SYLLABUS &

SYLLABUS & PROCEEDINGS SUMMARY

PROCEEDINGS SUMMARY

American Psychiatric Association
Annual Meeting • May 17-22, 1997
San Diego, California

FOR YOUR RECORDS

The Certificate of Attendance below is for your personal records.

This is to certify that

_____

was a registered
participant at the
150th Annual Meeting of the APA,
San Diego, CA, May 17-22, 1997
President's Theme: Strengthening Psychiatry's Dedication and Commitment to:
Compassionate Care • Educational Excellence • Creative Research

and participated in _____ hours of Category 1 CME activities during the meeting.

Harold I. Eist, M.D.
APA President

Melvin Sabshin, M.D.
Medical Director

Robert T.M. Phillips, M.D., Ph.D.
Deputy Medical Director

This certificate provides verication of your completion of CME activities at the APA Annual Meeting.

The American Psychiatric Association (APA) is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

The APA designates this continuing medical education activity for up to 66 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association and for the CME requirement of the APA. One hour of credit may be claimed for each hour of participation.

DAILY LOG FOR ATTENDANCE AT CME FUNCTIONS AT THE ANNUAL MEETING OF THE AMERICAN PSYCHIATRIC ASSOCIATION, May 17-22, 1997 San Diego, CA.

Members are responsible for keeping their own CME records and certifying compliance with the APA CME requirement to the APA Office of Education *after* completing the necessary 150 hours of participation. Reporting is on an honor basis. **No formal verification is needed.**

DAY	COURSE OR SESSION TITLE	# OF HOURS/CME CATEGORY
	TOTAL	

The APA's Continuing Medical Education Requirement

The Requirement

By referendum in 1974, the membership of the American Psychiatric Association (APA) voted to have participation in Continuing Medical Education (CME) activities be a condition of membership. The CME requirement aims at promoting the highest quality of psychiatric care through encouraging continuing professional growth of the individual psychiatrist.

Each member must participate in 150 hours of continuing medical education activities per three-year period. Of the 150 hours required, a minimum of 60 hours must be in Category 1 activities. Category 1 activities are sponsored or cosponsored by organizations accredited for CME and meet specific standards of needs assessment, planning, professional participation and leadership, and evaluation of learning.

In December 1983 the Board of Trustees ratified a change in reporting CME activities. Although the basic requirement of 150 hours every three years (with at least 60 hours in Category 1) remains the same, members no longer need to report these specific activities but need only sign a compliance statement to the effect that the requirement has been met.

Individual members are responsible for maintaining their own CME records and submitting a statement of their compliance with the requirement after completing the necessary 150 hours of participation. Members will be reminded and sent blank compliance statements when they are next due to confirm compliance with the requirement. APA certificates are issued only upon receipt of a complete report of CME activities; to receive an APA certificate you can submit a completed APA report form or use one of the alternate methods detailed below.

Obtaining an APA CME Certificate

You can obtain an APA CME certificate by using one of the following methods:

If you are licensed in California, Delaware, Hawaii, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Nevada, New Hampshire, New Mexico, Ohio, or Rhode Island, you may demonstrate that you have fulfilled your APA CME requirements by *sending the APA a copy of your reregistration of medical license*. These states have CME requirements for licensure that are comparable to those of the APA. Your APA certificate will be valid for the same length of time as the reregistration.

If you hold a current CME certificate from a state medical society having CME requirements comparable with those of the APA, you may receive an APA CME certificate by *sending the APA a copy of your state medical society CME certificate*. The APA will issue a CME certificate valid for the same period of time. The state medical societies currently having CME requirements comparable to those of the APA are Arizona, California, Florida, Kansas, New Jersey, Oregon, Pennsylvania, and Vermont.

If you have a current AMA Physician's Recognition Award (PRA), *forward a copy of your PRA to the APA* and you will receive an APA CME certificate with the same expiration date.

You also may *report your CME activities directly to the APA*, using the official APA report form. This form may be obtained from the APA Office of Education, 1400 K Street, N.W., Washington, D.C. 20005; (202) 682-6179.

APA Report Form

CME credits are reported to the APA Office of Education by Category as described below.

Category 1—Continuing Medical Education Activities with Accredited Sponsorship (60 hours minimum, no maximum). Category 1 activities are sponsored or cosponsored by organizations accredited for CME and meeting specific criteria of program planning and evaluation. Fifty hours of Category 1 credit may be claimed for each full year of internship, residency or fellowship training taken in a program that has been approved by the Accreditation Council for Graduate Medical Education (ACGME). Fifty hours of Category 1 credit (25 hours each for Parts I and II) may be claimed for the successful completion of the certification examinations of the American Board of Psychiatry and Neurology or the Royal College of Physicians and Surgeons of Canada. In addition 25 hours of Category 1 credit may be claimed for the successful completion of each of the following certifying examinations: Addiction Psychiatry, Administrative Psychiatry, Child Psychiatry, Forensic Psychiatry, and Geriatric Psychiatry. The other 90 credits may be taken in additional Category I activities or spread throughout activities in Category II.

Category 2—Some programs are presented by accredited sponsors, but do not meet the criteria for Category 1 and therefore are designated as Category 2. Activities included in Category 2 are: medical teaching, reading of professional literature, preparation and presentation of papers, individual study programs, consultation and supervision, and preparation for board examinations. You may claim credit for activities in Category 2 on an hour-for-hour basis.

Exemptions

All APA Life Fellows and Life Members who were elevated to that membership category on or before May 1976 are exempt from the CME requirement, but are urged to participate in CME activities. Members who became Life Members or Fellows after that date are not exempt.

Members who are retired are exempt from the requirement when the APA receives notification of their retirement. Any member who is inactive, ill or disabled may request an exemption from the CME requirement by applying to his or her District Branch Membership Committee. After determination that partial or total exemption from CME activities is warranted, the District Branch Membership Committee will forward its recommendation to the APA Office of Education. Application forms for exemption are available from the district branches, the Office of Education of the APA, or at the Office of Education exhibit in the APA Resource Center.

APA members residing outside the United States are required to participate in 150 hours of CME activities during the three-year reporting period, but are exempted from the categorical requirements.

CONTINUING MEDICAL EDUCATION
SYLLABUS
AND
SCIENTIFIC PROCEEDINGS

IN SUMMARY FORM

THE ONE HUNDRED AND FIFTIETH
ANNUAL MEETING OF THE
AMERICAN PSYCHIATRIC ASSOCIATION

San Diego, CA

May 17-22, 1997

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May 1997

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FOREWORD

This book incorporates all aspects of the *Scientific Proceedings in Summary Form* as published in previous years and, additionally, information required to be published as a syllabus for continuing medical education.

Readers should note that most summaries are accompanied by a statement of educational objectives, and a list of references for each session or individual paper.

We wish to express our appreciation to the authors and other contributors for their cooperation in preparing the necessary materials so far in advance of the meeting. Our special thanks are also extended to Patricia Turgeon, Sheena Majette, and Roberta Walker in the Office to Coordinate Annual Meetings.

Sidney H. Weissman, M.D., *Chairperson*
Richard Balon, M.D., *Vice-Chairperson*
Scientific Program Committee

Full Texts

As an added convenience to users of this book, we have included mailing addresses of authors. **Persons desiring full texts should correspond directly with the authors.** Copies of papers are not available at the meeting.

1997 ANNUAL MEETING
TOPIC AREAS FOR THE SCIENTIFIC PROGRAM

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2. Alcohol and Substance Abuse Disorders
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7. Infant and Childhood Disorders
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50. Couple and Family Therapies
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GUIDE TO USING THE TOPIC INDEX

Use this index to find sessions of interest to you. There are four overall topics: Disorders, Practice and Subspecialty Areas, Treatments, and Other Issues. Under each overall Topic, you will find the formats (type of session) listed alphabetically. Within each format you will find the individual presentation or sessions listed by number.

TOPIC INDEX

DISORDERS

PRACTICE AREAS

SUBSPECIALTY AREAS OR SPECIAL INTERESTS

TREATMENTS

OTHER ISSUES

Harold I. Eist, M.D.

PAPER NO. 1: PRESIDENTIAL ADDRESS

Strengthening Psychiatry's Commitment to: Compassionate Care, Educational Excellence and Creative Research

Compassionate care, educational excellence, and creative research are the hallmarks of American psychiatry. They are the pillars that form the enduring foundation of our field. The logo for the APA Annual Meeting in San Diego, however, includes three sails, not pillars, reflecting dynamic movement and energy, progress and change. Our three sails have enormous strength and flexibility. They are responsive, not rigid. Current political, insurance, and business practices threaten the care of our patients and the integrity of our field as never before.

We have been required, in the face of this looming devastation, to marshal our impressive array of strengths.

In mobilizing these strengths, we have significantly improved the morale of our organization and focussed, for the first time in our history, all of our components on six key initiatives: **1) Building ever-expanding strategic alliances**—through public, corporate, and small business education; **2) Ethics**—our sword and armor; **and confidentiality**—the *sine qua non* of the doctor-patient relationship; **3) Managed care**—bringing its depredations under control; **4) Legislation and litigation**—we need laws to control "market excesses" and promote equity; **5) Medical education and research**—critical not only to future generations of our people but to all peoples of the world and; **6) The AMA**—we are increasing our influence in the house of medicine and need its ongoing support to succeed with our initiatives.

Gazing at the sailboats on beautiful San Diego Bay will serve as a reminder of the storm-tossed seas we have traversed, the perilous times ahead, and that we are winning.

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PAPER SESSION 1—CURRENT ISSUES IN BIOLOGICAL PSYCHIATRY

No. 2
DOPAMINE BETA-HYDROXYLASE ACTIVITY IN PTSD

Mark B. Hamner, M.D., *Department of Psychiatry, RH Johnson VAMC, 109 Bee Street (116A), Charleston SC 29401-5703;* Paul Gold, Ph.D.

EDUCATIONAL OBJECTIVES:

To recognize the clinical relevance of psychotic and nonpsychotic subtypes of PTSD and the potential role of DBH as a biological marker for these subtypes.

SUMMARY:

Objective: Recognition and treatment of chronic psychotic features associated with post-traumatic stress disorder (PTSD) are of increasing clinical interest. Altered dopamine beta-hydroxylase (DBH) activity as a function of psychosis has been reported in mood disorders, which are also frequent in the comorbidity of PTSD. We therefore evaluated DBH activity in PTSD patients with and without psychotic features as well as in another chronic psychotic population, those with schizophrenia.

Methods: Thirty-seven patients meeting DSM-III-R criteria for PTSD or schizophrenia (using the SCID-P) had DBH enzyme activity assayed photometrically and completed vital signs and appropriate clinical rating scales including the Clinician Administered PTSD Scale (CAPS) and Positive and Negative Syndrome Scale (PANSS).

Results: DBH was significantly higher in PTSD patients with psychotic features than in patients without psychotic features (80.6 ± 13.4 versus 42.1 ± 7.3 uM/min, $t = 2.76$, $df = 15$, $p < 0.01$). DBH was also significantly elevated in the PTSD group compared with the schizophrenia group (52.7 ± 7.61 versus 6.63 ± 4.1 uM/min, $t = 5.26$, $df = 35$, $p < 0.0001$). There were no significant correlations with age, vital signs, or PANSS or CAPS scores.

Conclusions: DBH activity may differentiate psychotic and nonpsychotic subtypes of PTSD. Since DBH is a genetic marker, this may reflect individual vulnerabilities to developing psychosis in the context of trauma.

REFERENCES:

1. Hamner MB, Fossey MD: Psychotic symptoms associated with post-traumatic stress disorder. *Neuropsychopharmacology,* 9:121S-122S, 1993.
2. Matuzas W, Meltzer HY, Uhlenhuth EH, et al: Plasma dopamine-betahydroxylase in depressed patients. *Biol Psychiatry,* 17:1415-1424, 1982.

No. 3
UNDERLYING DIAGNOSIS AND RESPONSE TO LORAZEPAM

Patricia I. Rosebush, M.D., *Department of Psychiatry, McMaster University, HSC-3G15/1200 Main West, Hamilton ON L8N 3Z5, Canada;* Michael F. Mazurek, M.D.

EDUCATIONAL OBJECTIVES:

To appreciate that catatonic patients with psychiatric illnesses other than schizophrenia are extremely responsive to treatment with lorazepam; to recognize that patients who develop catatonia in the context of an underlying medical/neurological disorder are also very responsive to benzodiazepine therapy.

SUMMARY:

Objective: The catatonic syndrome may respond dramatically to treatment with lorazepam. We determined the relationship between responsiveness to lorazepam and the primary underlying diagnosis in 80 patients who presented to our psychiatry service over an eight-year period.

Methods: Patients had to have evidence of four or more of the following catatonic signs: immobility, staring, mutism, rigidity, withdrawal, posturing/grimacing, negativism, waxy flexibility, echolalia, echopraxia, stereotypy, and verbigeration. They were observed for 24 hours prior to treatment with lorazepam 1-2 mg.

Results: 35 patients with underlying affective disorders were treated with lorazepam; in 34 (97%) the catatonia resolved within one to three hours. Twenty patients had schizophrenia; only seven (35%) responded, and of 15 patients with brief reactive psychosis, paranoid disorder, or atypical psychosis, 13 (87%) responded to lorazepam. Seven patients developed catatonia secondary to benzodiazepine withdrawal and all responded. Fourteen patients with catatonia were found to have primary underlying neurological or medical disorders including normal pressure hydrocephalus, viral encephalitis, adult GM_2 gangliosidosis, multi-infarct dementia, senile dementia, AIDS, NMS, paraneoplastic syndrome, temporal lobe epilepsy, or an uncharacterized neurodegenerative disorder. In 13 of these 14 patients (92%), the catatonia responded fully to lorazepam treatment.

Conclusion: Retarded catatonia is exquisitely responsive to low-dose lorazepam unless the underlying diagnosis is schizophrenia.

REFERENCES:

1. Rosebush PI, MacQueen GM, Mazurek MF: Late-onset Tay-Sachs disease presenting as catatonic schizophrenia: diagnostic and treatment issues. *Journal of Clinical Psychiatry* 56:8:347-353, 1995.
2. Rosebush PI, Mazurek MF: Catatonia secondary to benzodiazepine withdrawal. *Journal of Clinical Psychopharmacology* 16:315-319, 1996.

No. 4
A DECISION ANALYSIS MODEL OF NEUROLEPTIC DOSAGE

Douglas Mossman, M.D., *Department of Psychiatry, Wright State University, P.O. Box 927, Dayton, OH 45401-0927.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will understand how published data can be used to develop mathematical models of treatment response and side effects, be aware of the relationship between dose increases, response rates, and side effects, and recognize how decision analytic methods can influence dosing strategies.

SUMMARY:

Background: Although several published studies suggest that little benefit accrues from raising doses of "conventional" antipsychotic drugs above 500-800 chlorpromazine equivalents per day (CPZeq/d), institutionized patients with schizophrenia often receive larger doses. Decision analysis could alter this practice by helping clinicians select doses using quantitative models that incorporate the consequences of each dose, the likelihood of those consequences, and explicit risk-benefit weightings.

Method: This study representative published data to develop equations and graphs that describe dose-associated likelihoods of treatment response, side effects, and balances between benefits and incidence of side effects.

Results: Response rates fit a sigmoid curve that flattens at 500 CPZeq/d; a hyperbolic curve describing side effects reaches a plateau at much higher doses. Combining these curves creates a function showing that higher drug doses yield ever-diminishing returns, be-

cause as the dose increases, the numbers of side effects per benefitted patient also increases. Tables and graphs show clinicians how to use these results to critique their current practices and make explicit risk/benefit judgments about dosages.

Conclusion: Mathematical expressions for dose-related side effect and response rates are potentially useful tools for evaluating low-, intermediate-, or high-dosage neuroleptic treatment regimens.

REFERENCES:

1. McEvoy JP, Hogarty GE, Steingard S: Optimal dose of neuroleptic in acute schizophrenia: a controlled study of the neuroleptic threshold and higher haloperidol dose. *Arch Gen Psychiatry,* 48:739-745, 1991.
2. Bollini P, Pampallona S, Orza MJ et al: Antipsychotic drugs: is more worse? a meta-analysis of the published randomized control trials. *Psychological Medicine* 24:307-316, 1994.

PAPER SESSION 2—CRITICAL FACTORS IN THE TREATMENT OF DEPRESSION

No. 5
THE TIMING OF ANTIDEPRESSANT RESPONSE

Eric D. Peselow, M.D., *Department of Psychiatry, NYU School of Medicine, 32 Bassett Avenue, Brooklyn NY 11234;* Ronald R. Fieve, M.D., Lara Fieve, B.A., Nunzio Pomara, M.D.

EDUCATIONAL OBJECTIVES:

To present clinical data from several placebo-controlled drug studies to inform clinicians about true drug response pattern and to give the clinician clues to length of antidepressant drug trials.

SUMMARY:

Objective: The time to antidepressant response is an important issue in the management of the depressed patient. Though it has been frequently written that it often takes four to six weeks before the drug exerts its therapeutic effect, there has been little work done concerning either pattern of antidepressant response or length of time needed for antidepressant response. The purpose of this report is to analyze patterns of antidepressant response in patients who participated in one of several antidepressant/placebo trials.

Method: Our group conducted eight six-week, double-blind, placebo-controlled antidepressant trials involving almost 500 patients. Approximately 350 patients were treated for at least six weeks with an antidepressant (TCA, SSRI, or experimental agent) or placebo. Pattern analysis as defined by Quitkin et al. was employed. Based on CGI improvement at weeks 1-6, the patient was defined as a responder (CGI score of 2 or 1) or nonresponder (CGI of 3-7). If the patient improved to a CGI of 2 by one-step increments (i.e. had CGI of 4 one week, then CGI of 3, the next week, and then CGI of 2) he was considered a gradual responder; if he went from a CGI of 4 to 2 in one step, he was considered an abrupt responder; patients were subdivided as to whether they exhibited early (response in first two weeks) or late response (weeks 3-6). Response was also subdivided into persistent (CGI of 2 once reached was sustained) or nonpersistent.

Results: Overall, the major pattern of differential response was a pattern of gradual response that persisted. Patients who gradually responded by weeks 2, 3, and 4 tended to be on drug (29%) vs. placebo (7%). Patients who never responded tended to be on placebo (45%) vs. drug (23%). Other patterns did not differentiate. In addition complete nonresponse to drug at four weeks augured for no response at six weeks.

Conclusion: The importance of the above pattern analysis findings will be discussed.

REFERENCES:

1. Quitkin FM, et al: Identification of true drug response: use of pattern analysis. *Arch Gen Psychiatry* 41:782-786, 1984.
2. Khan A, et al: Onset of response in relation to outcome in depressed outpatients treated with placebo and imipramine. *Journal of Affective Disorders* 17:33-38, 1989.

No. 6
FAMILY FUNCTIONING, RECOVERY, AND CHRONIC DEPRESSION

Gabor I. Keitner, M.D., *Department of Psychiatry, Rhode Island Hospital, 593 Eddy Street, Providence RI 02903;* Christine E. Ryan, Ph.D., Erinn Dawson, M.A., Ivan W. Miller, Ph.D., Martin B. Keller, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be more aware of the significant family dysfunction that accompanies chronic depressions and improvements brought about with pharmacotherapy.

SUMMARY:

As part of a multisite clinical trials study we examined family functioning in outpatients diagnosed with chronic depression (N = 96) or double depression (N = 91) at baseline interview and after 12 weeks of randomized treatment with imipramine or sertraline. At the acute stage, patients with chronic depression rated all family dimensions on the Family Assessment Device (FAD) as unhealthy; those with double depression rated all but one dimension (Behavior Control) as unhealthy. After 12 weeks of treatment, those with chronic depression viewed their family's functioning as significantly improved in all seven family dimensions, while patients with double depression improved significantly in only two dimensions. Since depressive symptoms improved equally in both groups from baseline to week 12, the change in family functioning is not due to symptom change alone. After 12 weeks of pharmacotherapy the recovery status of both groups of depressed patients was significantly associated with improvement in six of the seven FAD dimensions. Finally, when compared with a sample of major depressed inpatients, outpatients with chronic or double depression perceived a similar degree of family dysfunction.

In conclusion, patients with chronic forms of depression experience considerable family dysfunction. Even though pharmacotherapy for these depressions is associated with significant improvement in perception of family functioning, chronically depressed patients continued to report several problem areas of family life.

REFERENCES:

1. Keitner GI, Ryan CE, Miller IW, et al: Role of the family in recovery and major depression. *Am J Psychiatry* 152:1002-1008, 1995.
2. Kocsis JH, Frances AJ., Voss C, et al: Imipramine and social-vocational adjustment in chronic depression. *Am J Psychiatry.* 145:997-999, 1988.

No. 7
SUICIDALITY IN MIXED VERSUS PURE MANIA

Joseph F. Goldberg, M.D., *Department of Psychiatry, Payne Whitney Clinic, 525 East 68th Street, New York NY 10021;* Jessica L. Garno, B.S., Andrew C. Leon, Ph.D., James H. Kocsis, M.D.

EDUCATIONAL OBJECTIVES:

Participants will understand the relationship between suicide risk and bipolar illness as a function of depressive severity in mania, and

also recognize the prognostic importance of suicidality in predicting acute remission from a manic episode.

