Interventions * PROMIS * Successful Aging * Cancer * Bioethics *

Special Interest Group topics:
* Clinicians * Ethnic Disparities * Neuroscience * Functional Somatic Syndrome * and Psychoneuroimmunology *

*** Town Hall Meeting to Discuss APS's Identity * Poster Sessions * Mentoring Program..and more!**

March 4 - 7, 2009 ~ Marriott Downtown, Chicago, IL USA

Choosing our Leaders

Doug Carroll, PhD
Daichi Shimbo, MD

Keen readers of the APS Newsletter will have seen the recent letters from senior members of the Society and heard the considerable debate surrounding the issue of the governance of the Society and, in particular, how we choose our leaders. Currently, nominations for leadership roles are sought from members and these and other potential candidates are reviewed by the Nominations Committee, currently comprising the President, immediate Past President, President Elect and three at-large members. The Nominating Committee then chooses a single candidate for each vacant leadership position and presents this slate to the Business Meeting at the Annual Business Meeting for ratification by the members present.

Early in 2008, Council resolved to review this process and established a Task Force that studied the procedures used by other learned societies and took soundings from the membership and a broad range of expert opinion both within and outside our Society. On the basis of its deliberations, the Task Force placed two options for change in front of Council during the September meeting. Both options included a revision in the make-up of the Nominating Committee, which would

> *A key change from existing practice...is that there will be elected seats on the Nominating Committee chosen by ballot of the membership...*

operate using explicit criteria approved by Council. Both also identified the need to communicate information on candidates for leadership vacancies to the membership and for web-based balloting of the membership.

The option eventually chosen by Council contained the following five propositions.

1. ***The Nominating Committee will be comprised of the current president (chair), immediate past-president, a Council member, and 3 at-large members***. At any given time, no more than 1 of the at-large members may be a past-president. The term for the Council member on Nominating Committee will be 1 year.

2. ***Nominating Committee will employ stated criteria***. Some of these criteria will be general qualifications that are applied each year and other criteria will be flexible from year-to-year as circumstances change and particular needs are identified. All criteria will be discussed and approved beforehand by Council.

3. ***Normally two qualified candidates will be named for each of the elected seats on the Nominating Committee***. Two candidates will be named for the 3 at-large Nominating Committee member positions and the Council member position on the Nominating Committee. The Nominating Committee will continue to select a single nominee for the positions of President-Elect, Secretary Treasurer, and Council. As described in our by-laws, a petition process exists for adding names to the ballot.

4. ***General membership will elect leaders via web-based balloting*** in the weeks leading up to the Annual Meeting.

5. ***Information on candidates will be made available.*** Information will be distributed to all members at the time of the election and will consist of a) brief professional history, b) list of qualifications in positions of leadership generally and, specifically, roles in other non-profit organizations, c) history of membership, activities and roles in the APS, and d) brief personal statement related to the position sought.

A key change from existing practice, as you can see, is that there will be elected seats on the Nominating Committee chosen by ballot of the membership normally from among two candidates per seat. For other leadership positions there will remain only one candidate on the ballot.

The society's nominations and elections procedures are enshrined in its by-laws. Accordingly, revisions to our by-laws to accommodate these changes to our nominations and elections procedures were passed by a vote of the membership late last year. Council believes that these are important and progressive changes, and very much capture its intention to increase membership involvement in the governance of the society. As Council members, we unreservedly commend them to you.

2008-2009 APS Psychosomatic Medicine Interest Groups

funded by the American Psychosomatic Society

UMDNJ-Robert Wood Johnson

University of California Davis School of Medicine

University of Minnesota Medical School Duluth

Eastern Virginia Medical School (EVMS)

Medical Faculty, University of Szeged, Szeged, Hungary

Klinikum rechts der Isar - Technical University Munich

Madrid Autonoma University

University of Toronto

University of Pennsylvania

North Shore-Long Island Jewish Health System, Albert Einstein College of Medicine

For information, please visit http://www.psychosomatic.org/ed_res/index.htm

2009 Slate of Nominees for Leadership Positions

On January 6th, the APS Council was pleased to announce to members the 2009 slate of nominees for election this Spring. These individuals were selected by the Nominating Committee from among all those nominated and included many qualified and highly-valued APS members. A description of the various qualifications and other considerations employed by the Nominating Committee is available on our website at http://www.psychosomatic.org/about/committee_Nominating.htm

Among other changes, you should note that most positions on the Nominating Committee will be chosen by the membership from among two or more candidates. This year, we will vote for one of two candidates for an at-large seat on the Nominating Committee, and also for one of two candidates for a Council member seat on the Nominating Committee. A single nominee for president-elect and each of the open Council seats is named below. Unless additional candidates are added by petition as outlined in our By-laws, those individuals will run uncontested.