SUMMARY:

Objective: Recent reports have suggested that suicidal ideation arises more frequently during dysphoric or mixed mania than in pure mania. However, it remains an open question whether suicidality derives from the presence of depression alone or is a function of the overall severity of illness. It is also uncertain whether the presence of suicidality may have negative prognostic implications in the acute treatment of mixed mania. The current study evaluated prior suicide attempts and current suicidality among pure and mixed manic inpatients.

Method: 181 DSM-III-R bipolar I inpatients were rated as having pure or mixed manic features along standardized guidelines. Data were obtained from clinical records regarding previous suicide attempts, current symptoms, and time to remission using weekly Clinical Global Improvement (CGI) scores. Factors hypothesized to predict remission were assessed by logistic regression.

Results: 1) prior suicide attempts were more common in mixed (35%) than pure (9%) mania ($p < .05$), as was suicidal ideation during the current hospitalization ($p < .05$); 2) the likelihood of remission declined by 66% per week of hospitalization for each suicide attempt made prior to admission (OR = 0.44, 95% CI = 0.23 to 0.84); 3) suicidality was associated with a greater number of depressive symptoms ($r = .55$, $p < .001$) and more severe psychopathology at baseline ($r = .23$, $p < .01$); 4) suicidality was not more prevalent among rapid cyclers.

Conclusions: Suicidality is more common among bipolar patients with dysphoric mania and may be a function of severity of illness. Past suicidality may be a marker for future presentations of both mixed mania and recurrent suicidality. Suicidality is strongly associated with a delayed time course to remission from acute bipolar episodes.

REFERENCES:

1. Dilsaver SC, Chen Y-W, Swann AC, et al: Suicidality in patients with pure and depressive mania. *Am. J. Psychiatry* 151:1312-1315, 1994.
2. Strakowski SM, McElroy SL, Keck PE, Jr., et al: Suicidality among patients with mixed and manic bipolar disorder. *Am. J. Psychiatry* 153:674-676, 1996.

PAPER SESSION 3—DOES GENDER MATTER: ISSUES IN DIAGNOSIS AND TREATMENT

No. 8
DOES THE GENDER OF A PATIENT OR THE GENDER OF A THERAPIST IMPACT THE TREATMENT OF PATIENTS WITH MAJOR DEPRESSION?

Caron Zlotnick, Ph.D., *Department of Psychiatry, Butler Hospital, 345 Blackstone Boulevard, Providence RI 02906;* M. Tracie Shea, Ph.D., Irene Elkin, Ph.D.

EDUCATIONAL OBJECTIVES:

To demonstrate knowledge of the role of therapist gender and therapist-patient gender matching and mismatching in the process and outcome of therapy with depressed patients.

SUMMARY:

Objectives: Should patients be referred to the same gender therapist? Is gender of the therapist a critical factor? The present study investigated the role of gender in the process and outcome of therapy in the treatment of depressed patients.

Method: Subjects were 203 depressed patients who participated in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. All subjects received either interpersonal therapy, cognitive behavior therapy, imipramine plus clinical management, or placebo plus clinical management. Therapists included in this study were 20 males and seven females who, according to specific criteria, were deemed competent in their respective treatment approaches.

Results: The study found that among depressed patients, therapist gender and therapist-patient gender matching was unrelated to treatment process and outcome (i.e., post-treatment scores on the Hamilton Rating Scale for Depression, scores on the Empathy subscale of the Barrett-Lennard Relationship Inventory early in treatment and at termination, and dropout rates), controlling for type of treatment and severity of pretreatment depressive symptoms. Furthermore, interactions between the different groupings of therapist-patient by gender and the level of therapist's experience or whether therapists were younger or older than patients were not associated with treatment process and outcome. Also, patients who were matched with the gender of therapist whom they believed would be most helpful versus patients who were mismatched with the gender of therapist whom they believed would be most helpful did not respond differently to treatment. These findings were duplicated when examining the effects of gender within only the psychotherapeutic modes of treatment.

Conclusion: Our findings suggest that selected pairing according to gender of therapist, gender of patient, or even patients' beliefs about the gender of a therapist does not impact the treatment of patients with major depression.

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2. Kaplan AG: Female or male therapists for women patients: new formulations. *Psychiatry* 48:111-121, 1985.

No. 9
THERAPIST-PATIENT, RACE-SEX MATCH: A PREDICTOR OF TREATMENT DURATION

Joseph A. Flaherty, M.D., *Department of Psychiatry, University of Illinois, 912 South Wood Street, MC 913, Chicago IL 60612;* Susan Adams, M.S., Sonja D. Nelson, M.S.

EDUCATIONAL OBJECTIVES:

To enhance treatment program effectiveness through examination of provider databases; to demonstrate knowledge about the research literature on gender and ethnic match of patient and therapist.

SUMMARY:

Objective: The present study investigated the effect of therapist-client race and gender match on use of outpatient adult mental health services. Past investigations have typically explored the role of either race or gender in treatment.

Method: The sample consisted of patients who initiated outpatient (nonaddiction) treatment at the University of Illinois at Chicago department of psychiatry's adult services between July 1, 1995 and December 31, 1995. Excluding patients with less frequently occurring diagnoses, the final sample consisted of 213 African-American (156 female), 229 white (146 female), and 91 Hispanic (62 female) patients.

Results: Logistic regression analysis was performed for the dichotomous dependent variable, treatment dropout; and multiple regression analysis was run for the continuous dependent variable, length

of treatment. In both regression analyses, age, payment source, first language, and diagnostic grouping were entered as covariates. Match was a significant predictor of length of treatment ($p < .01$) and dropout ($p < .05$). Treatment was longer for race- and-sex-matched and sex-matched groups (respectively, 8.9 and 8.3 encounters) than for the nonmatched group (5.7 encounters). Subsequent analyses revealed that therapist-client sex and race matching was a stronger predictor of length of treatment for female than for male patients.

Conclusion: The implications of these findings for treatment assignment, patient satisfaction, and outcomes in traditional and managed care systems will be discussed.

REFERENCES:

1. Mogul KM: Overview: the sex of the therapist. *Am J Psychiatry* 139:1-11, 1982.
2. Flaskerud JH: Matching clients and therapist ethnicity, language, and gender: a review of research. *Issues Mental Health Nursing*, 11:321-336, 1990.

No. 10
SCHIZOPHRENIC AND DEPRESSIVE OUTCOME: DOES SEX MATTER?

Linda S. Grossman, Ph.D., *Department of Psychiatry, University of IL at Chicago, 912 South Wood Street (MC913), Chicago IL 60612;* Martin Harrow, Ph.D., James R. Sands, Ph.D., Joseph A. Flaherty, M.D.

EDUCATIONAL OBJECTIVES:

1) To inform psychiatrists about potential gender differences in course and outcome of major psychiatric disorders including schizophrenia, schizoaffective disorders, other psychotic disorders, and other nonpsychotic disorders. 2) To discuss implications of gender differences in patients followed up prospectively one decade after their initial hospitalizations for these major psychiatric disorders.

SUMMARY:

Objective: To determine whether gender is an important influence on clinical course and outcome in major psychiatric disorders, we followed up a large sample of patients, interviewing them as part of the Chicago Follow-up Study, to provide longitudinal data about their posthospital adjustment and functioning.

Method: We assessed a sample of 262 patients, including 73 schizophrenics, 39 schizoaffectives, 65 other psychotic patients, and 85 nonpsychotic patients. All patients were evaluated prospectively at index hospitalization and then followed up four times over the next 10 years. They were assessed for positive and negative symptoms, psychosocial functioning, rehospitalization, medication treatment, and overall outcome.

Results: 1) Female schizophrenia patients had significantly better overall outcomes and fewer completed suicides than males. 2) The same pattern of course and outcome emerged for the other psychotic patients. 3) In contrast to the schizophrenia patients, gender did not influence clinical course or outcome for the nonpsychotic patients. 4) When premorbid functioning was controlled, sex differences in outcome for the schizophrenics diminished.

Conclusions: The results emphasize the importance of gender analysis in studies of patients with major psychiatric disorders. The data indicate that gender differences in clinical course and outcome are influenced by a number of factors, including premorbid functioning, differing societal demands, treatment differences, and other differences. Patterns in long-term course and outcome for psychotic vs. nonpsychotic patients indicate that gender differences are diagnosis-specific.

REFERENCES:

1. McGlashan TH, Bardenstein KK: Gender differences in affective, schizoaffective, and schizophrenic disorders. *Schizophrenia Bulletin*; 16(2):319-329, 1990.
2. Bardenstein KK, McGlashan TH: Gender differences in affective, schizoaffective, and schizophrenic disorders: a review. *Schizophrenia Research*; 3:159-172, 1990.

PAPER SESSION 4—DILEMMAS IN MANAGED CARE

No. 11
BEHAVIORAL HEALTH PER MEMBER PER MONTH: HOW LOW CAN WE GO?

Bentson H. McFarland, M.D., *Department of Psychiatry, Oregon Health Science Univ, 3181 SW Sam Jackson Pk Rd, OPO2, Portland OR 97201*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize per-member per-month capitation rates that may be too low to provide minimally adequate behavioral health care.

SUMMARY:

Objective: Behavioral health carve-out firms are now quoting capitated payment rates below $3 per member per month (PMPM). The objective of this study was to determine whether or not adequate care can be provided at these low rates.

Method: The study is a simulation project focusing on a commercial population all of whose enrollees are under age 65. It is assumed that behavioral health clinicians provide services that, on average, conform to national guidelines. Incidence and prevalence of the major mental health and substance use disorders are derived from national psychiatric epidemiology data. Unit costs are based on data from the Milliman and Robertson actuarial firm.

Results: The model appears to be valid since in several scenarios using midrange parameter values it generates PMPM cost figures that are within 10% of those from a large health maintenance organization. Conversely, it is difficult to construct scenarios in which beneficiaries receive even minimally adequate behavioral health care with capitated payment rates below $2 PMPM.

Conclusion: Even in a commercial population it may not be feasible to deliver minimally adequate behavioral health care for less than $2 per member per month.

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2. McFarland BH: Ending the millennium. *Community Mental Health Journal* 32:219-222, 1996.

No. 12
SATISFACTION AMONG PRIVATE PRACTICE PSYCHIATRISTS: IMPACT OF MANAGED CARE

Martin A. Goldstein, M.D., *436 East 69th St., Apt 3E, New York NY 10021;* Thomas P. Kalman, M.D.

EDUCATIONAL OBJECTIVES:

To inform participants regarding economic characteristics of private practice psychiatry in New York City; to demonstrate significant correlations of variations in income and career satisfaction ratings

with managed care provider status; to improve awareness of negative perceptions held by private practice psychiatrists of some trends in psychiatry.

SUMMARY:

Objective: The purpose of the study was to obtain information from a group of Manhattan-based private practice psychiatrists regarding aspects of their professional activities. The areas of inquiry were: general information (years in practice, size of practice, managed care participation), economic factors (yearly gross revenues, fee schedules), attitudes towards managed care, and career satisfaction.

Method: A two-page, 24-item questionnaire was sent to 100 randomly selected private practitioners with a return envelope designed to assure anonymous participation.

Results: Forty percent returned completed questionnaires. Gross revenues were nearly level for the years 1993-5; however, practitioners engaged in managed care averaged approximately 20% lower annual revenues than those not on a provider panel. In general, respondents were less satisfied with practice than three years ago; managed care providers were significantly less satisfied with practice than nonmanaged care participants. The perception that psychiatry is becoming a more difficult profession was widely held.

Conclusion: This study provides data that support anecdotal accounts of demoralization among private practice psychiatrists, especially documenting differences between managed care providers and providers not in managed care (contradicting the belief that New York City has been immune to the impact of managed care).

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2. Dorwart RA: Physicians' incomes under health reform: psychiatrists' dilemma. *Harvard Rev Psychiatry* 2:113-114, 1994.

No. 13
MEDICAL MALPRACTICE IN THE ERA OF MANAGED CARE

Eugene L. Lowenkopf, M.D., *150 East 77th Street, New York NY 10021-1922;* Abe M. Rychik, J.D.

EDUCATIONAL OBJECTIVES:

To recognize the psychiatrist's obligations with respect to utilization review; to appreciate the issues that arise in contracts with managed care organizations; to generally be aware of malpractice issues in the arena of managed care; to enhance the practitioner's ability to anticipate and avert liability.

SUMMARY:

The advent of managed care has shifted the focus of the health care profession to cost containment. This has significantly altered the decision-making process in medicine and threatens the demise of physician autonomy. Formerly, the individual physician decided how to treat the patient and proceeded accordingly; consequently, it was reasonable that he or she would be held accountable for the outcome. In the managed care environment, with frequent utilization review procedures, the physician suggests a course of treatment, but the decision to provide or withhold treatment lies with the managed care organization. In this climate who should be held liable if something goes wrong? Courts have traditionally held a physician ultimately liable to his or her patient. Is this traditional analysis still viable when the determination of the medical necessity of the patient's treatment is no longer exclusively the province of the physician? This paper reports on recent cases in this field and examines the legal principles that have been invoked. It concludes with recommendations and suggestions for risk management.

REFERENCES:

1. Hirshfeld EB: Economic considerations in treatment decisions and the standard of care in medical malpractice litigation. *JAMA*, 264:2004-2012, 1990.
2. Appelbaum PS: Legal liability and managed care. *American Psychologist*, 48:251-257, 1993.

PAPER SESSION 5—UNDERDETECTED PROBLEMS IN ADULT PSYCHIATRY

No. 14
CLINICAL SPECTRUM OF ADHD IN ADULT WOMEN

Kytja Voeller, M.D., *Department of Psychiatry, University of Florida, Box 100234, Health Science Ctr, Gainesville FL 32610;* Rudy Bogoian, M.D., Gary Geffken, Ph.D., Mary Garofalakis, M.A., Paula Edge, B.P.S.

EDUCATIONAL OBJECTIVES:

To recognize ADHD as a possible diagnosis in women who are not responding to standard psychotherapeutic interventions, and to list comorbid conditions that may contribute to exacerbation of symptoms and impaired functioning.

SUMMARY:

Objective: To describe the clinical characteristics of adult women with ADHD.

Method: 22 women (mean age 32; range 20-56 years) were evaluated in our adult ADHD clinic. Childhood behaviors were reviewed, a psychiatric interview for comorbid diagnoses was conducted, and a medical and educational history was taken. A WAIS-R and other neuropsychological testing was performed.

Results: Patients were referred by therapists (58%), physicians, school officials, or self. Students complained of poor academic performance, whereas the other patients complained of difficulty managing daily activity. Eighteen (82%) met retrospective DSM (III-R and/or IV) criteria for childhood ADHD, and all described current disabling symptoms of inattention, restlessness, and impulsivity. Women in early menopause and one 23-year-old with secondary ovarian failure reported an exacerbation of symptoms. All women described fluctuation of symptoms across the menstrual cycle. Fifteen (68%) had comorbid depression/dysthymia; two polydrug/alcohol abuse; nine (40.9%) had a significant previously undiagnosed reading disability; three were hypothyroid. Two patients were felt not to have ADHD; seven others met criteria but did not wish to comply with treatment protocols. Of the 13 patients who were treated, 12 reported dramatic improvement in functioning.

Conclusion: The diagnosis of ADHD is made four to nine times more frequently in males than females. However, cerebral metabolic studies have shown that ADHD females differ from controls more significantly than do males, suggesting that women may be more severely affected. Most of these women had a history of ADHD in childhood but were not diagnosed. A decrease in estrogen appeared to play a role in the clinical presentation, and a disproportionately large number were hypothyroid. There was also fluctuation in medication requirements across the menstrual cycle. Additionally, although dyslexia co-occurs in close to 50% of children with ADHD, it is rarely identified in adults. In this group of bright women, close to half showed evidence of reading disability that impaired their school performance. This preliminary study would suggest that women tend to be underdiagnosed.

REFERENCES:

1. Berry CA, Shaywitz SE, Shaywitz BA: Girls with attention deficit disorder: a silent majority? a report on behavioral and cognitive characteristics. *Pediatrics*, 76:801-809, 1985.
2. Zametkin AJ, Liebenauer LL, Fitzgerald GA, et al: Brain metabolism in teenagers with attention-deficit hyperactivity disorder. *Archives of General Psychiatry*, 50:333-340, 1993.

No. 15
ADHD IN ADULTS WITH ANXIETY DISORDERS

Catherine L. Mancini, M.D., *Department of Psychiatry, McMaster Medical Center, 1200 Main Street West, Hamilton ON L8N 3Z5, Canada;* Michael A. Van Ameringen, M.D., Deana Figueiredo, B.Sc., Jonathan Oakman, Ph.D.

EDUCATIONAL OBJECTIVES:

To recognize the relationship between childhood attention deficit/hyperactivity disorder and anxiety disorders; to recognize the prevalence of childhood and adult ADHD in an anxiety disorders sample.

SUMMARY:

Objective: High rates of comorbidity are found in adult attention deficit/hyperactivity disorder (ADHD), particularly depression, anxiety disorders, antisocial personality disorder, and substance use disorders. This investigation studied patients in an anxiety disorder clinic who have a childhood history of ADHD.

Method: One hundred and forty-nine anxiety disorder patients were assessed using the SCID and measures of anxiety, depression, and disability. The Wender Utah Rating Scale was administered to obtain a retrospective diagnosis of childhood ADHD. Patients were then given the Targeted Attention-Deficit Disorder Symptoms Rating Scale to elicit a current diagnosis of ADHD.

Results: Thirty-six patients (24%) qualified for a childhood diagnosis of ADHD. These patients tended to be male, have an increased lifetime history of alcohol abuse/dependence and dysthymia, and an increased mean number of comorbid diagnoses. They demonstrated significantly higher scores on the Beck Depression Inventory, State-Trait Anxiety Inventory, and Social Adjustment Scale-Self Report. Of these 36 patients, 45% continued to meet criteria for ADHD in adulthood.

Conclusion: ADHD is thought to occur in 5% of school-aged children, with up to one half continuing to exhibit symptoms into adulthood. The rate of childhood ADHD in our sample is higher than that found in the general population, suggesting that ADHD may be a precursor to anxiety disorders.

REFERENCES:

1. Biederman J, Faraone SV, Spencer T, et al: Patterns of psychiatric comorbidity, cognition and psychosocial functioning in adults with attention deficit hyperactivity disorder. *Am J Psychiatry* 150(12):1792-1798, 1993.
2. Shekim WO, Asarnow RF, Hess E, et al: A clinical and demographic profile of a sample of adults with attention deficit hyperactivity disorder, residual state. *Comprehensive Psychiatry* 31(5):416-425, 1990.

No. 16
SEXUAL ASSAULT OF ADULT MEN: AN EPIDEMIOLOGICAL STUDY

Michael B. King, M.D., *Department of Psychiatry, Royal Free Hospital, School of Medicine Rowland Hil, St. London NW3 2QG, United Kingdom;* Adrian Coxell, M.Sc., Gillian Mezey, M.D.

EDUCATIONAL OBJECTIVES:

To describe the prevalence and characteristics of sexual assault on men; to explore the nature of their help seeking and how services might be improved.

SUMMARY:

Objectives: To assess prevalence of sexual assault on adult men in the community and in prisons, the effects of assaults, and the nature of help seeking.

Method: A structured interview was designed, computerized, and subject to test-retest reliability. A number of family practices (FP) and probation services (PS) in England, one Genito-Urinary Medicine (GUM) Centre, and the largest youth custody centre in Europe are taking part. Men who understand English are asked to take part. The interview begins with screening questions leading to questions about assaults as adults/children, circumstances of the assault(s), nature of the assailants, type of assault(s), after-effects, sexuality and sexual behavior, help seeking, and current psychological and alcohol status.

Results: 2,300 men in the FP setting, 800 attending PSs, and 270 attending GUM have been interviewed so far. Preliminary findings indicate that of men recruited in FP, 4% have been sexually assaulted as children and 3% as adults. In addition, 9% of men in GUM report a sexual assault as an adult. Detailed results of the factors described above will be presented.

Conclusions: Sexual assault of adult men is a common, largely undescribed problem. The findings of this first European epidemiological study of sexual assault of men will have important implications for the understanding of male sexual assault in all Western countries.

REFERENCES:

1. Mezey G, King MB: *Male Victims of Sexual Assault.* Oxford University Press, Oxford, 1992.
2. Coxell A, King MB: Sexual assault on men. *Journal of Sexual and Marital Therapy* (in press).

PAPER SESSION 6—CONTEMPORARY TOPICS IN CONSULTATION/LIAISON PSYCHIATRY

No. 17
DEPRESSION AND WOMEN'S POST HEART ATTACK RISK

Francois Lesperance, M.D., *Montreal Heart Institute, 5000 East Belanger Street, Montreal QC H1T 1C8, Canada;* Nancy Frasure-Smith, Ph.D., Mario Talajic, M.D., Martin Juneau, M.D., Martial G. Bourassa, M.D.

EDUCATIONAL OBJECTIVES:

To recognize the prognostic importance of depressive symptoms following heart attack for both women and men; to understand that the increase in risk is independent of measures of cardiac disease severity and of about the same magnitude as previous heart attack.

SUMMARY:

We recently reported that depression increases cardiac mortality following myocardial infarction (MI). The sample size (n = 222; 49 women) precluded examining the risk separately for men (M) and women (F). A total of 281 F and 611 M responded to the Beck Depression Inventory (BDI) one week post-MI. All patients received usual physician care. Survival was compared using Cox proportional hazards regression. We found that 32.4% of patients (25.6% M, 47.0% F; $p < .0001$) had BDI scores ≥ 10 (at least mild to moderate depression). By one year, 42 patients (17 W) died from cardiac

causes (p for gender = .36). Elevated BDI scores significantly predicted cardiac mortality overall (Hazards Ratio (HR) = 3.17; 95% CI = 1.64-6.11). There was no interaction of gender and depression (p = .94). The BDI-related risk for F (HR = 3.19; 95% CI = 1.02-10.03) was similar to that for M (HR = 3.01; 95% CI = 1.31-6.95). The impact of depressive symptoms remained after control for age and previous MI (adjusted HR for F = 3.48; 95% CI = 1.11-10.92; adjusted HR for M = 2.89; 95% CI = 1.25-6.69). We conclude that while women are more likely to have elevated BDI scores following MI, depression substantially increases the one-year risk of mortality for both genders. Additional study is needed to determine whether treatment of depression influences post-MI survival.

REFERENCES:

1. Frasure-Smith N, Lespérance F, Talajic M: Depression following myocardial infarction: impact on 6-month survival. *JAMA* 270:1819-1825, 1993.
2. Frasure-Smith N, Lespérance F, Talajic M: Depression and 18-month prognosis following myocardial infarction. *Circulation* 91:999-1005, 1995.

No. 18
SOCIAL IMPAIRMENT AND DEPRESSION AFTER TRAUMATIC BRAIN INJURY

Sergio Paradiso, M.D., *Department of Psychiatry, University of Iowa, Medical Education Building, Iowa City IA 52242;* Rafael Gomez-Hernandez, M.D., Todd Kosier, M.S., Robert G. Robinson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the different psychosocial dimensions associated with poststroke major depression during the acute and chronic phases of the disease.

SUMMARY:

Objective: Previous studies have demonstrated that social impairment is associated with major depression throughout the first year following traumatic brain injury (TBI). This study was undertaken to examine the specific social factors that were associated with poststroke depression.

Method: A consecutive series of 65 patients with closed head injuries were cross-sectionally and longitudinally examined using a semistructured psychiatric interview and 13 factors derived from the Social Functioning exam (SFE) during hospital care and three, six, nine and 12 months follow-up.

Results: Depressed subjects showed poorer social function at the initial evaluation, six, nine, and 12 months. Poor job satisfaction prior to injury and fear of job loss as well as impaired ability of the family to cope with chronic illness were significantly associated with depression at the initial evaluation. Impaired close personal relationships as well as continued fear of job loss were associated with depression at six, nine, and 12 months following TBI.

Conclusion: These finding suggest that different psychosocial factors may play an etiologic role in depression during the acute TBI period compared with the chronic period. These findings also support the need for early social intervention in cases of traumatic brain injury.

REFERENCES:

1. Morton MV, Wehman P: Psychosocial and emotional sequelae of individuals with traumatic brain injury: a literature review and recommendations. *Brain Injury* 9:81-92, 1995.
2. Fedoroff JP, Starkstein SE, Forrester AW, et al: Depression in patients with acute traumatic brain injury. *Am J Psychiatry* 149:918-923, 1992.

No. 19
PRIMARY FIBROMYALGIA AND ITS RESPONSE TO FLUOXETINE

Dory G. Hachem, M.D., *Psych Hospital of the Cross, Jall-Eddib, Beirut 00178, Lebanon;* Patricia J. Vivian, M.S., Edouard F. Azouri, M.D.

EDUCATIONAL OBJECTIVES:

The participant should be able to recognize that the clinical symptoms and signs of primary fibromyalgia are subtle and subjective and often mask an underlying depressive disorder that would benefit from fluoxetine treatment.

SUMMARY:

Objective: The purpose of this study was to evaluate the efficacy of fluoxetine in the treatment of primary fibromyalgia.

Method: Twenty-four female outpatients meeting the criteria for primary fibromyalgia were treated with 20mg of fluoxetine daily for a period of 10 weeks. A matched control group consisting of 23 patients was given a placebo. Patients were assessed at baseline and weekly thereafter with the Hamilton Rating Scale for Depression and the Beck Depression Inventory.

Results: From the outcome it emerged that fluoxetine was more effective than placebo in reducing the depressive and painful symptomatology of primary fibromyalgia patients. Eighty percent of the patients taking fluoxetine had good response, while only 20% in the control group showed an improvement.

Conclusions: These results indicate that primary fibromyalgia may be a form of masked depression in which certain somatic symptoms are prominent. There is strong evidence that both conditions share similar underlying neurochemical disturbances, namely a serotonergic deficiency, and that judicious use of fluoxetine will be helpful in the vast majority of patients with primary fibromyalgia.

REFERENCES:

1. Ahles T, Khan S, Yunus M, et al: Psychiatric status of patients with primary fibromyalgia: a blind comparison of DSM-III diagnoses. *American Journal of Psychiatry*, 148:1721-1726, 1991.
2. Finestone DH, Ober SK. Fluoxetine and fibromyalgia. *JAMA*, 264:2869-2870, 1990.

PAPER SESSION 7—THE RHYTHMS OF LIFE: CURRENT RESEARCH ON CHRONOBIOLOGY OF MENTAL ILLNESS

No. 20
MELATONIN EXCRETION UNRELATED TO SLEEP

Daniel F. Kripke, M.D., *Department of Psychiatry, University of CA at San Diego, 9500 Gilman Drive, Dept 0667, La Jolla CA 92093-0667;* Shawn D. Youngstedt, Ph.D., Jeffrey A. Elliott, Ph.D.

EDUCATIONAL OBJECTIVES:

To caution patients that the usefulness of melatonin for sleep needs further study.

SUMMARY:

Popular media and advertising have claimed that melatonin promotes sleep because age-related deficiencies cause increased insomnia. As part of a larger study, urinary excretion of the metabolite 6-sulphatoxymelatonin (6SMT) was compared with sleep. Selected for complaints of insomnia or depression, 42 volunteers aged 60-79 collected fractional urine specimens over two 24-hour periods. At the same time, wrist actigraphs and sleep logs were used to estimate

sleep in the home during continuous one-week recordings. The 6SMT was assayed by ELISA, so that the daily pattern of excretion could be established. Then the daily rate of 6SMT excretion (corrected for time-of-day of sampling) was estimated from all data for a given volunteer by computing the mesor (fitted mean) of the best-fitting 24-hour cosine. Neither estimated total sleep time nor the amount of wake-after-sleep-onset (WASO) had any significant correlation with mesor excretion of 6SMT, nor was there any trend for volunteers with the lowest excretion to have the worst sleep. The results are inconsistent with the hypothesis that melatonin deficiency is a major cause of insomnia. As the study progresses, interactions of sleep with the circadian phase of 6SMT excretion will also be examined. (Supported by AG12364.)

REFERENCES:

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2. Tzischinsky O, Shlitner A, Lavie P: The association between the nocturnal sleep gate and the nocturnal onset of urinary 6-sulphatoxymelatonin. *J. Biol. Rhythms.* 8:199-209, 1993.

No. 21
MENSTRUAL PHASE RESPONSE TO NOCTURNAL LIGHT

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EDUCATIONAL OBJECTIVES:

To understand the phase of the menstrual cycle at which night lights shorten abnormally long cycles.

SUMMARY:

Objective: The aims of the study were to replicate observations that nocturnal light may normalize menstrual cycles in oligomenorrheic women and to test whether the effects of light are menstrual-cycle-phase-dependent.

Method: Thirty-eight women with long menstrual cycles were treated for one to three cycles, each of which was preceded and followed by at least one untreated cycle. Treatments were 100 watt bedside lights administered for five nights at three different phases of the menstrual cycle (between nights 4-12, 11-19, and 22-30).

Results: On average, the treatment and post-treatment cycle lengths were significantly reduced (more than 10%) compared with the duration of baseline cycles. Obvious reductions of the treatment cycle lengths were obtained with lights administered between the first third and the second half of the cycle (almost 25% reduction), whereas treatments in earlier and later phases of the cycle appear to be less effective.

Conclusion: The results suggest that a bedside lamp used on nights prior to ovulation can reduce the duration of long menstrual cycles.

REFERENCES:

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2. Lin MC, Kripke DF, Parry BL, Berga SL: Night light alters menstrual cycles. *Psychiatry Res.* 33:135-138, 1990.

No. 22
SEASONAL MOOD PATTERNS IN EATING DISORDERS

A. Missagh Ghadirian, M.D., *Department of Psychiatry, Allan Memorial Institute, 1025 Pine Avenue, West, Montreal QC H3A 1A1, Canada;* Nadia Marini, B.A., Sheila Jabalpurwala, Ph.D., Howard Steiger, Ph.D.

EDUCATIONAL OBJECTIVES:

The participants will become familiar with patterns of mood changes of patients who manifested seasonal symptoms of depression and eating behavior.

SUMMARY:

There has been an increasing body of research literature suggesting a seasonal pattern of mood fluctuations and eating behavior in bulimic patients. Blouin et al. (1992) found that bulimic eating patterns are influenced by seasonal variation and light availability. Lam et al. (1991) reported that many bulimic patients showed mood changes proportionate to seasonal affective disorder (SAD). There is a logical connection between SAD and bulimia nervosa (BN), as patients with both disorders show increased appetite and carbohydrate craving and probably share a common neurobiologic abnormality such as serotonergic dysfunction. The aim of this study was to determine the prevalence of SAD in a sample of 257 consecutively evaluated outpatients admitted to an eating disorders clinic (253 females and four males with a mean age of 27.6 ± 8.1 years). Eating disorder diagnosis was established on the basis of DSM-III-R criteria, and a modified version of the Seasonal Pattern Assessment Questionnaire (SPAQ) was used to determine seasonality among patients. The sample consisted of the following: 53.7% bulimics, 28.4% anorexics, and 17.9% were classified as having an eating disorder not otherwise specified (ED NOS).

The results indicated that 27.2% of eating disorder patients met SAD criteria. Of this group, 71.4% were bulimic, 18.6% were anorexic, and 10.0% were nonspecified. The authors will discuss the details and additional findings.

REFERENCES:

1. Blouin A, Blouin J, Aubin P, et al: Seasonal patterns of bulimia nervosa. *American Journal of Psychiatry*, 149:73-81,1992.
2. Lam RW, Solyom L, Tompkins A: Seasonal mood symptoms in bulimia nervosa and seasonal affective disorder. *Comprehensive Psychiatry*, 32:552-558, 1991.

PAPER SESSION 8—DIAGNOSTIC AND TREATMENT ISSUES IN CHILDREN AND ADOLESCENTS

No. 23
TEMPERAMENT OF KOREAN CHILDREN WITH ASTHMA

S. Peter Kim, M.D., *Department of Psychiatry, Samsung Medical Center, 50 Ilwon-Dong, Kangnam-Ku, Seoul 135-230, South Korea;* Seong-Goo Choi, M.D., Sang-Yeop Kim, M.D., Yoo-Sook Joung, M.D., Sungdo D. Hong, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will have gained knowledge about temperament—its definition, research methods, and clinical applications, and also will be able to recognize temperamental profiles of asthmatic children for early detection and determination of their developmental and parenting needs.

SUMMARY:

The objective of this study is to determine temperamental characteristics of Korean children with bronchial asthma. An earlier preliminary study (Kim SP, Ferrara A, Chess S, 1980) shows that asthmatic children, as a group, are significantly different from two other control

groups (children with eczema, allergic rhinitis, or both without asthma: normal healthy children).

The parents of 114 Korean children with bronchial asthma, ages 2 to 9 years, completed the Parental Temperamental Questionnaire by Thomas and Chess (1997). The questionnaire was translated into Korean and standardized for a Korean population (Kim et al, 1996). The data collected were of ordinal type, ranked from 1 to 7, and the nonparametric Mann-Whitney U Test was utilized. Any child with a suspected history or diagnosis of premature birth, organic brain syndrome, mental retardation, childhood psychosis, congenital physical anomaly, hereditary disease, or any other medical or surgical conditions, other than asthma, requiring continuous physician's care was excluded from the study population.

The results show that Korean asthmatic children are characterized by lower adaptability and higher intensity of reaction, in line with the preliminary study results. The temperamental profile approximately corresponds to the slow-to-warm-up constellation of the New York Longitudinal Study. The findings strongly suggest the existence of a distinct temperamental profile of asthmatic children. Early detection of the profile may be of great value for parents and child health care providers in understanding the asthmatic child's correct developmental needs and in determining appropriate parenting approaches for chronically ill children at a risk for behavioral disorders.

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No. 24
COGNITIVE IMPAIRMENT IN ADOLESCENT SCHIZOPHRENIA

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EDUCATIONAL OBJECTIVES:

To more fully appreciate the fact that even when stabilized on neuroleptic medication, adolescent patients with schizophrenia exhibit brain dysfunction that affects a broad range of cognitive functions, especially attention and working memory.

SUMMARY:

Objective: The purpose of this study is to determine whether adolescent schizophrenia is characterized by neuropsychological deficits that are similar to those that are evident in first-episode and chronic schizophrenic patients.

Methods: We have compared the neuropsychological test performance of age-matched normal controls (N = 17) and medicated adolescent outpatients with schizophrenia (N = 17). Patients were referred from adolescent psychiatric services of community hospitals, adolescent services of psychiatric hospitals, community treatment centers, residential care facilities, and psychiatrists in private practice. Normal controls were recruited on hospital bulletin boards and/or hospital newsletters at both a university-based hospital and a county public hospital. The mean age ±SD was 15.7 (1.65) for the patient group and 14.9 (1.27) for the controls. The neuropsychological test battery included measures of attention (Paced Auditory Serial Addition Test, Stroop Test, Digit Span Distraction Test); working memory (Trigram Recall Test with Interference); learning and memory (Selective Reminding List Learning Test, Logical Memory Subtest-Wechsler Memory Scale-Revised, Recognition Memory Test); generative naming (Controlled Oral Word Retrieval, Category Instance Generation); executive functions (Maze Subtest-Wechsler Intelligence Scale for Children-Revised-WISC-R, Wisconsin Card Sorting Test); and visuospatial functions (Judgment of Line Orientation Test). Prorated IQ measures based upon the Information, and Similarities and Block Design subtests of WISC-R were analyzed separately.

Results: Adolescents with schizophrenia were impaired on 13 of the 16 neuropsychological measures, with IQ showing a trend toward being lower in the patient group. Effect sizes were larger for measures of working memory and attention. By contrast, effect sizes were smaller for measures of learning and memory, generative naming, visuospatial functions, and executive functions. The important role of attention and working memory deficits in adolescent schizophrenia is quite consistent with that which occurs in both first-episode and chronic adult patients with schizophrenia. Formal comparison of effect sizes with previously published findings in chronic, treatment-resistant schizophrenic patients showed that learning and memory, generative naming, and visuospatial and executive functions do not appear to be as severely impaired in adolescents with schizophrenia, although attention and working memory appear to be comparably impaired. Informal comparison with previous published findings in first-episode schizophrenic patients showed a similar pattern.

Conclusions: These findings suggest that while attention and working memory deficits are preeminent in adolescents with schizophrenia, the more global and severe deficits in memory, generative naming, and visuospatial and executive functions emerge sometime between adolescence and early adulthood.

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No. 25
RISPERIDONE IN THE MANAGEMENT OF PSYCHOTIC ADOLESCENTS: AN OPEN TRIAL

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be able to recognize some of the complications associated with the pharmacotherapy of psychoses occurring in early adolescence. The value of gradual titration of dosage and the use of better-tolerated novel neuroleptics such as risperidone will be discussed.

SUMMARY:

Objective: We report on the use of the novel antipsychotic, risperidone, in the treatment of 12 young adolescents with psychotic disorders and discuss the implications of our findings for both risperidone as an agent in treatment-resistant adolescents and as a first-line agent.

Method: Twelve patients with treatment-resistant psychoses between the ages of 15 and 17 subsequently treated with risperidone were identified. All patients had received treatment while inpatients on Westmead Hospital's acute adolescent unit in the previous two years. The unit is an eight-bed, purpose-built, secure facility for the treatment of adolescents with psychoses or major depression. It receives referrals from all over the state of New South Wales, Australia, and utilizes a multimodal approach to management, including an on-site classroom.

Results: Nine patients showed substantial improvement and seven had no adverse effects. Only one patient required permanent cessation of risperidone because of unacceptable side effects.

Conclusions: Risperidone was effective and well tolerated in this group of adolescents with treatment-resistant psychoses. Controlled trials are required to establish the value of risperidone as a safe, effective treatment of first choice in young adolescents with schizophrenia.

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PAPER SESSION 9—IMPROVEMENTS IN THE TREATMENTS OF SCHIZOPHRENIA

No. 26
NEW DRUGS AND NEW STRATEGIES FOR SCHIZOPHRENIA

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EDUCATIONAL OBJECTIVES:

To demonstrate the ability to utilize new drugs and new strategies for the acute, continuation, and maintenance phases of schizophrenia.

SUMMARY:

Objective: Although conventional antipsychotics have been found to be effective for the treatment of schizophrenia, response is incomplete and unsatisfactory. Two new medications, clozapine and risperidone, were introduced in the U.S. in the early 1990's, two others (sertindole and olanzapine) are imminent, and others are being tested in Phase II and III trials. In addition, there are now substantial data from the NIMH Treatment Strategies in Schizophrenia study on combining drug with family therapy interventions.

Method: We will provide an overview of the outcome data from both combined treatment studies as well as the current status of 1) the conventional antipsychotics, 2) new atypicals, and 3) antipsychotics available only outside of the U.S.

Results: Data from ongoing and completed controlled trials suggest that compared with conventional antipsychotics, clozapine is effective for a subgroup of treatment-resistant patients but management is difficult and costly. The new atypicals, i.e. risperidone, sertindole, and olanzapine, are as efficacious for positive symptoms, are somewhat more effective for negative symptoms in the acute phase, and have a lower risk of extrapyramidal side effects. Combining drug with family therapy does not allow for reduced dosage.

Conclusion: New antipsychotics now available (and in the pipeline) appear to offer new treatment options depending on the phase of the illness. Head-to-head comparisons of safety and efficacy for specific subgroups of patients are needed in order to develop data-based algorithms.

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1. Glick ID, Lecrubier Y, Montgomery S, et al: Efficacious and safe psychotropics not available in the United States. *Psych Annals,* 25(2):354-361, 1996.

No. 27
SMOKING CESSATION TREATMENT IN SCHIZOPHRENIA

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EDUCATIONAL OBJECTIVES:

To recognize the problem of smoking for schizophrenia patients and the need to encourage cessation; to develop an understanding of some methods of helping them to quit.

SUMMARY:

Objective: Schizophrenia patients smoke more than the average population and more than other psychiatric diagnostic groups. The affective, cognitive, and social difficulties and the symptoms that many schizophrenia patients experience suggest that existing smoking cessation programs are not appropriate for them. The purpose of this study was to conduct an open trial to assess efficacy and feasibility of a smoking program that was modified to meet the specific needs of this population.

Method: Forty outpatients with schizophrenia who wanted to stop smoking were recruited. Four separate groups with 10 subjects were held for seven sessions. The same two therapists conducted all groups. Adherence to the modified program was monitored. Assessments were held pre-group, post-group, and at three months. Assessments included the Positive and Negative Syndrome Scale, the Simpson-Angus Scale, nicotine dependence, and a biochemical measure of nicotine metabolite.

Results: Sixteen (40%) had stopped smoking post-group and seven (18%) remained abstinent at three months. These changes were significant ($p < 0.001$) and are comparable to quit rates for nonpsychiatric populations. There was significant improvement of nicotine dependence ($p < 0.001$) and no changes in symptoms.

Conclusions: Results suggest that stopping smoking is possible for individuals with schizophrenia, especially if the treatment is specifically designed for this population.

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2. Glassman H, Cigarette smoking: implications for psychiatric illness. *American Journal of Psychiatry,* 150:546-553, 1993.

No. 28
DOES CLOZAPINE REDUCE SYSTEM-WIDE HOSPITAL COSTS?

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EDUCATIONAL OBJECTIVES:

To understand that effective therapies reduce hospital costs.

SUMMARY:

Objective: To study the extent to which a 50-patient clozapine program reduces hospital costs.

Method: A province-wide statistical file tracks the longitudinal course of care in all mental hospitals and general hospital psychiatric units. Bed-days were analyzed for admissions before (T1) and after the start (T2) of a full clozapine program. This analysis focuses on bed use by admissions for acute care, rather than on long-term hospital residents.

Results: 1) The diagnostic distribution was remarkably stable. The number of individuals hospitalized with schizophrenia, affective psychoses or other diagnoses did not change. 2) Hospital use for schizophrenia and other diagnoses decreased while affective psychoses did not change. The following table shows the values for T1 and the percentage change by T2. Days per patient include all hospitalizations during the period.

Diagnostic	Patients		Hospital days		Days per patient	
	T1= 100%	T2	T1= 100%	T2	T1= 100%	T2
Schizophrenia	1,989	0%	61,542	−19%	30.9	−19%
Affective psych.	3,202	0%	4,300	− 1%	23.2	− 1%
Other diagnoses	8.099	0%	79,719	−17%	9.8	−17%
ALL diagnoses	13,290		215,561	−12%	16.2	−12%

3) There was a 19% reduction in system-wide bed-days for patients with schizophrenia. 4) While paying $6.5 thousand drug costs per cozapine patient per year, there was a system wide reduction for schizophrenia of $1.8 million.

Conclusions: 1) System-wide economic analyses are essential to demonstrate savings following new therapies. Clinical trials, by themselves, are insufficient for extrapolating system effects.