Second, elections will be web-based for the first time. The election will take place during the weeks leading up to our March meeting. Watch for an email in late February about the election process. At that time, additional information will be posted regarding the background and qualifications of all candidates.

President-elect (1)
Paul Mills, PhD, University of California at San Diego
Paul brings many years of experience within APS leadership during which time he made innumerable valuable contributions. In addition to serving on Council, Paul chaired the Awards Committee for several years, served on Program Committee, and most notably wrote an NIH meeting grant that brought $100k to offset our annual meeting costs and support our APS Scholars Awards (given to promising young investigators). Paul's leadership and interpersonal skills have been particularly notable and should help facilitate good working relationships among the executive committee, Council, standing committees, journal staff and Society administrators.

Council members (3)
Jos Brosschot, PhD, University of Leiden, The Netherlands
Gaston Kapuku, MD, PhD, Medical College of Georgia, and
Karen Weihs, MD, University of Arizona

These three nominees for Council were selected for their general leadership within our field and also for the representation they would bring to Council. More specifically, considering the composition of Council after outgoing members depart it was considered important to maintain or increase representation of individuals working in non-cardiovascular research, physicians, persons of color, and those residing outside the US.

Nominating Committee Member-at-large (1)
Roland von Känel, MD, Univ Hospital Inselspital, Switzerland and
Francis Creed, MD, Manchester Royal Infirmary, England

The current Nominating Committee does not include any non-US members yet 28% of current members are international. With that in mind, the current nominees for Nominating Committee member-at-large were selected for their history of active contributions to the Society as well as for being residents of non-US countries.

Nominating Committee Council Member (1)
Willem Kop, PhD, University of Maryland and
Martica Hall, PhD, University of Pittsburgh

The choices for Council member on the Nominating Committee were based upon breadth of professional contacts, level of engagement in the organization, and contributions to recent discussions of the elections process.

The Society is grateful for the contributions of its leaders who will complete their terms this March. That includes immediate past president, Bill Lovallo, Council members, Mustafa al'Absi, Susan Girdler and Roland von Känel, Program Chair, Christoph Herrmann-Lingen, and Nominating Committee member-at-large, Margaret Chesney. These individuals and other out-going committee chairs will be recognized at the Business meeting in Chicago.

Calendar

March 4-7, 2009 in Chicago, Illinois, USA ~ 67th Annual Scientific Meeting of the American Psychosomatic Society. For information please contact info@psychosomatic.org or 703-556-9222.

April 22 - 25, 2009 in Montreal, Quebec Canada ~ 30th Annual Meeting & Scientific Sessions of the Society of Behavioral Medicine. For information, please contact Holland Marie LaFave at 414-918-3156 or visit www.sbm.org

March 10-14, 2010 in Portland, Oregon, USA ~ 68th Annual Scientific Meeting of the American Psychosomatic Society. For information please contact info@psychosomatic.org or 703-556-9222.

AMERICAN PSYCHOSOMATIC SOCIETY

6728 Old McLean Village Drive
McLean, VA 22101-3906
(703) 556-9222
FAX (703) 556-8729
Email: info@psychosomatic.org
www.psychosomatic.org

APS 67th Annual Scientific Meeting

"Psychosomatic Research and Care Across the Life Course"

March 4 - 7, 2009
Marriott Downtown
Chicago, IL USA

The APS Newsletter is published 3 times a year by the American Psychosomatic Society with the cooperation of Degnon Associates.

Comments and Suggestions are invited. Remember, this is YOUR Newsletter.

The deadline for submission for our next Newsletter is March 16.

Please send correspondence to the APS Newsletter Editor
Mary-Frances O'Connor, PhD
6728 Old McLean Village Drive
McLean, VA 22101-3906
Fax: 703-556-8729
Email: info@psychosomatic.org