2) Further analyses (now under way) are needed to assess the extent to which clozapine patients contributed to these reduced costs.

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1. Essock SM, Hargreaves WA, Dohm FA, et al: Clozapine eligibility among state hospital patients. *Schizophrenia Bulletin* 22:15-25, 1996.
2. Reid WH, Mason M, Toprac M: Savings in hospital bed-days related to treatment with clozapine. *Hospital and Community Psychiatry* 45:261-264, 1994.

PAPER SESSION 10—SUICIDAL RISKS ACROSS THE LIFE SPAN

No. 29
SUICIDE RISK IN ADOLESCENT INPATIENTS

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EDUCATIONAL OBJECTIVES:

To recognize important psychological and behavioral correlates of suicide risk in adolescents who are psychiatrically hospitalized. Participants will recognize the implications of the findings for theory, future research, and clinical practice.

SUMMARY:

Objective: To examine the interplay among classes of psychological and behavioral variables thought to represent amplifiers and attentuators for suicide risk in psychiatrically hospitalized adolescents.

Method: 150 adolescent inpatients (81 males and 69 females) were administered a battery of psychometrically well-established psychological self-report measures soon after admission. Suicide risk was assessed using the Suicide Risk Scale (SRS). Other measures used included: Beck Depression Inventory (BDI); Depressive Experiences Questionnaire (DEQ); Hopelessness Scale for Children (HSC); Impulsivity Scale (IS); Past Feeling and Acts of Violence Questionnaire (PFAV); and Rosenberg Self-Esteem Scale (RSES).

Results: As expected, the BDI (r = .75), HSC (r = .62), IS (r = .38), PFAV (r = .27), and two DEQ factors (dependency (r = .43) and self-criticism (r = .59)) were significantly associated with suicide risk ($p < .001$); RSES was negatively associated with suicide risk (r = -.71, $p < .0000$). Multiple regression analyses were performed to ascertain the joint and independent contributions of these measures (while taking into account gender and the presence of mood disorders) to the prediction of suicide risk. We accounted for 68% of the variance in suicide risk (F (9, 140) = 32.5, $p < .0000$). Significant independent contributions to the prediction of suicide risk were made by the presence of a mood disorder, BDI, DEQ-dependency, DEQ-self-criticism, and PFAV.

Conclusions: Our findings suggest a complex interplay between psychological factors (depression, dependency, self-criticism) and behavioral factors (impulsivity, violence) contributes to suicide risk in psychiatrically hospitalized adolescents.

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1. Pinto A, Whisman MA: Negative affect and cognitive biases in suicidal and nonsuicidal hospitalized adolescents. *J Am Acad Child Adolesc Psychiatry* 35:158-165, 1996.
2. Lewinsohn PM, Rohde P, Seeley JR: Adolescent suicidal ideation and attempts: prevalence, risk factors, and clinical implications. *Clin Psychol Sci Prac* 3:25-46, 1996.

No. 30
DO ANTIDEPRESSANTS REDUCE SUICIDE RISK?

Charles L. Rich, M.D., *Department of Psychiatry, University of South Alabama, 3421 Medical Pk Dr West, Ste 2, Mobile AL 36693;* Goran B. Isacsson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the role of pharmacoepidemiology in evaluating whether antidepressants reduce suicide risk.

SUMMARY:

Objective: In spite of the availability of antidepressant medication for several decades, it has not been shown that such medication lowers the risk for suicide in depressed patients. This report explores this apparent paradox by means of pharmacoepidemiological methods.

Method: Existing data on the prevalence of depression in the population and among suicides as well as data on antidepressant treatment in depressed suicides were compared with previously unpublished data on the use of antidepressants in the population.

Results: The calculated risk for suicide among depressed patients in Sweden who were treated with antidepressants was 141 per 100,000 person-years and, among the untreated, 259 per 100,000 person-years (i.e. 1.8 times higher among the untreated). There has also been a decrease in suicides in Sweden corresponding with increased numbers of antidepressant prescriptions in recent years.

Conclusion: This report supports the hypothesis that antidepressant medication decreases the risk for suicide in depressed patients. One reason this has not been obvious in the general suicide statistics may be that so few depressed people are treated with antidepressants. Effective suicide prevention strategies should include intensified efforts to recognize and treat more depressed people.

REFERENCES:

1. Isacsson G, Holmgren P, Wasserman D, Bergman U: Use of antidepressants among people committing suicide in Sweden. *BMJ* 308:506-509, 1994.
2. Isacsson G, Bergman U, Rich CL: Antidepressants, depression and suicide: an analysis of the San Diego study. *J Affect Disord* 32:277-286, 1994.

No. 31
SCHIZOPHRENIA SYMPTOMS AND SUICIDAL BEHAVIORS

Wayne S. Fenton, M.D., *Research, Chestnut Lodge Hospital, 500 West Montgomery Avenue, Rockville MD 20850;* Thomas H. McGlashan, M.D., Crystal R. Blyler, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be able to understand the role of diagnostic subtypes and positive and negative symptoms as predictors of suicide in patients with schizophrenia spectrum disorders.

SUMMARY:

Objective: Patients with schizophrenia are at high risk for premature death from suicide. This report examines the relationship between schizophrenia subtype, positive/negative symptoms and suicidal behaviors in patients followed up 20 years after index assessment.

Methods: Patients from the Chestnut Lodge Follow-up Study with schizophrenia spectrum disorders (N = 295) were retrospectively assessed with the Positive and Negative Syndrome Scale, classical subtype criteria, and criteria for the Deficit Syndrome. Suicidal behaviors during the follow-up period were ascertained based on interviews with patients and/or relatives.

Results: 39% of patients reported suicidal thoughts and 22% reported suicide attempts over the follow-up; 6.4% died from suicide. Patients dead from suicide showed significantly *lower* negative symptom severity at index admission. Suicide risk was eight times *greater* among patients with paranoid subtype and significantly *lower* among patients with the deficit subtype. Independent group analyses for nonlethal suicidal behaviors yielded predictor relationships similar in direction, but less powerful.

Conclusions: These data suggest that negative symptoms such as diminished drive, blunted affect, and social and emotional withdrawal counter the emergence of suicidality in schizophrenia and define a group at relatively low risk for suicide. The later age of onset, intermittent illness, and relative preservation of affect and cognition associated with paranoid schizophrenia may encompass preconditions for the emergence of despair and suicide.

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PAPER SESSION 11—CONTROVERSIES IN CONTEMPORARY PSYCHIATRY

No. 32
PHYSICIAN-ASSISTED SUICIDE IN PSYCHIATRY

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EDUCATIONAL OBJECTIVES:

To recognize and systematically evaluate the complexities that psychiatrists will be faced with when patients ask for assisted suicide. These complexities, inherent to the psychiatric profession, make careful consideration of requests even harder than in somatic medicine.

SUMMARY:

In the Netherlands, physician-assisted suicide (PAS) can officially and legally be performed on psychiatric patients who request it provided that proper criteria are met. This constitutes a new development in the international debate. After a brief introduction on current developments concerning PAS, the official guidelines for PAS in psychiatry will be systematically examined. A recent juridical test case is described, which has served to accelerate the debate. It is concluded that important aspects of psychiatric practice are not adressed in the guidelines, which were primarily intended for use in somatic medicine. Assessment of treatment perspective in psychiatry is insufficient to warrant such a vital decision, boundaries of the therapeutic relationship are violated, and the therapist's inability to objectively assess the patient's wish to die is overlooked. Since the general public will continue to ask for clarity on the issue of euthanasia and PAS, the authors believe that a continuing and open discussion is the best option for proceeding towards more consensus on this delicate issue.

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2. Legemaate J, Gevers S: Physician-assisted suicide in psychiatry: developments in the Netherlands 1996. *Cambridge Quarterly of Health Care Ethics*: Accepted for publ. 1996/97.

No. 33
AIDS PHOBIA AND WILLINGNESS TO TREAT AIDS PATIENTS

David R. Kopacz, M.D., *Department of Psychiatry, University of IL at Chicago, 912 South Wood Street (MC913), Chicago IL 60612;* Linda S. Grossman, Ph.D., Debra L. Klamen, M.D.

EDUCATIONAL OBJECTIVES:

1) To inform psychiatrists who are active in teaching medical students that negative attitudes about AIDS can affect their students' belief that as future doctors they will have the right to refuse to care for AIDS patients. 2) To discuss this adverse impact of AIDS phobia, and to suggest educational approaches for psychiatrists to help their students adjust their attitudes and choices.

SUMMARY:

Objective: Psychiatrists are often responsible for teaching medical students about AIDS-related psychiatric disorders. We studied the degree to which medical students' attitudes about AIDS affect decisions they might make regarding patient care. We asked: 1) What are medical students' attitudes about AIDS? 2) Does students' knowledge level of AIDS correlate with their attitudes? 3) Do students' attitudes affect their willingness to treat AIDS patients?

Method: We surveyed 72 second-year medical students at the start of their course in human sexuality at a large urban midwestern medical school. We used a questionnaire adapted from others used in previous research that inquired about students' demographics, sexual activity, attitudes toward AIDS and homosexuality, and prior experience with AIDS patients.

Results: 1) Significantly more AIDS phobia was found in students who had no homosexual friends or prior exposure to HIV+ patients. 2) There was no significant association between students' level of AIDS knowledge and their attitudes toward AIDS. 3) Students with more negative attitudes toward AIDS and homosexuality were significantly less willing to treat AIDS patients.

Conclusions: Several important implications emerged: 1) Negative attitudes correlate with decreased willingness to treat AIDS patients.

2) Knowledge level does not affect willingness to treat. Psychiatrists active in medical education must address students' negative attitudes as well as impart knowledge. Our results suggest that psychiatrists may need to address students' fear of infection and AIDS phobia before some students will be able to incorporate and utilize didactic instruction about AIDS. Further research is necessary to determine effective ways to change students' negative attitudes toward AIDS.

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2. Weyant RJ, Simon MS, Bennett ME: Changes in students' attitudes toward HIV-infected patients as the students progress through medical school. *Acad Med.* 68(5):377-379, 1993.

No. 34
RESIDENTS' DIFFERENTIAL ATTITUDES AND PERCEPTIONS OF INTERNATIONAL MEDICAL GRADUATES AND AMERICAN MEDICAL GRADUATES

Jamal Fawaz, M.D., *Department of Psychiatry, University of Maryland, 645 West Redwood Street, Baltimore MD 21201;* Lisa B. Dixon, M.D., Michael A. Torres, M.D.

EDUCATIONAL OBJECTIVES:

To identify how the racial and ethnic backgrounds of residents influence their perceptions of each other; to understand how the increase in the number of international medical graduates and racial diversity may influence psychiatric training and practice.

SUMMARY:

Objective: This study was designed to determine the differential perceptions and attitudes of a group of psychiatry residents towards American medical graduates (AMGs) and international medical graduates (IMGs).

Methods: A total of 52 psychiatry residents completed an anonymous survey (response rate = 81%) in which they rated how the three different resident groups (white AMGs, black AMGs, and IMGs) are "perceived by most residents" along 11 different dimensions. Analyses determined if the ratings of the three resident categories differed.

Results: Statistically significant differences were found on group ratings of eight of the 11 dimensions. White AMGs were rated as more competitive, competent, highly valued, "having an attitude," psychologically oriented, having more opportunities, more invested in the program, and less scrutinized. IMGs were at the other extreme, with ratings of black AMGs falling between those of IMGs and white AMGs.

Conclusion: This study suggests that there are considerable differences in residents' perceptions about their colleagues based on ethnic and racial backgrounds. More cultural awareness and understanding is essential in training programs.

REFERENCES:

1. The 1993-1994 APA Census of Residents.
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PAPER SESSION 12—NEW ISSUES IN THE TREATMENT OF SEXUAL DYSFUNCTION

No. 35
GINKGO BILOBA FOR DRUG-INDUCED SEXUAL DYSFUNCTION

Alan J. Cohen, M.D., *Department of Psychiatry, University of CA at SF, 37 Quail Court, #200, Walnut Creek CA 94596;* Barbara D. Bartlik, M.D.

EDUCATIONAL OBJECTIVES:

The presentation will give essential information regarding the action and administration of gingko biloba for sexual dysfunction. Presumed psychopharmacologic mechanisms will be discussed.

SUMMARY:

In an open trial, ginkgo biloba, an herb derived from the bark of the Chinese ginkgo tree, noted for its cerebral enhancing effects, was found to be 84% effective in treating antidepressant-induced sexual dysfunction due predominantly to selective serotonin reuptake inhibitors (SSRIs) (N = 63). Women (N = 33) were more responsive to the sexually enhancing effects of ginkgo biloba than men (N = 30), with relative success rates of 91% versus 76%. Ginkgo biloba generally had a positive effect upon all four phases of the sexual response cycle: desire, excitement (erection and lubrication), orgasm, and resolution (afterglow). This study originated from the observation that geriatric patients on ginkgo biloba for memory enhancement noted improved erections. Patients exhibited sexual dysfunction secondary to a variety of antidepressant medications including SSRIs, SNRIs, MAOIs, and tricyclics. Dosages of ginkgo biloba extract ranged from 60mg qd to 180mg bid (average 209 mg/d). The common side effects were gastrointestinal disturbances, headache, and general CNS activation.

The presentation will include a discussion of presumed pharmacologic mechanisms, including effects upon platelet-activating factor, prostaglandins, peripheral vasodilatation, and central serotonin and norepinephrine receptor activity. Hypotheses regarding the basis for the observed gender differences will be included.

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No. 36
SEXUAL DYSFUNCTION INDUCED BY SRIS

Lawrence A. Labbate, M.D., *Department of Psychiatry, Medical University of SC, VA Med Ctr/109 Bee Street #116, Charleston SC 29401;* CPT Jamie B. Grimes, M.D., Alan H. Hines, M.D., Marvin A. Oleshansky, M.D.

EDUCATIONAL OBJECTIVES:

Participants should recognize the nature and time course of serotonin reuptake inhibitor (SRI) induced sexual dysfunction; that premorbid sexual dysfunction is related to change in sexual function following SRI use; that women are more likely to experience anorgasmia; and that some aspects of sexual function may improve with SRIs.

SUMMARY:

Objective: To determine the effect of three serotonin reuptake inhibitors (SRIs) on sexual function over three months.

Method: This was a naturalistic study of patients presenting to a psychiatric clinic. Selected patients were evaluated in a three-month prospective study of the effect of three SRIs [fluoxetine (N = 32), sertraline (N = 25), and paroxetine (N = 18)] on five aspects of sexual function: libido, erection/lubrication, orgasm quality, orgasm delay, and sexual frequency. Measurements were made at baseline and at each month on the five factors by a 10cm visual analogue scale (VAS).

Results: Seventy-five patients (mean age 35.1, SD = 11; 44 women; 66 Caucasian) with primary diagnoses major depression N = 44; panic disorder N = 15; OCD N = 6; social phobia N = 10 were

enrolled. On all five factors, depressed patients had lower baseline scores than anxious patients ($p < 0.0001$), and all mean scores were reported as less than normal for self. For depressed patients, mean VAS scores declined at month one, but by month three, only orgasm delay and orgasm quality were statistically lower than baseline ($p < 0.001$), while sexual frequency and libido improved nonsignificantly. Erection and lubrication declined nonsignificantly. For anxious patients, mean VAS scores for sexual frequency, libido, erection, and lubrication declined nonsignificantly and improved by month three to near normal, but orgasm delay and orgasm quality were below baseline scores ($p < 0.05$). Thirty-nine patients completed all visits; ANOVA for repeated measures revealed significant differences in orgasm delay, orgasm quality for men and women ($p < 0.001$), and for erection in men ($p < 0.02$). Lubrication, libido, and sexual frequency were not appreciably changed over the course of three months. There was no time by drug interaction, or time by diagnosis interaction. Post hoc analysis, however, revealed that orgasm delay persisted nearly unchanged over three months with sertraline and paroxetine ($p < 0.03$), but nearly returned to baseline with fluoxetine ($p = 0.30$). Women tended to be anorgasmic more than men at month one (26% vs 8%, $p = 0.08$) and were statistically more likely to be anorgasmic at month two (19% vs 0%, $p < .03$). At month three, 7% ($N = 2$) of women, and 0% of men reported anorgasmia ($p =$ NS). Diagnosis was not related to anorgasmia. Three men reported benefit with premorbid premature ejaculation.

Conclusion: SRIs are commonly associated with sexual dysfunction. Orgasm delay and orgasm quality may not recover after three months, though erection and lubrication may decline and improve. Libido and sexual frequency may not change significantly with SRIs. SRI-induced sexual dysfunction seems independent of these drugs or diagnoses.

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2. Hsu JH, Shen WW: Male sexual side effects associated with antidepressants: a descriptive clinical study of 32 patients. *Int J Psychiatry in Medicine* 25(2):191-201, 1995.

No. 37
SILDENAFIL, A NEW ORAL TREATMENT FOR ERECTILE DYSFUNCTION: AN EIGHT-WEEK, DOUBLE-BLIND, PLACEBO-CONTROLLED, PARALLEL GROUP STUDY

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EDUCATIONAL OBJECTIVES:

After this presentation the participant should have gained knowledge of a new oral compound, sildenafil, that is being developed to treat male erectile dysfunction. All erectile function parameters that are used in the NIH definition, namely frequency, firmness, and duration of erections are improved by sildenafil, leading to an increase in sexual satisfaction.

SUMMARY:

Objective: The NIH defines erectile dysfunction (ED) as an inability to attain and/or maintain penile erection sufficient for satisfactory sexual performance. Sildenafil has been found to be an effective and well-tolerated peripherally acting oral medication for the treatment of ED with no known organic cause. One aim of this study was to determine if patients must continue taking sildenafil to maintain the benefit reported during open treatment.

Method: 205 male patients (mean age 54; range 19-71 years) with ED, who had stabilized on a clinically effective sildenafil dose during a 16-week, open, patient-driven, dose-escalation study, were randomized to receive either their optimum dose of sildenafil (10, 25, 50, or 100 mg) or double-blind (DB) placebo for eight weeks. The numbers of patients receiving 10, 25, 50, and 100 mg doses of sildenafil at the end of the open-label period were three (2%), 23 (11%), 60 (29%), and 118 (58%), respectively. Patients were instructed to take a dose as required, about one hour prior to sexual activity, but not more than once daily. A total of 80 patients (39%) had a diagnosis of psychogenic ED; 125 (61%) had a diagnosis of mixed ED. Efficacy was recorded using a 10-item self-administered instrument; results for Q4, 5, 6, and 10 are shown below.

Results: Questionnaire responses for Q4-6 were graded from 0 (no sex stimulation or no erections) or 1 (never) to 5 (almost every time) and for Q10 from 1 (very dissatisfied) to 5 (very satisfied).

Question	Treatment Group	Start of DB Mean (SD)	End of DB Mean (SD)	Sildenafil-Placebo at End of DB* Mean (95% CI)
Q4: frequency of erections	sildenafil	4.20(1.06)	4.24(1.14)	1.82(1.47-2.18)
	placebo	4.42(1.02)	2.42(1.45)	
Q5: firmness of erections	sildenafil	4.27(1.02)	4.19(1.24)	2.03(1.64-2.42)
	placebo	4.39(0.96)	2.19(1.53)	
Q6: duration of erections	sildenafil	3.87(1.21)	3.86(1.38)	1.85(1.42-2.25)
	placebo	3.95(1.15)	2.00(1.50)	
Q10: sexual satisfaction	sildenafil	4.08(0.88)	3.89(1.09)	1.42(1.11-1.73)
	placebo	4.12(0.86)	2.46(1.14)	

*Difference between sildenafil and placebo groups estimated from the ANCOVA model

Conclusion: Sildenafil is an effective oral treatment for erectile dysfunction. Most patients will report a loss of effect if sildenafil is discontinued.

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1. Boolell M, et al: Sildenafil: an orally active type 5 cyclic GMP-specific phosphodiesterase inhibitor for the treatment of penile erectile dysfunction. *Int J Impotence Res* 8:47-52, 1996.
2. Boolell M, et al: Sildenafil, a novel effective oral therapy for male erectile dysfunction. *Br J Urol* 78:257-261, 1996.

PAPER SESSION 13—SPECIAL ISSUES IN ANTIDEPRESSANT TREATMENT

No. 38
A PLACEBO-CONTROLLED TRIAL OF PAROXETINE VERSUS IMIPRAMINE IN DEPRESSED HIV-POSITIVE OUTPATIENTS

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EDUCATIONAL OBJECTIVES:

To recognize, understand, and more effectively treat HIV-associated depression. The participant should be able to demonstrate knowledge about treatment of HIV-associated depression with both imipramine and paroxetine.

SUMMARY:

In this double-blind, placebo-controlled, 12-week trial of paroxetine vs. imipramine, 72 patients with a major depressive episode (21-item Ham-D of ≥ 18) were randomized to receive either paroxetine

(n = 24), imipramine (n = 25), or placebo (n = 23). Safety and tolerability were measured by the SAFETEE general inquiry. Fifty-five patients completed six weeks and 43 completed 12 weeks. Both paroxetine (x dose 31.8 ± 9.1mg) and imipramine (dose 161.5 ± 45.2) were significantly more effective than placebo, but were not different from each other for Ham-D [$F(2,40) = 4.33$, $p < .02$], CGI [$F(2,40) = 4.53$, $p < .02$], and PGI [$F(2,40) = 3.33$, $p < .05$] in completers. For completers, the eight-week CGI response rates were 56% for paroxetine, 54% for imipramine, and 22% for placebo. For the intent-to-treat group, the eight-week CGI response rates were 50% for paroxetine, 56% for imipramine, and 19% for placebo. Because of the high prevalence of somatic complaints there were few drug-placebo differences in side effects. There was greater sedation and tachycardia on imipramine than on paroxetine. Unlike most clinical trials, there were more dropouts on medication as compared with placebo, and this was unrelated to HIV stage or class (AIDS vs. HIV+). Depressed patients with HIV infection respond to a TCA (imipramine) or SSRI at the same increased rate compared with placebo, but appear to be more sensitive to their side effects.

REFERENCES:

1. Rabkin JG, Rabkin R, Harrison W, Wagner G: Effect of imipramine on mood and enumerative measures of immune status in depressed patients with HIV illness. *Am J Psychiatry* 151(4):516-523, 1994.
2. Grassi B, Gambini O, Scarone S: Notes on the use of fluvoxamine as treatment of depression in HIV-1 infected subjects. *Pharmacopsychiatry* 28(3):93-4, 1995.

No. 39
COURSE OF ANTIDEPRESSANT TREATMENT AND PRESCRIBER SPECIALTY

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EDUCATIONAL OBJECTIVES:

To describe the relationships of prescriber specialty and other patient characteristics to the course of antidepressant pharmacotherapy, as measured by rates of premature termination and subtherapeutic dosing; to recognize limitations of observational research in measuring these relationships.

SUMMARY:

Objective: To assess the relationship between course of antidepressant pharmacotherapy and prescriber specialty.

Method: Pharmacy claims from a nationwide database of HMO and fee-for-service payers were analyzed retrospectively. Adults (n = 3,328) prescribed no antidepressants for nine months, and thereafter prescribed a tricyclic or SSRI antidepressant, were followed 13 to 16 months after initial prescription. Outcomes measures were rates of treatment termination before one month and subtherapeutic dosing, defined as failure to receive at least one prescribed daily dose at or above commonly cited thresholds (e.g., 100 mgs. imipramine for nonelderly).

Results: Patients whose initial tricyclic prescription was by a psychiatrist were less likely ($p < .05$) to terminate prematurely (26%) than patients of nonspecialists (38%) or other medical specialists (35%). Among patients taking tricyclics for at least three months, those with at least one psychiatrist prescription had a higher ($p < .00001$) rate of therapeutic dosing (73%) than patients of nonspecialists (29%) or other specialists (30%). For SSRIs, premature termination rates were low and therapeutic dosing rates high across prescriber types. Findings persisted controlling for the younger age and lower nonantidepressant drug costs of psychiatrists' patients.

Conclusion: Findings support increasing use of psychiatrists in tricyclic pharmacotherapy. For nonpsychiatrist prescribers, SSRIs may be preferable.

REFERENCES:

1. Katon W, VonKorff M, Lin E, et al: Collaborative management to achieve treatment guidelines: impact on depression in primary care. *JAMA* 273:1026-1031, 1995.
2. Sturm R, Wells KB: How can care for depression become more cost-effective? *JAMA* 273:51-58, 1995.

No. 40
MODERATE ALCOHOL USE AND CONTINUATION ANTIDEPRESSANT THERAPY

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EDUCATIONAL OBJECTIVES:

To understand the impact of alcohol consumption in response to continuation treatment with antidepressants.

SUMMARY:

Objective: We wanted to assess whether alcohol consumption affects treatment outcome and/or changes over time among patients who have responded to acute antidepressant treatment and are followed for up to seven months while on continuation therapy.

Methods: Eligible subjects were 94 depressed outpatients who initially met DSM-III-R criteria for major depressive disorder according to the SCID-P and then showed full response to open treatment with fluoxetine 20 mg/day. These patients were then followed for seven months while receiving treatment with fluoxetine 40 mg/day with or without cognitive therapy. Patients with a lifetime history of alcohol abuse/dependence had been in full remission for at least the 12 months preceding entry into the protocol. Alcohol consumption was assessed in all patients at the beginning and end of the continuation phase.

Results: Of the 94 patients enrolled in the study, 55 completed the continuation phase and 39 did not complete this phase either due to relapse (n = 7) or discontinuation (n = 32). While 27 (50%) of the 54 moderate drinkers completed the continuation phase, 28 (70%) of the 40 nondrinkers completed the same phase, this difference being statistically significant (chi square: 3.8; $p = .05$). No significant changes in alcohol consumption were detected at the end of the continuation phase among these patients.

Conclusion: It appears that patients who continue to consume alcohol after responding to an antidepressant are more likely to fail to complete continuation treatment with the same antidepressant.

REFERENCES:

1. Worthington JJ, Fava M, Agustin CM, et al: Consumption of alcohol, nicotine and caffeine among depressed outpatients: relationship with response to treatment. *Psychosomatics*, in press.
2. Akiskal HS: Factors associated with incomplete recovery in primary depressive illness. *J Clin Psychiatry* 43:266-271, 1982.

PAPER SESSION 14—THE BIOLOGY OF EXTRAPYRAMIDAL SYMPTOMS

No. 41
EXTRAPYRAMIDAL SYMPTOM PROFILES IN OLDER NEUROLEPTIC-NAIVE PATIENTS

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EDUCATIONAL OBJECTIVES:

To appreciate that older psychiatric, neuroleptic-naive patients have a high incidence of EPS when treated with neuroleptics, despite the use of a low-dose regimen.

SUMMARY:

Objective: To determine the extrapyramidal-side-effect (EPS) profile in neuroleptic-naive older patients treated with neuroleptics.

Methods: For the past five years we have been prospectively studying EPS in all patients with psychosis admitted to our 24-bed, general psychiatry inpatient unit who have not been previously exposed to neuroleptic medication. Sixty-seven patients were 55 years of age or over. In addition to completion of psychiatric scales, the following movement disorder scales were completed before neuroleptic medication was initiated and three times a week during the course of hospitalization by an experienced research nurse blind to medication regimens: the Abnormal Involuntary Movement Scale (AIMS), the Barnes Akathisia Scale (BAS), and scales we have developed to assess dystonia and parkinsonism. Haldol was the neuroleptic used in all but six cases, with a mean daily dosage of 141.2 ± 64.8 mg. a day in chlorpromazine equivalents (CPZE).

Results: Six patients (9%) had dystonic reactions requiring treatment, 31 (46%) developed akathisia, and 40 (55%) became parkinsonian. In the vast majority of cases, the akathisia and parkinsonism was clinically significant and necessitated intervention.

Conclusion: Despite the use of low-dose neuroleptics, older patients are at considerable risk of significant EPS.

REFERENCES:

1. Rosebush PI, Mazurek MF: Complicating factors in the analysis of acute drug-induced akathisia [Letter to the editor]. *Archives of General Psychiatry* 52:878-879, 1995.
2. Sweet, RA, Mulsant BH, Kunik ME, et al: Phenomenology and prevalence of neuroleptic-induced akathisia in late life. *American Journal of Geriatric Psychiatry* 1:2:136-142, 1993.

No. 42
TREATMENT OF EXTRAPYRAMIDAL SYNDROMES IN RISPERIDONE-TREATED PATIENTS

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EDUCATIONAL OBJECTIVES:

After this presentation the participant will be able to recognize that while antipsychotic therapy with risperidone is associated with lower rates of treatment of EPS than those found with traditional antipsychotics, individuals treated with an average of 4 mg/day of risperidone still require medications for EPS at unexpectedly high rates.

SUMMARY:

Objective: The frequency of risperidone-induced extrapyramidal side effects remains unclear. In order to assess the need for treatment of extrapyramidal side effects in patients converted to antipsychotic therapy with risperidone, the treatment of EPS in risperidone-treated patients was retrospectively analyzed.

Method: Records of 51 patients with schizophrenia, schizoaffective disorder, or psychotic mood disorders who had been converted to antipsychotic treatment with risperidone were reviewed. Rates of treatment with EPS medications before and after conversion to risperidone were calculated. For those 39 who had been prescribed anticholinergic agents, propanolol, or dopaminergic medications for EPS while on traditional antipsychotics, subsequent prescriptions of these medications three months after the initiation of risperidone were also analyzed.

Results: Rates of prescriptions for extrapyramidal side effects were reduced from 39/51 (76%) before risperidone to 21/51 (41%) afterwards; 16/39 (41%) of those who were treated for side effects prior to conversion to risperidone received treatment afterwards. Only 5/12 patients previously untreated for side effects were treated after starting risperidone. The maximum risperidone dose was 8 and the average was 4.

Conclusion: Patients converted to risperidone are less likely to require prescriptions for extrapyramidal side effects. However, even at low doses, risperidone is associated with significant rates of EPS.

REFERENCES:

1. Marder SR, Meibach RC: Risperidone in the treatment of schizophrenia. *Am J Psychiatry* 151:825-835, 1994.
2. Daniel DG, Goldberg TE, Weinberger DR, et al: Different side effect profiles of risperidone and clozapine in 20 outpatients with schizophrenia or schizoaffective disorder: a pilot study. *Am J Psychiatry* 153:417-419, 1996.

No. 43
NEUROLEPTIC-INDUCED DOWNREGULATION OF MIDBRAIN DOPAMINERGIC NEURONS IS ATTENUATED BY BENZTROPINE OR LORAZEPAM

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EDUCATIONAL OBJECTIVES:

To promote awareness of neurobiological changes associated with neuroleptic administration and their relevance for extrapyramidal side effects; to review the interactions of psychopharmacological agents used in the treatment of psychosis.

SUMMARY:

Objective: The extrapyramidal side effects of neuroleptic medications can be ameliorated by anticholinergic agents such as benztropine (BENZ) and by benzodiazepines such as lorazepam (LOR). We recently showed that haloperidol (HAL) induces persistent downregulation of dopaminergic neurons in the substantia nigra (SN). We studied whether BENZ or LOR could modify this effect.

Methods: Four groups of rats received daily doses of either 1) saline, 2) HAL 2 mg/kg, 3) HAL+BENZ 1.8 mg/kg, or 4) HAL+LOR 0.4 mg/kg for eight weeks (n = 8 per group). The rats were sacrificed three weeks after the final dose and the brains were stained for the dopaminergic cell marker tyrosine hydroxylase (TH). Data were analysed by ANOVA and post-hoc t-tests.

Results: The number of TH immunoreactive neurons in SN was reduced by 22% in the HAL group vs. controls ($p < 0.0001$). This effect was significantly attenuated when the HAL was administered in conjunction with either BENZ or LOR (HAL vs. HAL+BENZ, $p < 0.005$; HAL vs. HAL+LOR, $p < 0.05$).

Conclusions: HAL caused persistent downregulation of dopaminergic neurons in SN. This effect was attenuated by adjunctive treatment with benztropine or lorazepam. These observations may relate to the neurobiology of neuroleptic-induced extrapyramidal syndromes.

REFERENCES:

1. Levinson AJ, Garside S, Rosebush PI, Mazurek MF: Tardive suppression of dopamine neurons in substantia nigra but not ventral tegmental area following neuroleptic administration. *Proceedings of the 149th Annual Meeting of the American Psychiatric Association*, NR p. 116, 1996.

2. Mazurek MF, Rosebush PI: Circadian pattern of acute neuroleptic-induced dystonic reactions. *Am J Psychiatry* 153:708-710, 1996.

PAPER SESSION 15—BEYOND FUNCTIONAL IMAGING: NEW WAYS TO USE THE BRAIN

No. 44
PET WITH (F-18)FLUORODOPA IN TOURETTE'S DISORDER

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the basic principles of positron emission tomography with [F-18]fluorodopa and its application in research in psychiatric disorders. Participants also will learn about exciting findings regarding dopamine function in Tourette's disorder.

SUMMARY:

Dopamine function has been implicated in the etiology of Tourette's disorder (TD). Using positron emission tomography, presynaptic accumulation of [fluorine-18]fluorodopa was measured in basal ganglia (caudate nucleus and putamen), ventral tegmental complex (substantia nigra and ventral tegmentum), and frontal and occipital cortices of 11 children with TD (age: 15.2 ± 1.9 years; 8 males/3 females), and 10 healthy controls (age: 14.9 ± 1.7 years; 7 males/3 females). Results were expressed as ratios of specific to nonspecific (occipital cortex) radioactive counts ([fluorine-18]). [fluorine-18] ratio was significantly higher in the left caudate ($df = 19$, $t = 2.2$, $p = 0.04$) and at a trend level in the right posterior putamen ($df = 19$, $t = 1.75$, $p = 0.097$) and the right ventral tegmental complex ($df = 19$, $t = 1.8$, $p = 0.08$) in TD subjects compared with controls.

	Left Caudate Nucleus	*Right Posterior Putamen*	*Right Ventral Tegmental Complex*	*Anterior Medial Frontal Cortex*
Control Ss(N=10)	3.07 ± 0.88	2.61 ± 0.87	1.09 ± 0.48	1.15 ± 0.47
TD Ss(N=11)	3.67 ± .73	3.18 ± 0.61	1.67 ± 0.88	1.13 ± 0.41

These findings support a dopaminergic abnormality in regions of both dopaminergic nerve terminals and cell bodies while sparing the frontal cortex. Caution is warranted in interpreting these findings, and replication studies are needed.

REFERENCES:

1. Braun AR, Randolph C, Stoetter B, et al: The functional neuroanatomy of Tourette's syndrome: an FDG-PET study. II: relationships between regional cerebral and associated behavioral and cognitive features of the illness. *Neuropsychopharmacology* 13(2):151-68, 1995.
2. Turjanski N, Sawle GV, Playford ED, et al: PET studies of the presynaptic and postsynaptic dopaminergic system in Tourette's syndrome. *J Neurol Neurosurg Psychiatry* 57(6):688-92, 1994.

No. 45
NONINVASIVE MONITORING OF BRAIN FUNCTION

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EDUCATIONAL OBJECTIVES:

To understand a new method for brain imaging using quantitative electroencephalography (QEEG), and to evaluate potential applications in psychiatric research and practice.

SUMMARY:

Objective: PET is powerful for assessing brain function, but utilization is limited by cost and dosimetry factors. Quantitative electroencephalography (QEEG) is a less-costly, noninvasive technique. We performed this study to determine if QEEG cordance could provide substantially similar information to PET.

Method: We performed 33 15-H2O PET scans on six right-handed male subjects while they were resting or performing simple motor tasks. Markers containing 22 NaCl were placed over EEG electrode sites to visualize recording sites on PET images. EEG data were acquired simultaneously with the PET scan, and cordance was calculated for the same period during which perfusion was measured. The association between cordance and perfusion was examined using multiple regression.

Results: A strong association between cordance and perfusion for subjects resting or performing motor tasks in the eyes-closed state. Data from the theta, alpha, and high-beta bands had a correlation of 0.61 with perfusion. Cordance was indistinguishable from PET in accurately identifying activation located in the right or left hemisphere. EEG power had weaker associations with perfusion and did not accurately identify activation.

Conclusion: Cordance may provide information that is similar to PET. Cordance may have utility for studying brain activity in psychiatry research or practice.

REFERENCES:

1. Leuchter AF, Cook IA., Mena I, et al: Assessment of cerebral perfusion using quantitative EEG cordance. *Psychiatry Research: Neuroimaging,* 55:141-152, 1994.
2. Gratton ST, Woods RP, Mazziotta JC, Phelps ME: Somatotopic mapping of the primary motor cortex in humans: activation studies with cerebral blood flow and positron emission tomography. *Journal of Neurophysiology,* 66:735-743, 1991.

No. 46
BEYOND FUNCTIONAL IMAGING: COMBINING FUNCTIONAL IMAGING (SPECT, PET, MRI) WITH TRANSCRANIAL MAGNETIC STIMULATION

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EDUCATIONAL OBJECTIVES:

To understand that combining visualization of brain function with noninvasive stimulation represents a powerful tool for understanding brain function and developing new therapies.

SUMMARY:

Objective: Powerful new imaging tools (PET, SPECT, fMRI) now allow noninvasive examination of brain activity. Unfortunately, neuroanatomic insights have not as yet translated into therapies. Further, imaging a change in regional brain activity does not explain the relationship between regional activity and a task or disease. Transcranial magnetic stimulation (TMS) involves placing an electromagnet on the scalp, activating superficial cortical neurons by creating a rapidly changing focal magnetic field. Merging conventional functional imaging with TMS would allow for the active investigation and visualization of brain networks and direct explora-

tion of causal brain behavior relationships, potentially targeting TMS therapies.

Methods: Initial work at NIMH and MUSC has explored combining TMS and the following functional imaging techniques: 1) combining TMS with split-dose FDG PET or perfusion SPECT, 2) locating motor cortex with TMS, and then using external fiducials and echoplanar BOLD fMRI or O15 PET during a motor task, 3) placing magnetic coils (TMS) in an MRI scanner to image the magnetic fields produced and regional brain effects.

Results: These approaches have advantages, disadvantages, and specific methodologic problems. This talk reviews these techniques and summarizes the findings to date.

Conclusion: Combining TMS with functional imaging represents a powerful research tool for directly exploring brain-behavior relationships, with the potential of targeting brain regions for stimulation in order to treat neuropsychiatric diseases.

REFERENCES:

1. Roberts DR, Vincent DJ, Speer A, et al: Multimodality mapping of motor cortex: comparing echoplanar BOLD fMRI and transcranial magnetic stimulation. *J Neural Transmission.* (in press 1997).
2. George MS, Wassermann EM, Post RM: Repetitive transcranial magnetic stimulation (rTMS): a neuropsychiatric tool for the twenty-first century. *J Neuropsychiatry Clin Neurosci* (in press 1996).

PAPER SESSION 16—SCHIZOPHRENIA: NEW RESEARCH FINDINGS

No. 47
INCREASING VENTRICLES IN ONE OF THE SCHIZOPHRENIAS

Thamilarasi R. Nair, M.D., *Department of Psychiatry, Southwestern Medical Center, 4500 South Lancaster Road/116A, Dallas TX 76248;* James D. Christensen, Ph.D., Narinder Kumar, Ph.D., Eilene J. Mayhew, B.S.N., David L. Garver, M.D.

EDUCATIONAL OBJECTIVES:

To understand that there are different etiological processes among schizophrenics, and one subgroup appears to have an active neurodegenerative process.

SUMMARY:

Objective: To determine if there is progressive cerebral ventricular volume expansion in schizophrenia

Method: Blind volumetric analysis of 3-D MRI data using ANALYSE provided total ventricular volumes for controls and for 15 patients (age 29.9 ± 8.3) at two time points separated by 2.5 ± 0.9 years. Normality of change in ventricular volumes was assessed by admixture analyses with clustering.

Results: With a 1.8% error in estimating total ventricular volume, ventricular volumes were 17.9 ± 2.0 cm^3 for controls and 22.8 ± 8.7 cm^3 for patients ($p = 0.10$) at index scan. From index to subsequent scan the rate of ventricular enlargement was 0.2 ± 0.1 cm^3/yr in controls. Patients showed a rate of ventricular expansion of 4.5 ± 3.3 cm^3/yr, a rate whose distribution failed to meet criteria for normality ($p < 0.001$). Volumetric expansion in patients clustered into two groups ($F = 90.18$; $p < 0.001$). The first cluster ($n = 8$) showed expansion indistinguishable from controls (0.8 ± 0.5 cm^3/yr), while the second cluster ($n = 7$) had a significantly greater rate of ventricular expansion (4.4 ± 1.6 cm^3/yr) as compared with controls ($p < 0.02$).

Conclusions: These results suggest that there are two subpopulations of schizophrenic patients: one group shows ventricular expansion indistinguishable from controls, while the other exhibits rapidly expanding ventricles, suggesting an active neurodegenerative process.

REFERENCES:

1. Woods B: Progressive ventricular enlargement in schizophrenia: comparison to bipolar affective disorder and correlation with clinical course: *Biological Psychiatry* 27:341-352, 1990.
2. Shenton M: Application of automated MRI volumetric measurement techniques to the ventricular system in schizophrenia and in normal controls. *Schizophrenia Research*, 5:103-113, 1991.

No. 48
SCHIZOPHRENIC THINKING: CONTEXT AND WORKING MEMORY

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EDUCATIONAL OBJECTIVES:

Participants will be informed about recent research on mechanisms that may be involved in thought disorder in schizophrenia patients and bipolar patients. They also will gain a better understanding of recent models of schizophrenic thought disorder, which have emphasized difficulties in working memory in the prefrontal cortex.

SUMMARY:

Purpose: The present research was designed to study mechanisms involved in thought disorder in schizophrenia, focusing on the influence of loss of context and impaired working memory, both of which have been proposed as central features in newer models of thought pathology.

Method: To evaluate these mechanisms, we assessed 240 patients, including 71 acute schizophrenia patients, 35 bipolar patients, and control groups of 48 other psychotic patients and 86 nonpsychotic patients. We employed standardized measures of thought disorder and a newly constructed measure, pretested for inter-rater reliability, to assess both total absence of context and straying from the context.

Results: 1) Surprisingly, less than 15% of schizophrenia patients showed strong evidence of complete ignoring of context. 2) Thought-disordered schizophrenia patients and bipolar patients strayed from the context significantly more than non-thought-disordered patients ($p < .01$), but not all thought-disordered patients strayed from the context. 3) Bipolar patients strayed from the context significantly more frequently than schizophrenia patients ($p < .05$).

Conclusions: Mechanisms involved in straying from the context contributed to thought disorder in bipolar patients more than to thought disorder in schizophrenia patients. When direct measures of overt use of context were employed, only mixed support was found for recent formulations about a strong relationship between schizophrenic thought disorder and holding the external context "on-line" in working memory.

REFERENCES

1. Baddeley, AD, Hitch GJ: Developments in the concept of working memory. *Neuropsychology*, 8(4):485-493, 1994.
2. Goldman-Rakic PS: Working memory dysfunction in schizophrenia. *The Journal of Neuropsychiatry and Clinical Neurosciences*, 6:348-357, 1994.

No. 49
PSYCHOSIS AFTER PRENATAL EXPOSURE TO RUBELLA

Alan S. Brown, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, Unit 2, New York NY 10032;* Patricia Cohen, Ph.D., Raymond Goetz, Ph.D., Ezra S. Susser, M.D.

EDUCATIONAL OBJECTIVES:

To understand the potential association between prenatal exposure to rubella and schizophrenia.

SUMMARY:

Objective: We sought to examine whether prenatal exposure to rubella virus is a risk factor for psychosis in adulthood.

Method: The exposed study population was a birth cohort of 70 children with serologic evidence of prenatal rubella exposure, who were enrolled in a prospective community study. The unexposed birth cohort consisted of 153 individuals with no evidence of gestational rubella exposure, also from a prospective community study. All subjects received a comprehensive psychiatric assessment, the Diagnostic Interview Schedule for Children, during a follow-up interview in early adulthood. We compared the frequency of positive responses to individual psychotic symptoms and the proportion of subjects meeting the A, D, and E criteria for schizophrenia between the rubella-exposed and unexposed birth cohorts.

Results: The rubella-exposed cohorts as compared with the unexposed cohort, had substantial and significantly increased frequencies of several psychotic symptoms, including mind reading (11.3% vs. 3.5%, p = .03), thought insertion (14% vs. 0.7%, p = .00005), grandiose delusions (8.5% vs. 0%, p = .0008), and auditory (14% vs. 0.7%, RR, p = .00005) and visual hallucinations (9.9% vs. 2.1%, p = .01). The A, D, and E criteria for schizophrenia (DSM-IV) were met by 17.1% (12/70) of the rubella-exposed individuals versus only 1.3% (2/153) of the unexposed (RR = 13.1, 95% CI = 3.0, 57.0, p = .00002). There was no relation of psychotic symptoms to congenital deafness.

Conclusion: These findings suggest that prenatal rubella exposure may be a risk factor for psychotic disorders.

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2. Whitley RJ, Stagno S: Perinatal viral infections. In: Scheld WM, Whitley RJ, Durack DT (eds), *Infections of the Central Nervous System,* Raven Press, Ltd. New York, 1991.

PAPER SESSION 17—ABUSE OF CHILDREN: A FRAGILE ALLIANCE BETWEEN MEDICINE AND THE LAW

No. 50
MANDATORY REPORTING OF CHILD ABUSE: A SURVEY OF MENTAL HEALTH PRACTITIONERS' REPORTING PATTERNS

Johannes G. Dalmasy-Frouin, M.D., *Department of Psychiatry, University of Maryland, 645 West Redwood Street, Baltimore MD 21201;* Lisa B. Dixon, M.D.

EDUCATIONAL OBJECTIVES:

To identify factors that influence practitioners' decisions to report child abuse; to understand legal obligations to report child abuse.

SUMMARY:

Objective: This study aimed to determine whether mental health professionals (MHPs) would adhere to statutes mandating that they report *all* allegations of childhood abuse, regardless of the current age of the patient, years since the alleged abuse, and patients' wishes.

Methods: A randomly selected sample of MHPs in an academic psychiatry department completed a survey with vignettes in which a patient disclosed a history of past abuse (N = 82, response rate = 69%). Respondents were asked if they would report the case given different patient demographic factors, settings of disclosure, and circumstances of abuse.

Results: Respondents were much less likely to report the abuse if the patient was an adult (29% if patient adult, 84% if patient a child, p < .0001), if the disclosure occurred in psychotherapy vs. a forensic setting (p < .05), and if the abuse was nonsexual rather than sexual (p < .02). Likelihood of disclosure did not vary by patient gender and diagnosis.

Conclusion: This study suggests that the decision to report child abuse, particularly in cases of adult disclosures, is complex and may vary according to setting and nature of abuse, even in the presence of legal compulsions to report.

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1. Berlin FS, et al.: Effects of statutes requiring psychiatrists to report suspected sexual abuse of children. *Am J Psych* 148:449-453, 1991.
2. Crenshaw WB, Lichtemberg JW: Mental health providers and child sexual abuse: an analysis of the decision to report. *Journal of Child Sexual Abuse* 2, 4: Fall(1993).

No. 51
THE CHILD ADVOCACY TEAM IN CHILD ABUSE AND NEGLECT OR DIVORCE LEGAL ACTIONS

Jack C. Westman, M.D., *Department of Psychiatry, University of Wisconsin, 6001 Research Park Boulevard, Madison WI 53719*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to define a child advocacy team; understand the indications for the team; know how to form a team; determine the relevance of a team to the participant's practice; and access more detailed information about the operations of a team.

SUMMARY:

This report describes the child advocacy team as an effective means of integrating professional and volunteer activities for a particular family during the full term of a child protection or divorce legal action. Children and adolescents who enter the courts because of abuse and neglect or divorce disputes often have complicated problems that involve their families, schools, social workers, mental health clinicians, and other professionals and volunteers. Unless these systems are integrated, the resulting fragmentation and lack of continuity of services are costly in both humanistic and financial terms.

The bases for this presentation are the prospective analyses of the outcomes of 80 child advocacy team cases and the modus operandi of the University of Wisconsin Child Advocacy Service over the last 20 years. This report describes the principles of child advocacy; the characteristics of the professional systems involved in child advocacy; the techniques of child advocacy; the planning conference, therapeutic evaluation process, team meetings, report preparation, and coutroom participation of the child advocacy team; and the analysis of case outcomes.

The child advocacy team is a new and efficacious paradigm for integrating the mental health, legal, social service, educational, and child development systems.

REFERENCES:

1. Westman JC: *Who Speaks for the Children? A Handbook of Class and Individual Child Advocacy.* Sarasota, FL: Professional Resources Exchange, 1991
2. Westman JC: The child advocacy team in child abuse and neglect matters. *Child Psychiatry and Human Development* 26:221-234, 1996

No. 52
FALSE CHILD SEXUAL ABUSE ALLEGATIONS

Jiri Raboch, M.D., *Department of Psychiatry, Charles University, Le Karlovu 11, Prague 2 12821, Czech Republic.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should know about cases of false child sexual abuse allegation. Thorough psychiatric evaluation of the alleged perpetrator, including phallometric assessment, could contribute to the clarification of these cases.

SUMMARY:

Objective: The frequency of false child sexual abuse (CSA) allegations is of significant legal and clinical importance. Its percentage varies broadly in various studies from 2% to 55%.

Method: In the years 1993-1995 we were provided as court experts with 100 cases of alleged CSA. After studying all the court materials, we divided the alleged perpetrators into three groups: I. "True accusation," n = 61. II. "False accusation," n = 15. III. Spurious cases, n = 24. After thorough clinical evaluation including various questionnaires and phallometric assessment we analysed the differences between groups I and II.

Results: The majority of group I men showed some form of psychopathology and about 50% of them had abnormal sexual preference according to phallometric assessment.

Conclusions: CSA is a delicate issue and all interested parties should handle it very carefully. Complex psychiatric evaluation of the alleged perpetrator could contribute to the clarification of these cases.

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1. Kutchinsky B: Child sexual abuse: prevalence, phenomenology, intervention, and prevention. *Nordisk Sexologi* 12:51-61, 1994
2. Mikkelsen EJ, Gutheil TG, Emens M: False sexual abuse allegations by children and adolescents: contextual factors and clinical subtypes. *Am J Psychotherapy* 46:556-570, 1992

PAPER SESSION 18—DIAGNOSIS AND MANAGEMENT OF ANXIETY DISORDERS

No. 53
IS COGNITIVE PROCESSING NECESSARY FOR A PANIC ATTACK?

Harold W. Koenigsberg, M.D., *Department of Psychiatry, Cornell Med Center/NY Hospital, 21 Bloomingdale Road, White Plains NY 10605;* Charles P. Pollak, M.D., Dominic J. Ferro, M.D.

EDUCATIONAL OBJECTIVES:

To describe the current neurobiological and psychological models of panic induction and to understand the role of sleep data in helping to separate the role of cognitive processes and biological processes in panic induction.

SUMMARY:

Objective: The finding that biochemical agents induce panic attacks resembling spontaneous panic in panic disorder (PD) patients raised the possibility that a central neurobiologic mechanism for panic disorder could be identified. Alternatively, psychological models have been proposed that posit that challenge agents induce panic simply by inducing interoceptive sensations that initiate chains of catastrophic cognitions in PD patients, leading to panic. This study assesses whether panic attacks can be initiated biochemically in the absense of such cognitions, by determining whether panic can be induced directly from stage 3-4 sleep, when cognitive processing is minimal.

Method: Panicogenic doses of caffeine were administered intravenously to eight panic disorder patients and 11 healthy controls during stage 3-4 sleep.

Results: Panic attacks were induced by caffeine infusions directly from stage 3-4 sleep in three subjects and subclinical panic in an additional three. PD subjects experienced significantly more panic symptoms in response to the sleep infusions than did controls ($p = .016$).

Conclusions: Conscious appraisal and cognitive processing of interoceptive sensations is not a necessary condition for the generation of panic attacks. In addition, even when daily caffeine intake is controlled for, panic disorder patients show a greater sensitivity to caffeine than controls during stage 3-4 sleep.

REFERENCES:

1. Koenigsberg HW, Pollak CP, Fine J, Kakuma T: Lactate sensitivity in sleeping panic disorder patients and healthy controls. *Biol Psychiatry* 32:539-542, 1992.
2. Margraf J, Ehlers A, Roth WT: Sodium lactate infusions and panic attacks: a review and critique. *Psychosom Med* 48:23-51, 1986.

No. 54
THE COURSE AND PROGNOSIS OF SOCIAL PHOBIA

Catherine L. Woodman, M.D., *Department of Psychiatry, University of Iowa, 200 Hawkins Drive, Iowa City IA 52242;* Russell Noyes, Jr., M.D., Janette Lamberty,

EDUCATIONAL OBJECTIVES:

To compare the severity and course of social phobia with those for generalized anxiety disorder and panic disorder, to learn what factors are associated with a good prognosis for each disorder; and to understand the course and prognosis of social phobia and the factors that predict a better outcome for the disorder.

SUMMARY:

Social phobia is a common anxiety disorder, yet there is limited information available about the natural history and prognosis of the disorder. This study examined the stability of the diagnosis and the uniformity of the course and outcome in patients with naturalistically treated social phobia in a four-year, prospective, follow-up study. Patients with naturalistically treated panic disorder (PD) and generalized anxiety disorder (GAD) were used as a comparison group.

Methods: 50 patients with social phobia, 68 patients with GAD, and 64 patients with PD who were recruited through the news media for drug treatment studies and evaluated at the University of Iowa psychiatry clinic an average of four years prior to follow-up (range 3-7) were relocated and reinterviewed. Participation was 80%. Follow-up instruments included: 1) SCID, modified for DSM-IV; 2) LIFE, modified for anxiety and depression; 3) Psychiatric Rating Scales to evaluate symptomatology of each diagnosed disorder over the follow-up period on a monthly basis; 4) Clinical Global Impression Scales (CGI); 5) HAMA; 6) Hopkins Symptom Checklist; 7) FQ; 8) STAI; 9) Beck Depression and Beck Anxiety Inventory; 10) Davidson Social Phobia Scale, to achieve lifetime and current diagnoses, severity of illness over the follow-up period and several investigator-rated and self-rated assessments of anxiety, depression, and quality of life. The LIFE instrument also documents medical illness and health-care utilization in the follow-up period.

Results: At baseline, there were some significant demographic differences between the three groups. In addition, the social phobia and GAD groups had less severe illness than the PD group, as measured by the CGI and clinician-rated as well as self-rated instruments.

At follow-up, there was diagnostic stability for social phobia, GAD and PD. There was not a statistical difference in the severity

of illness, as the PD group had improved significantly more than the social phobia and GAD groups. Significantly fewer social phobia probands were in full or partial remission at follow-up, and had less full remission over the follow-up period. Results from various other measures will be reported.

Conclusions: Social phobia is a less severe disorder than PD when it is diagnosed. However, it has less remission and longer periods of symptoms over time, making it a disorder that longitudinally can be as severe as PD. It is important to recognize the severity of social phobia when it is diagnosed in the medical setting, because effective treatment is available.

REFERENCES:

1. Noyes R, Woodman CL, Garvey MJ, et al: Generalized anxiety disorder vs. panic disorder—distinguishing characteristics and patterns of comorbidity; *J Nerv Ment Dis* 180:369-379, 1992.
2. Fyer AJ, Mannuzza S, Chapman TF, et al: A direct interview family study of social phobia. *Arch Gen Psychiatry* 50:286-293, 1993.

No. 55
THE LONG-TERM TREATMENT OF PANIC DISORDER

R. Sandlin Lowe III, M.D., *Department of Psychiatry, NYU School of Medicine, 550 First Avenue, New York NY 10016;* Eric D. Peselow, M.D., Mary T. Guardino, Sunil D. Khushalani, M.D., Wieslawa Tomaszewska, M.D.

EDUCATIONAL OBJECTIVES:

To review the literature and present data on the long-term course of panic disorder in terms of symptom reduction, quality of life, and consumer satisfaction

SUMMARY:

Objective: It is estimated that about 10% of the population will have a panic attack at some point in their life, with 4% meeting criteria for a limited symptom attack and 2% meeting criteria for a full-blown attack. Though various pharmacologic and cognitive-behavioral treatments are effective in short-term treatment for panic attacks, the efficacy and long-term course of panic disorder remain unstudied.

Method: To date we have followed 105 patients who after 12 weeks of initial pharmacotherapy (antidepressants or anxiolytics + antidepressants) recovered with a complete cessation of full-blown or limited-symptom panic attacks. Patients were followed over a succeeding 3-42 month period (average 27 months) on the medication to which they had responded until one of three outcomes: termination well (all patients continuously well until July 31, 1996 the endpoint of this preliminary analysis), dropout, or relapse with relapse (having a breakthrough full-blown or limited-symptom attack). All these patients at baseline and at three-month intervals were rated with the Hamilton Anxiety Scale, Panic Inventory, Montgomery-Asberg Depression Scale, and CGI..

Results: Over an average 27-month course, 46 (43%) patients had at least one full-blown attack and 68 (64%) had at least a limited-symptom attack. Phobic avoidance and initial degree of anticipatory anxiety negatively correlated with length of time free of a full-blown and limited-symptom attack. The probability of remaining free of a full-blown panic attack was 74% at one year, 53% at two years, and 34% at three years. Patients who received cognitive-behavioral treatment + pharmacotherapy had better outcomes.

Conclusion: There was a high rate of recurrence of panic disorder despite treatment. We will also analyze long-term course in terms of consumer satisfaction and quality of life.

REFERENCES:

1. Pollack MH, Otto MW: Anxiety disorders: longitudinal course and treatment. *Psychiatric Clinics of North America*, December, 1995.
2. Katschnig H, et al: Long-term follow-up after a drug trial for panic disorder. *British Journal of Psychiatry* 167:487-494, 1995.

PAPER SESSION 19—PSYCHIATRIC ISSUES IN WOMEN

No. 56
SSRI'S VERSUS TRICYCLIC ANTIDEPRESSANTS FOR POSTPARTUM DEPRESSION

Katherine L. Wisner, M.D., *Department of Psychiatry, Case Western Reserve Univ., 11400 Euclid Avenue, Suite 200, Cleveland OH 44106*

EDUCATIONAL OBJECTIVES:

To recognize postpartum depression, a frequent disorder in new mothers, and to be able to select appropriate antidepressant treatments.

SUMMARY:

Objective: Depression that interferes with maternal functioning occurs in 10%-15% of postpartum women. Rapid treatment is imperative. We tested the hypothesis that the serotonin specific reuptake inhibitors (SSRI) were more effective than tricyclics (TCA) in our openly treated outpatient population.

Method: Sequential records of 30 women with nonpsychotic postpartum-onset major depression (PPMD) were reviewed to determine drug response. The women were diagnosed by clinical examination and the Inventory to Diagnose Depression (IDD). Response was defined as 50% reduction in the initial IDD score by week 6, 7, or 8 of treatment.

Results: The response rate for SSRI was 80% (8/10) and for TCA was 60% (12/20). Additionally, the response to subsequent drug therapy was evaluated. Two of the eight nonresponders to TCA had ECT. The six remaining patients were treated with an SSRI, and four (67%) responded to the SSRI. For the two SSRI nonresponders, both responded to the next drug selected (an SSRI and a TCA).

Conclusions: These naturalistic data suggest that SSRI's are superior to TCA's for the treatment of PPMD. The results from this small sample are not statistically significant (Fisher's Exact, $p = 0.25$), and the difference in response proportions is small (.2), as would be expected from a comparison of two active antidepressants.

REFERENCES:

1. Wisner KL, Peindl K, Hanusa BH: Symptomatology of affective and psychotic illnesses related to childbearing. *J Affective Disorder* 30:77-87, 1994.
2. Wisner KL, Perel JM, Findling RL: Antidepressant treatment during breastfeeding. *Am J Psych* 153:1132-1137.

No. 57
IMPACT OF PREGNANCY ON RISK FOR RELAPSE OF MDD

Lee S. Cohen, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC 815, Boston MA 02114;* Laura M. Robertson, B.A., Jill Goldstein, Ph.D., Deborah A. Sichel, M.D., Lynn R. Grush, M.D., Lisa S. Weinstock, M.D.

EDUCATIONAL OBJECTIVES:

The objective of this presentation is to describe the risk for relapse in women who maintain or discontinue antidepressant medications before and during pregnancy and to explain how this pattern affects risk for postpartum affective disorder.

SUMMARY:

Objective: The purpose of this study was to assess the impact of pregnancy on risk for relapse of major depressive disorder (MDD).

Method: This report describes the course of 28 women with histories of MDD who were prospectively followed in a longitudinal study of mood and anxiety disorders during pregnancy and the postpartum period. Using a diagnostic timeline keyed to the SCID-P, presence of MDD was recorded retrospectively for the nine months prior to conception, and then prospectively at three-month intervals across pregnancy and the first nine postpartum months. Changes (if any) in pharmacotherapy for this 18-month period were also noted. Relapse rates of MDD were compared using Kaplan-Meier survival analysis during pregnancy and the nine months prior to conception in those women who discontinued or maintained antidepressant treatment.

Results: Of 28 women, 60.7% (N = 17) were on maintenance treatment and euthymic nine months prior to conception. Eleven of these women continued antidepressant treatment through conception, while six discontinued antidepressant treatment. During the nine pregravid months, 83.3% of those who attempted to discontinue antidepressant experienced a relapse of MDD as compared with 45.5% of those who continued maintenance treatment. Of women on maintenance treatment and euthymic at the time of conception (N = 18), six continued taking antidepressants throughout pregnancy, while 12 discontinued treatment. In both groups, 83.3% experienced relapse. No significant difference in time to relapse was found between pregnancy and the nine months prior to pregnancy in the women who discontinued antidepressant treatment. However, pregnant women on maintenance treatment experienced a significantly shorter time to relapse than women on maintenance treatment prior to pregnancy.

Conclusion: Rates of relapse appear high in the setting of antidepressant discontinuation during pregnancy. Maintenance treatment does not necessarily confer protection against relapse of MDD in gravid women.

REFERENCES:

1. Frank E, Kupfer DJ, Jacob M, et al: Pregnancy related affective episodes among women with recurrent depression. *Am J Psychiatry* 144:288-293, 1987.
2. O'Hara MW: *Postpartum Depression: Causes and Consequences*, New York, Springer-Verlag, 1994.

No. 58
DIAGNOSTIC STATUS OF WOMEN WHO PRESENT WITH PMS

Jennie W. Bailey, B.A., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC 815, Boston MA 02114;* Lee S. Cohen, M.D., Cassandra P. Morabito, Ph.D., Rebecca Lamm, B.A., Jerrold F. Rosenbaum, M.D.

EDUCATIONAL OBJECTIVES:

The objective of this presentation is to discuss the high prevalence of Axis I disorders among women who present with PMS. The implications of these findings for the screening and treatment of this population will also be discussed.

SUMMARY:

Objective: Many women suffer from symptoms of premenstrual reactivity of mood and anxiety and present to a spectrum of clinicians for evaluation and treatment of PMS. Several studies have suggested that these women have a higher prevalence of lifetime and current psychiatric disorders than the general population. The purpose of this study was to evaluate systematically a cohort of women who responded to an advertisement outlining a study of potential treatment for PMS and subsequently to describe their diagnostic status.

Methods: Two hundred women responded to advertisements outlining a PMS treatment study. All respondents were interviewed by phone to assess diagnostic status using a questionnaire keyed to the Structured Clinical Interview for Diagnosis.

Results: Based on the phone interview, approximately 40 percent of total respondents met criteria for one or more Axis I disorders. The three most prevalent Axis I disorders were major depressive disorder, dysthymia, and panic disorder.

Conclusion: Many patients with primary complaints of PMS may suffer from underlying mood and anxiety disorders. The extent to which these psychiatric disorders go unrecognized and untreated as they present under the aegis of PMS has important implications for the screening and treatment of this population.

REFERENCES:

1. Harrison WM, Endicott J, Nee J, et al: Characteristics of women seeking treatment for premenstrual syndrome. *Psychosomatics* 30:405-411, 1989.
2. Pearlstein TB, Frank E, Rivera-Tovar A, et al: Prevalence of axis I and axis II disorders in women with late luteal phase dysphoric disorder. *Journal of Affective Disorders* 20:129-134, 1990.

PAPER SESSION 20—NEW FINDINGS IN GERIATRIC DEPRESSION

No. 59
DYSTHYMIA IN ELDERLY PEOPLE LIVING IN DUBLIN

Brian A. Lawlor, M.D., *Department of Psychiatry, St. James Hospital, James Street, Dublin, Ireland;* Michael Kirby, M.D., Irene Bruce, R.N., Alicia Radic, M.D., Davis Coakley, M.D.

EDUCATIONAL OBJECTIVES:

To explain the clinical features of dysthymia in older people.

SUMMARY:

Objective: The purpose of this study was to describe the clinical features of dysthymia in a community sample of elderly people living in Dublin.

Method: Community dwelling elderly on family practitioner lists were screened using the GMS-AGECAT system. All AGECAT depressed 'cases' were then interviewed by a trained psychiatrist using a DSM-III-R checklist to identify cases of dysthymic disorder.

Results: A total of 921 elderly people were screened and 31 cases of dysthymia (20 females, 11 males, mean age 75 ± 6.6 years) were ascertained. The mean age at onset of dysthymia was 58 ± 23 years (range 14-91) and the mean duration of dysthymia was 18 years (range 2-62). The majority of cases were of late onset and were unrelated to chronic nonaffective Axis I or II disorders, with only 16% and 13% having comorbid Axis I and Axis II diagnoses, respectively. Interestingly, 68% reported a major life event at the onset of dysthymia. Only 26% were receiving antidepressant treatment at the time of assessment, and 29% had ever received antidepressants. Few dysthymics (13%) were attending psychiatric services at the time of assessment.

Conclusions: Dysthymia in older people is primarily affective rather than characterological, is often triggered by stressful life

events, and is significantly underdetected and undertreated in primary care settings.

REFERENCES:

1. Weissman MM, Leaf PJ, Bruce ML, Florio MS: The epidemiology of dysthymia in five communities: rates, risks, cormorbity, and treatment, *Am J Psychiatry* 815-819, 1988.
2. Devanand MD, Mitchell MD, et al: Is dysthymia a different disorder in the elderly?, *Am J Psychiatry*, 151:11, 1592-1599, 1994.

No. 60
RELAPSE RATES IN GERIATRIC DEPRESSION

G. Alan Stoudemire, M.D., *Department of Psychiatry, Emory University, 1355 Clifton Road NE, 5th Flr, Atlanta GA 30322;* Connie D. Hill, Ph.D., Marti Marquardt, R.N., Sandy Dalton, R.N., Barbara Lewison, B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be able to evaluate the likelihood of relapse in geriatric depression and identify therapeutic strategies to improve remission rates in this population.

SUMMARY:

This study was designed to determine relapse rates in geriatric depression after treatment with either antidepressants or electroconvulsive therapy. Thirty-nine patients, average age 71 years, were diagnosed by SCID interviews and DSM-III-R criteria to have nonpsychotic, nonbipolar major depression. After assessment with the Hamilton Rating Scale for Depression and the Mattis Dementia Rating Scale, patients were treated with either antidepressants or electroconvulsive therapy. Patients were then followed for an average of 18 months and relapse rates determined by use of the Longitudinal Interval Follow-up Evaluation (LIFE) instrument.

Ninety percent of patients recovered from their index episode. Relapse rates of both groups of patients (AD or ECT) as determined by the LIFE instrument were approximately 29%. The time to relapse was 23.5 weeks for the AD-treated patients and 37.5 weeks for ECT-treated patients. A trend for cognitive improvement as a result of treatment was observed in both groups.

The results indicate that while the majority of patients with geriatric depression will show a high rate of positive response to treatment, almost one-third may relapse in the first year. Efforts should be directed toward intensive pharmacologic and psychosocial therapies to decrease relapse rates in this patient population.

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1. Sackeim HA, Prudic J, Devanand DP, et al: The impact of medication resistance and continuation pharmacotherapy on relapse following response to electroconvulsive therapy in major depression. *J Clin Psychopharmacol* 10:96-104, 1990.
2. Alexopoulos GS, Meyers BS, Young RC, et al: Recovery in geriatric depression. *Arch Gen Psychiatry* 53:305-312, 1996.

No. 61
TELEMEDICINE RATINGS OF GERIATRIC DEPRESSION

Beverly N. Jones, M.D., *Department of Psychiatry, Bowman Gray School of Med, Medical Center Boulevard, Winston-Salem NC 27157;* Lynn Exum, M.A., Beth Melton, Ph.D.

EDUCATIONAL OBJECTIVES:

To understand the application of low-cost videoconferencing equipment in the assessment of geriatric depression; to recognize the factors that contribute to patient satisfaction and acceptance; and to list equipment options and communications requirements for establishing telemedicine linkages using PC-based videoconferencing equipment.

SUMMARY:

Objective: To determine reliability of telemedicine assessments of geriatric depression.

Method: Fifty-six geriatric patients on an inpatient psychiatry unit participated in a psychiatric interview conducted using low-cost, PC-based videoconferencing equipment. A psychiatrist administered the Major Depression section of the SCID using videoconferencing equipment to see and hear the participant, while a second rater simultaneously completed SCID ratings while observing the participant face-to-face. Reliability of telemedicine SCID ratings was assessed using Cohen's Kappa. A satisfaction questionnaire compared the telemedicine interview with traditional face-to-face interview. Descriptive and factor analyses of the satisfaction ratings were made.

Results: Agreement between the two raters for all SCID items was significant ($p < .001$ for all items) with kappas ranging from 0.63 to 0.96, as was diagnosis of major depressive syndrome and determining the role of organic factors or bereavement in the etiology. Satisfaction ratings ranged from 2.37 to 2.98, with a score of 3 indicating equal satisfaction as face-to-face. Factor analysis yielded three domains (Comfort, Accuracy, Sensation), which explained 68% of the variation in satisfaction.

Conclusions: These preliminary results indicate high reliability between telemedicine and face-to-face ratings of geriatric depression. Participants' ratings of satisfaction and comfort indicate that telemedicine assessment of geriatric depression is acceptable to patients.

REFERENCES:

1. Baer L, Cukor P, Jenike M, et al: Pilot studies of telemedicine for patients with obsessive-compulsive disorder. *Am J Psychiatry* 152:9 1383-1385, 1995.
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PAPER SESSION 21—THE SPECTRUM OF COMORBIDITY IN SCHIZOPHRENIA: FROM SEXUALITY TO DEPRESSION

No. 62
A BLINDED TRIAL ON THE COURSE AND RELATIONSHIP OF DEPRESSIVE SYMPTOMS IN SCHIZOPHRENIA

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize that depressive symptoms are a common complicating factor in the course of schizophrenia and are treatment responsive.

SUMMARY:

Depressive signs and symptoms during the longitudinal course of schizophrenia are common. They have been associated with a worsened prognosis and a higher risk of self-harm. Secondary depression, whether part of the disease or related to conventional neuroleptic pharmacology, contributes to the devastating long-term impact of schizophrenia on both victim and family. Novel antipsychotic drug candidates introduce new pharmacological avenues that may differ-

entially impact schizophrenic signs and symptoms including depression.

This was a 17-country investigation where 1996 subjects with schizophrenia or a related diagnosis were randomized to a blinded, comparative trial of the novel antipsychotic olanzapine (5-20 mg/day) or the conventional D_2 antagonist, haloperidol (5-20 mg/day). Subjects were evaluated with several instruments including the PANSS, extracted BPRS, MADRS, and Simpson-Angus. The trial consisted of two phases: an acute six-week and a 46-week blinded maintenance period. Depressive signs and symptoms of at least moderate severity (MADRS $\geq$ 16) were seen in slightly over half of all subjects. While both treatments were associated with acute baseline to endpoint improvement on the MADRS, olanzapine improvements were statistically significantly superior to haloperidol ($p = .001$). Furthermore, the olanzapine response rate (≥50% MADRS improvement and completed more than three weeks of acute treatment) was also significantly higher ($p = .001$). A path-analysis demonstrated that while improvement in subjects' positive and/or negative symptoms was associated with mood improvement (indirect effect), the majority of the olanzapine treatment effect seen on mood was a primary or direct effect (57%) and this direct effect of olanzapine alone was statistically significantly greater than that of haloperidol ($p < .001$). Depressive signs and symptoms in schizophrenia are treatment responsive and may represent a separate dimension of schizophrenic psychopathology. The pleotrophic pharmacology of olanzapine, through one or more non-D_2 mediated pathways, likely contributed to a superior treatment effect. These findings have implications for the biochemical mechanisms underlying secondary depression in schizophrenia and the possibility for improved patient outcomes through better control of mood disorders accompanying schizophrenia.

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2. Koreen AR, Siris SG, Chakos M, et al: Depression in first-episode schizophrenia. *Am J Psychiatry* 150:1643-1648, 1993.

No. 63
WHEN SCHIZOPHRENIA AND GENDER DYSPHORIA COEXIST

Sharon G. Dott, M.D., *Department of Psychiatry, University of Texas, 301 University Blvd., D28, Galveston TX 77555-0428;* David P. Walling, Ph.D., Collier M. Cole, Ph.D., Walter J. Meyer III, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to recognize coexisting factors in schizophrenia and gender dysphoria. Participants should also be able to understand appropriate treatment goals for these dually diagnosed individuals.

SUMMARY:

Individuals who present with both schizophrenia and gender dysphoria are considered relatively rare. Until recently, professionals often considered transsexualism to be a presentation of schizophrenia, resulting in the misdiagnosis of many individuals. However, a number of cases have been identified in which both disorders are present, thus requiring proper recognition and treatment of both.

Methods: A chart review was conducted of 400 individuals undergoing surgical gender reassignment. Clinical interviews had previously been conducted on these individuals. Additionally, individuals diagnosed with schizophrenia (n = 88) were surveyed on transgender issues.

Results: Approximately 10% (n = 9) of the individuals diagnosed with schizophrenia identified themselves as having a desire to be of the opposite sex, even after they had been stabilized on medications. A review of these data revealed that many had talked with a mental health professional regarding this desire, but only two had actually sought consultation for gender reassignment surgery. In the population of gender dysphoric subjects, six individuals were concurrently diagnosed with schizophrenia, three had been surgically reassigned.

Conclusion: Schizophrenia and gender dysphoria may coexist as separate disorders. A diagnosis of schizophrenia does not rule out gender reassignment surgery. However, psychiatric stability is important before proceeding with treatment. Guidelines for treating the coexisting conditions will be discussed.

REFERENCES:

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2. deCuypere G: Schizophrenia and symptomatic transsexualism: two case reports. *European Psychiatry.* 8:163-167, 1993.

No. 64
RISKING IT ALL? SEXUAL BEHAVIOR IN SCHIZOPHRENIA

David P. Walling, Ph.D., *Department of Psychiatry, University of Texas, 301 University Blvd, D28, Galveston TX 77555-0428;* Sharon G. Dott, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should understand the importance of recognizing sexual behaviors and attitudes in individuals diagnosed with schizophrenia. Participants should also be aware of related psychoeducational needs in this population.

SUMMARY:

Objective: Little research exists examining sexual behavior and attitudes in a schizophrenic population. Many reasons may account for this lack of documentation. Societal factors deemphasize the sexuality of those with disabilities, whether physical or mental. Additionally, treatment has exclusively focused on controlling symptomatology rather than exploring the lifestyles of those with schizophrenia. This study was conducted to determine the level of sexual activity and behaviors and beliefs about sexuality in a schizophrenic population.

Methodology: Subjects (n = 88) were recruited from a community mental health center and all had a diagnosis of schizophrenia. Subjects were administered a general information/demographics questionnaire and sexual behavior and attitudes questionnaire.

Results: Female subjects in this study were more sexually active than their male counterparts and reported more satisfaction with their sexual contacts. Subjects had a poor understanding of communicable disease risk factors and associated prevention techniques. The majority of subjects denied use of prevention techniques when engaging in sexual behaviors.

Conclusions: Limited sexual activity reported by many subjects may result from both the social and cognitive deficits noted in schizophrenia. However, while sexual contacts are limited for many, those encounters reported were more likely to involve unsafe sexual contact, thus putting this population at increased risk for communicable diseases.

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1. Katz R, Watts C, Santman J: AIDS knowledge and high risk behaviors in the chronic mentally ill. *Community Mental Health Journal* 30:395-402, 1994.

2. Gift T, Wynne L, Harder D: Sexual life events and schizophrenia. *Comprehensive Psychiatry.* 29:151-156, 1988.

PAPER SESSION 22—MENTAL AND PHYSICAL DISORDERS ACROSS CULTURES

No. 65
SOMATIZATION IN CHINESE AMERICANS AND CAUCASIAN AMERICANS

L.K. George Hsu, M.D., *Department of Psychiatry, New England Medical Center, 750 Washington St., Box 1007, Boston MA 02111;* Marshal F. Folstein, M.D.

EDUCATIONAL OBJECTIVES:

To recognize the clinical profile of somatization in Chinese Americans; recognize how this profile is different from that of Caucasian Americans; and diagnose and treat somatoform disorders in Chinese Americans.

SUMMARY:

Objective: We compared true somatization (TS), defined as persistent presentation of medically unexplained somatoform symptoms with the belief that they originated from undiagnosed physical illness, between Chinese and Caucasian Americans to determine (1) its relative prevalence, (2) its symptom profile, and (3) presence of concurrent psychiatric disorders.

Method: Consecutive series of 85 Chinese (55F, 30M) and 85 Caucasian (57F, 28M) patients referred for psychiatric care were evaluated by clinical interview and chart review for TS.

Findings: (1) TS was significantly more common among Chinese Americans than Caucasian Americans ($x^2 = 9.86$, df = 1, $p < 0.01$), both in males ($x^2 = 4.76$, df = 1, $p < 0.03$) and females ($x^2 = 5.77$, df = 1, $p < 0.02$). (2) In Caucasians, TS was related to age ($F = 7.98$, $p < 0.01$). (3) Chinese Americans complained predominantly of cardiopulmonary and vestibular symptoms, whereas symptoms of Caucasians corresponded more with those listed in DSM-IV for somatization disorder. (4) Pseudoneurological motor symptoms were more common in Caucasians (Fishers exact test $p = 0.023$). (5) Concurrent psychiatric disorders (major depression being the commonest) occurred in all somatizers. (6) 87% of Chinese and 50% of Caucasian somatizers responded to cognitive restructuring and antidepressants.

Conclusion: Cultural factors may account for the greater prevalence of TS in Chinese Americans particularly among those who are depressed or anxious. TS in Chinese Americans corresponded more with the profile of neurasthenia than undifferentiated somatoform disorder. TS in Chinese Americans may respond particularly well to antidepressants and cognitive restructuring.

REFERENCES:

1. Barsky AJ, Borus JF: Somatization and medicalization in the era of managed care. *J Am Med Assoc* 274:1931-1934, 1995.
2. Kellner R: Somatization: theories and research. *J Nerv Ment Dis* 178:150-160, 1990.

No. 66
NATIONAL COMORBIDITY SURVEY: REPLICATION IN ISRAEL

Andrew E. Skodol II, M.D., *Department of Psychiatry, NYS Psychiatric Institute, 722 West 168th Street, New York NY 10032;* Sharon Schwartz, Ph.D., Bruce P. Dohrenwend, Ph.D., Itzhak Levav, M.D., Patrick E. Shrout, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize similarities and differences between population rates, comorbidity, and demographic correlates of mental disorders in the U.S. and in Israel and their implications for service utilization.

SUMMARY:

Objective: The National Comorbidity Survey (NCS) of psychiatric disorders in the U.S. found that more than half of all lifetime disorders occurred in a small segment (14%) of the population who had a history of three or more disorders. Replication of this and other significant findings of the NCS in a general population cohort in Israel was the purpose of this study.

Method: RDC mental disorders were assessed by psychiatrists using a modified SADS-L interview among 5,200 Israeli men and women, aged 24-33. Population rates, comorbidity, and demographic correlates of disorders were determined.

Results: 17% of Israelis were diagnosed as having any current NCS mental disorder and 43% had at least one lifetime disorder. Only 4% had three or more lifetime disorders. The majority (63%) of severe disorders were among those who had only one lifetime disorder. Women were more likely to have affective disorders (OR = 2.4); men were at risk for substance abuse (OR = 3.4) and ASPD (OR = 6.7). Age was inversely related and ethnicity directly related to ASPD. Those with less than a high school education were more likely to have three or more disorders (OR = 2.6).

Conclusions: Some results of this replication study were consistent with the NCS, but others clearly diverged. Possible reasons for the differences and their implications for comorbidity and service utilization will be discussed.

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1. Kessler RC, McGonagle KA, Zhao S, et al: Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: results from the National Comorbidity Survey. *Arch Gen Psychiatry* 51:8-19, 1994.
2. Levav I, Kohn R, Dohrenwend, BP, et al: An epidemiological study of mental disorders in a 10-year cohort of young adults in Israel. *Psychol Med* 23:691-707, 1993.

No. 67
POSITIVE MENTAL HEALTH AND GOOD PHYSICAL HEALTH

George E. Vaillant, M.D., *Department of Psychiatry, Brigham & Womens Hospital, 75 Francis St, Boston MA 02138*

EDUCATIONAL OBJECTIVES:

At the conclusion of this paper, the audience should appreciate the powerful effect that absence of distress up to age 55 years has upon the subsequent aging process. They should have evidence to entertain the possibility that affective illness may reflect one end of a polygenic continuum as does low intelligence, rather than reflect a polygenic disorder as does diabetes.

SUMMARY:

Objective: A 55-year prospective study has attempted to determine the antecedents and consequences of positive mental and physical health in adult men. Since prior research demonstrated that affective disorder predicted accelerated aging, a comparison study was conducted to examine the late-life physical health of men selected to be as unlike men with major depressive disorder (MDD) as possible. The hypothesis was that they might be unusually long-lived.

Method: At age 52, 236 college men, selected for health and regularly followed since 1942, were divided into three categories of

lifetime psychological distress. Data showed that 63 undistressed men had never—prior to age 55—used mood altering drugs, consulted a psychiatrist, or abused alcohol; 74 men were classified as distressed, and prior to age 55 these 74 men had been adusers of alcohol *or* regular users of tranquilizers or psychiatrists. Included among the distressed group were 28 of 29 men classified MDD. The remaining 99 men were classified intermediate and served as a reference group. At age 70 and 75, the carefully assessed physical health of these three groups was contrasted.

Results: At age 70 the 63 undistressed men enjoyed markedly better health not only than the 74 distressed men but also than the 99 men in the intermediate group. Only three (5%) of the 63 undistressed had died by age 75 compared to 40% of U.S. males born in 1920, 25% of the 99 intermediate and 38% of the 74 distressed men ($p < .001$). Interestingly, the mean age of death of the subjects maternal grandfather (MGF) (a strong—and in theory x-linked—predictor of affective illness) also sharply differentiated the three groups. The differences among the three groups could not be explained by personality disorder. Nor could the differences in physical morbidity be explained by cigarette, dietary, and alcohol abuse or by physical health prior to age 55.

Conclusions: The findings lend support to the hypothesis that risk of affective disorder may lie along a continuum. At the opposite pole from men afflicted with MDD are men with stable lifestyles, a life-long absence of psychic distress, low neuroticism, long-lived MGF, and unusually good physical health in late life.

REFERENCES:

1. Vaillant GE, Roston D, McHugo GJ: An intriguing association between ancestral mortality and male affective disorder. *Archives of General Psychiatry*, 49:709-715, 1992.
2. Vaillant GE, Orav J, Meyer SE, et al: Late life consequences of affective spectrum disorder. *International Psychogeriatrics* 8:1-20, 1996.

PAPER SESSION 23—HEALTH SERVICES ISSUES

No. 68
DOWNSIZING AND CLOSING A HOSPITAL: MANAGERIAL ISSUES

Erica Weinstein, M.D.,M.B.A, *Marlboro Psychiatric Hospital, 546 County Road, #520, Marlboro NJ 07746-1099*

EDUCATIONAL OBJECTIVES:

To understand managerial issues involved in downsizing an institution, including recognition of competing underlying priorities; to recognize the unpredictable effects of "minor" events; and to apply observations about stabilizing staff and maintaining morale.

SUMMARY:

The process of closing a hospital and its antecedent downsizing is a complex process that has been occurring with some frequency as a result of deinstitutionalization and the pressure for more efficient use of health care (especially inpatient) resources. There is a large literature on corporate downsizing, as there is on deinstitutionalization. This report concerns the effective management of the downsizing and closure of a public psychiatric hospital. Observations may be relevant to health care institutions in general, in both private and nonpsychiatric settings.

The issue is approached via clinical/administrative evaluation of the ongoing downsizing of a large public psychiatric hospital in New Jersey, which is slated for closure in 1998. Analytic tools that can assist managers in such situations are described, with case examples, including identifying competing underlying priorities and identifying the types of "minor" delays that can have widespread unforeseen consequences in an interdependent system.

Problems of planning under conditions of uncertainty are described as are problems of stabilizing staff. The question of "morale" is discussed, with examples provided of typical problems and adaptive solutions.

REFERENCES:

1. Snyder W III: Hospital downsizing and increased frequency of assaults on staff. *H & CP*, 45:378-381, 1994.
2. Castellani PJ: Closing institutions in New York State: implementation and management lessons. *Journal of Policy Analysis and Management* 11:593-611, 1994.

No. 69
DATA FROM HOSPITAL MAINFRAMES PLUS DATABASE MANAGER EQUALS PRACTICE PROFILES AND RESEARCH DATABASES

David B. Klass, M.D., *Dept of Mental Health, 100 West Randolph, Suite 6-400, Chicago IL 60601;* Daniel J. Luchins, M.D., Adam P. Klass, B.A.

EDUCATIONAL OBJECTIVES:

Professional practice profiles are not that difficult to construct. Given information entered by pharmacy and labs in a hospital and practice guidelines constructed by psychiatrists it is possible within a database manager, to create an automated set of practice profiles. We will demonstrate how this can be done.

SUMMARY:

Hospital mainframe computers can be a rich source of information. We took raw data entered by pharmacies and laboratories in their normal course of business and together with practice guidelines initiated by psychiatrists and with a database manager, constructed an automated set of physician practice profiles. New starts and chronic use of Tegretol, valproic and divalproic acid, antidepressants, lithium, or any drug in the pharmacy file are matched with required blood tests: liver functions, CBC, thyroids etc.. We obtain for each physician (N = 500) in this 20-hospital system the number of searches and tests completed. The physicians receive their own results and comparisons with the group.

The same databases produced by the database manager in the process of this monitoring also serve as excellent sources of clinical information and research. Detailed, easy to read drug histories are available for each patient at the touch of a keystroke as are instant queries yielding summary data of drugs, lab tests, and their relationships. Data also show relationships between drug pattern usage and various outcome measures that some of the hospitals have in their files: measures such as injuries, restraint use and time out of hospitals before return are ongoing subjects for research. The system has now been up and running for eight months.

REFERENCES:

1. Klein BEK, Klein R: Sounding board: report cards on cardiac surgeons: assessing New York State's approach. *N Engl J Med* 332:1229-1232, 1995.
2. Dauphinee WD: Assessing clinical performance: where do we stand and what might we expect?. *JAMA* 274:741-743, 1995.

No. 70
PROSPECTIVE STUDY OF THE IMPACT OF PSYCHIATRIC COMORBIDITY ON LENGTH OF HOSPITAL STAY OF ELDERLY MEDICAL/ SURGICAL INPATIENTS

George Fulop, M.D., *Behavioral Medicine, Mount Sinai Hospital, 1 Gustave Levy Place/Box 1228, New York NY 10029;* James J. Strain,

M.D., Marianne Fahs, Ph.D., James Schmeidler, Ph.D., Stephen L. Snyder, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the psychiatric disorders commonly observed among elderly medical inpatients and their impact on hospital stays.

SUMMARY:

Objectives: To determine the length of stay (LOS) in an acute care general hospital for elderly medical/surgical inpatients with and without a concurrent psychiatric comorbidity.

Method: 467 subjects with a minimum three-day stay were interviewed using the SCID for anxiety and depressive disorders, and the Mini Mental Status Examination for cognitive impairment (<24).

Results: 208 (44.5%) inpatients had a current episode of one or more psychiatric comorbidities: anxiety disorder—51 (10.9%); depressive disorder—88 (18.8%); or cognitive impairment—126 (26.9%). Patients with cognitive impairment had a significantly prolonged LOS compared with those without cognitive impairment (14.6 vs. 10.6 days). There was no difference in LOS for patients with and without anxiety disorders (11.6 vs. 11.6 days) or depressive disorders (11.0 vs. 11.8 days). In multivariate analyses, cognitive impairment, but not anxiety or depressive disorder, was a significant predictor associated with increased LOS when controlling for age, gender, ethnicity, functional status, and severity of medical illness.

Conclusion: In view of the limited resources available for screening elderly populations for psychiatric comorbidity, this study suggests the utility of identifying cognitive impairment and targeting it for interventions to reduce the clinical burden and the LOS. Supported by NIMH Grant R29-43378.

REFERENCES:

1. Fulop G, et al: Impact of psychiatric comorbidity on LOS of medical/surgical inpatients: a preliminary report. *Am J Psychiatry* 144:878-882, 1987.
2. Saravay SM, et al: Psychiatric comorbidity and LOS in the general hospital: a critical review of outcome studies *Psychosomatics* 35:233-252, 1994.

PAPER SESSION 24—NEW RESEARCH ON THE COURSE OF SCHIZOPHRENIA

No. 71
A CONTROLLED STUDY ON THE COURSE OF PRIMARY AND SECONDARY NEGATIVE SYMPTOMS

Todd Sanger, Ph.D., *Lilly Research Lab, Eli Lilly and Company, Lilly Corporate Ctr, DC 0538, Indianapolis IN 46285;* Gary D. Tollefson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize the differences between primary and secondary negative symptoms, and be able to critically assess treatment study results.

SUMMARY:

Negative symptoms of schizophrenia constitute an important and challenging aspect of the disease. Whether or not primary negative symptoms are "enduring" or treatment responsive is a question of keen interest. A controlled, double-blind trial was conducted for up to 52 weeks comparing three fixed ranges of the novel antipsychotic olanzapine (OLZ), placebo, and haloperido (HAL) (10-20 mg). A total of 335 inpatient DSM-III-R schizophrenic subjects were randomized. Treatment groups were compared with regard to their baseline to endpoint SANS summary score change and several additional secondary measures. A path analysis was also conducted to determine to what extent the total treatment effect on negative symptoms was contributed to by primary (direct) or secondary (indirect) i.e., positive symptom change, EPSE, or mood effects.

Both olanzapine low- and high-dose ranges achieved statistically significantly greater SANS summary score improvement than either placebo or haloperidol. Compared with placebo, olanzapine-high had a significantly greater primary symptom benefit upon negative symptoms ($p = 0.007$). "Direct" effects were significantly greater on all SANS dimensions except anhedonia-asociality. Relative to HAL, OLZ-high demonstrated a significantly greater effect on primary negative symptoms ($p = 0.030$). These "direct" effects were especially evident on the dimensions of affective flattening and avolition-apathy. The superior treatment effects associated with olanzapine were replicated in a negative symptom stratum ($N = 116$). In the overall sample, negative symptom improvement with olanzapine continued to build through week 14 and then was sustained through 52 weeks of maintenance therapy.

This study suggests that primary negative symptoms are treatment responsive. A significantly greater olanzapine than haloperidol effect (upon both primary and secondary negative symptoms) was likely related to the pleotrophic pharmacology of olanzapine, inclusive of dopamine, serotonin, muscarinic, and adrenergic activity. These results contribute to the hypothesis that negative symptoms may be under the influence of several neurotransmitters within one or more neuroanatomic circuits.

REFERENCES:

1. Andreasen NC, Arndt S, Alliger R, et al: Symptoms of schizophrenia: methods, meanings, and mechanisms. *Arch Gen Psychiatry* 52:341-351, 1995.
2. Carpenter WT, Conley RR, Buchanan RW, et al: Patient response and resource management: another view of clozapine treatment of schizophrenia. *Am J Psychiatry* 827-832, 1995.

No. 72
LONGITUDINAL COURSE OF SCHIZOAFFECTIVE DISORDER

Martin Harrow, Ph.D., *Department of Psychiatry, University of Illinois, 912 South Wood Street, Chicago IL 60612;* James R. Sands, Ph.D., Robert N. Faull, B.S., Linda S. Grossman, Ph.D., Joseph F. Goldberg, M.D.

EDUCATIONAL OBJECTIVES:

Participants will understand ways in which long-term clinical course and outcome in schizoaffective disorders differ from those of schizophrenia and bipolar disorders.

SUMMARY:

Purpose and Method: The research was designed to advance knowledge about the long-term course of schizoaffective disorders and to compare them with that of schizophrenia and bipolar illness. As part of the Chicago Follow-Up Study, 126 patients (including 35 schizoaffectives, 68 schizophrenics, and 23 bipolar patients) were assessed at acute hospitalization and then followed up four times over 10 years. Patients were assessed for affective syndromes, psychosis, psychosocial adjustment, medications, and overall functioning, using standardized interviews.

Results: 1) Less than 20% of the schizoaffectives showed sustained remission over the 10-year follow up. 2) Poor outcome schizoaffectives recovered more slowly than poor outcome bipolar patients ($p < .05$). 3) Good prognosis schizoaffectives showed better outcomes and less continuous disorder than good prognosis schizophrenics. 4) A higher percentage of schizoaffectives who showed subsequent

affective syndrome at follow up also showed accompanying psychotic syndromes ($p < .05$).

Conclusions: After controlling for premorbid adjustment and prognostic factors, the 10-year longitudinal data do not support the view that schizoaffective patients are just good-prognosis schizophrenics. The follow up data support hypotheses that schizoaffectives have more negative clinical courses than bipolar patients. The co-occurrence of affective syndromes and psychosis at follow up could support views of common underlying features involved in both symptom constellations.

REFERENCES:

1. Grossman LS, Harrow M, Goldberg JF, et al: Outcome of schizoaffective disorder at two long-term follow-ups: comparisons with outcome of schizophrenia and affective disorders. *American Journal of Psychiatry*, 148(10):1359-1365, 1991.
2. Williams PV, McGlashan TH: Schizoaffective psychosis, I: comparative long-term outcome. *Arch Gen Psychiatry*, 44:130-137, 1987.

No. 73
PARENTING AND ADJUSTMENT IN SCHIZOPHRENIA

Carol L.M. Caton, Ph.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, New York NY 10032;* Francine Cournos, M.D., Boanerges Dominguez, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be aware of research findings on gender differences in the relationship of parental status to adjustment in schizophrenia.

SUMMARY:

Objective: We explored whether patients with schizophrenia who became parents differed in clinical and social adjustment from childless patients.

Method: Subjects were 400 men and women with chronic schizophrenia originally selected on the basis of their housing status in connection with a case-control study of risk factors for homelessness. Study subjects were primarily members of ethnic minorities and were dependent on public entitlements. The cross-sectional design included assessments of concurrent substance abuse and antisocial behavior (SCID), positive and negative symptoms (PANSS), functional status (GAF), family support, and treatment compliance. The 158 patient-parents (47 men, 111 women) were compared with the 242 (153 men, 89 women) childless patients.

Results: Patient-parents of both genders were more likely than childless patients to have ever married or lived in a conjugal relationship, but these bonds were not long lasting. Women with children were remarkably similar to childless women on all of the study variables. Men with children who had never been homeless were less likely than childless men to have concurrent substance abuse, antisocial behavior, or positive symptoms. In contrast, men with children who were homeless had greater substance abuse and positive symptoms compared with childless men.

Conclusion: Findings indicate that there are gender differences in parenting and adjustment in schizophrenia, which interact with housing stability. Because parenthood among people with schizophrenia has become more common, a greater understanding of the association of parenthood with adjustment is needed.

REFERENCES:

1. Miller LJ, Finnerty M: Sexuality, pregnancy, and childrearing among women with schizophrenia spectrum disorders. *Psychiatric Services*, 47:502-506, 1996.
2. Apfel RJ, Handel MH: *Madness and Loss of Motherhood: Sexuality, Production, and Long-Term Mental Illness*. Washington, DC, American Psychiatric Press, 1993.

PAPER SESSION 25—MANAGEMENT OF CHRONICALLY MENTALLY ILL

No. 74
IDENTIFYING PERSISTENTLY POOR FUNCTIONING PATIENTS

John W. Goethe, M.D., *Clinical Research, Institute of Living, 400 Washington Street, Hartford CT 06106-3309;* Edward H. Fischer, Ph.D., Ellen A. Dornelas, Ph.D.

EDUCATIONAL OBJECTIVES:

To classify inpatients by functional status; to recognize predictors of functional outcome and service utilization for psychiatric inpatients; to describe patterns of treatment services used by patients with poor functional status.

SUMMARY:

Objective: The authors developed an index using admission data to evaluate the functional status of consecutive admissions at the time of hospitalization and at three, six, and 12 months postdischarge. They report the (a) proportion of inpatients with "poor" functioning on admission, (b) subsequent functional status and service utilization patterns of these patients, and (c) utility of this index for predicting future functioning.

Method: All consenting admissions (N = 1679) during a 1.5-year period were classified as "poor," "moderate," or "high" functioning based on seven variables: GAF, number of hospitalizations (lifetime and in last year), self-care capacity, and three patient ratings of global functioning. Functioning and psychiatric services utilized were assessed at follow-up.

Result: Functional status at admission was "poor" for 23.4%. More than half of this subgroup continued to have poor functioning at each follow-up point, and their service utilization rates were substantially higher compared with other patients (e.g., rehospitalization rates of 32% vs. 10%).

Conclusion: Identifying "high-risk" patients at admission informs policy and planning decisions and allows for special clinical interventions that may improve outcomes. Although preliminary, these findings suggest that it is possible to identify at admission many of the patients who will have persisting functional deficits.

REFERENCES:

1. Goethe JW, Dornelas EA, Fischer EH: A cluster analytic study of functional outcome after psychiatric hospitalization. *Compr Psychiatry* 37:115-121, 1996.
2. Stein RE, Perrin EC, Pless IB, Gortmaker SL, et al: Severity of illness: concepts and measurements. *Lancet* 2:1506-1509, 1987.

No. 75
CASE MANAGEMENT FOR HOMELESS PUBLIC INEBRIATES

Mark L. Willenbring, M.D., *Department of Psychiatry, VA Medical Center, 1 Veterans Drive, Minneapolis MN 55417*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants will understand the various applications of case management in public inebriates and their relative effectiveness.

SUMMARY:

Objective: This study compared the effectiveness and cost-effectiveness of three intensities of case management in homeless public inebriates.

Method: 263 homeless public inebriates presenting to a public detox center were randomly assigned to intensive (ISV; caseload = 12) or intermediate (INT; caseload = 45) case management or to episodic care only (EC). Subjects were treated for two years. Primary outcome measures were service utilization data obtained from agencies, including data on detox use, treatment, medical care, county welfare, and civil commitments. Case manager time logs and ethnography were used to evaluate fidelity of interventions.

Results: There were highly significant differences in activities of case managers in the two case management interventions, suggesting good fidelity of models. Case management resulted in significant reductions in use of detox and emergency and inpatient medical care in both ISV and INT groups, compared with EC, but ISV and INT groups did not differ. Cost savings amounted to almost $5,000/client/year, and even greater savings would be possible by targeting the intervention to the 75% most likely to respond.

Conclusion: Case management is a highly cost-effective intervention in homeless public inebriates. There is no advantage to a caseload of 12 over a caseload of 45.

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2. Willenbring ML: Integrating qualitative and quantitative components in evaluation of case management, in Ashery, R., *Progress and Issues in Case Management,* National Institute on Drug Abuse Research Monograph 127, DHHS Pub. No. (ADM) 92-1946, Washington, DC: Supt. of Docs., U.S. Govt. Print. Off., 1992.

No. 76
WHICH BIPOLAR PATIENTS RECEIVE ANTICONVULSANTS?

Joseph F. Goldberg, M.D., *Department of Psychiatry, Payne Whitney Clinic, 525 East 68th Street, New York NY 10021;* Andrew C. Leon, Ph.D., Jessica L. Garno, B.S., James H. Kocsis, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will gain familiarity with the clinical profile of bipolar patients who typically receive anticonvulsant mood stabilizers during ordinary treatment; they will recognize factors that may favor a response to anticonvulsants vs. lithium in bipolar disorder.

SUMMARY:

Objective: Treatment algorithms for bipolar disorder have sought to establish when patients should receive alternative or adjunctive pharmacotherapies to lithium. While the anticonvulsant mood-stabilizers divalproex (DVP) and carbamazepine (CBZ) have recently gained wider use, we attempted to discern the clinical profile of manic patients for whom these agents are most often used during naturalistic treatment.

Method: Clinical records were reviewed for 181 DSM-III-R bipolar I inpatients from 1991-1995 and assessed for past treatments and current symptoms. Baseline severity of illness was rated using Clinical Global Improvement (CGI) scores. Patients treated naturalistically with lithium, DVP, CBZ, or other regimens were compared on intensity of treatment and on key clinical and demographic features.

Results: 1) Compared with bipolar patients receiving lithium, those receiving DVP or CBZ were more likely to have previously relapsed while on lithium ($p < .05$), were older ($p < .05$), had more previous hospitalizations ($p < .05$), and tended to have histories of medication noncompliance ($p < .09$); 2) First- or second-episode patients more often received lithium than an anticonvulsant ($p < .05$); 3) DVP or CBZ blood levels were less often therapeutic than were lithium levels ($p < .05$); 4) Lithium augmentation with DVP or CBZ was more common than the use of DVP or CBZ alone for patients with multiple prior affective episodes.

Conclusions: Anticonvulsant mood stabilizers are often underdosed and currently may be used chiefly among chronic patients who may have been noncompliant or failed lithium prophylaxis. The full benefits of DVP or CBZ in mania could be diminished if clinicians preferentially reserve anticonvulsants for treatment-resistant populations. Just as lithium may be less effective if begun *late* in the course of illness, so too might the *early initiation* of anticonvulsant mood stabilizers be crucial for an optimal response.

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PAPER SESSION 26—THE CONTRIBUTION OF CHILDHOOD ABUSE TO PSYCHOPATHOLOGY

No. 77
TRAUMATIC SEXUAL ABUSE: VICTIM TO PERPETRATOR

Jon A. Shaw, M.D., *Department of Psychiatry, University of Miami Sch of Med, 1611 NW 12th Avenue, Miami FL 33136*

EDUCATIONAL OBJECTIVES:

To become familiar with the sprectrum of psychiatric morbidity and personality disturbances found in severe adolescent sex offenders requiring residential treatment; to become aware of the important role of sexual victimization in the history of the adolescent sex offender.

SUMMARY:

Objective: To study adolescent sex offenders who have been sexually victimized in childhood, to explicate their psychopathology, to understand the process of how sexual victimization can be transduced into a pattern of sexual aggression.

Method: 42 adolescent sexual offenders were assessed for Axis I & II psychopathology and history of sexual victimization. They were administered the NIMH Diagnostic Interview Schedule for Children (DISC-2), Structured Clinical Interview for DSM-III-R Personality Disorders (SCID II), and the Diagnostic Interview for Borderlines (DIB-R).

Results: The average offender had 3.1 Axis I psychiatric diagnoses. Of the boys, 68% had more than four personality diagnoses. Twenty-eight (70%) reported a history of sexual victimization. The average age of victimization was 6.1 years. Fifteen percent were abused by women. The Abused/Abuser hypothesis is presented from a developmental, social learning, and psychodynamic perspective with illustrative clinical vignettes.

Conclusions: Sexual victimization is an important etiological determinant in sexual offending behavior. The adolescent sex offender demonstrates considerable Axis I psychopathology as well as Axis II personality disturbances. The spectrum of intense affects associated with sexual victimization such as sexual excitement, sexual arousal, helplessness and rage, sadism and masochism, love and betrayal, pleasure and unpleasure may be woven into one's central

masturbatory fantasy and become a motivational structure. It is evident that sexual aggressive behavior not only serves a sexual aim but also is in the service of narcissism in which the wish is to split off the damaged and emasculated self and to restore an earlier narcissistic state of limitless power and control.

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2. Shaw J, Campo-Bowen A, Applegate B, et al: Young boys who commit serious sexual offenses: demographics, psychometrics and phenomenology, *Bull Am Acad Psychiatry Law,* 21:399-408, 1993.

No. 78
CORRELATES OF CHILDHOOD ABUSE IN ADOLESCENTS

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to recognize important psychological, behavioral, and personality correlates of childhood abuse in adolescents who are psychiatrically hospitalized. Participants will recognize the implications of the findings for theory, future research, and clinical practice.

SUMMARY:

Objective: To examine psychiatric correlates of childhood abuse in psychiatrically hospitalized adolescents.

Method: 194 adolescent inpatients were administered a battery of psychometrically well-established psychological self-report measures soon after admission. Childhood abuse was assessed using the Childhood Abuse Scale of the Millon Adolescent Clinical Inventory (MACI; Millon et al., 1993). MACI Childhood Abuse scores of <30 and >75 were used to create our two study groups—Low Abuse (n = 56) versus High Abuse (n = 30), respectively.

Results: The two groups did not differ in gender, ethnicity, or Global Assessment of Functioning (GAF) scores. The two groups did not differ diagnostically, except that major depressive disorder was diagnosed significantly more frequently in the High Abuse group. In contrast, the two groups differed significantly on most measures of psychological disturbance examined by our assessment battery. The High Abuse group had significantly higher ($p < .001$) scores on the following: Beck Depression Inventory, Depressive Experiences Questionnaire, Hopelessness Scale, Suicide Risk Scale, Past Feeling and Acts of Violence Scale, Impulsivity Scale, Drug Abuse Screening Test, and the Alcohol Abuse Involvement Scale. Likewise, the High Abuse group was characterized by significantly higher scores on many MACI subscales suggestive of greater personality disturbance.

Conclusions: In our sample of psychiatrically hospitalized adolescents, patients who report childhood abuse are characterized by a complex array of severe psychological and behavioral problems that distinguish them from those patients who do not report childhood abuse. Adolescents who report childhood abuse show greater depression, psychological distress, self-criticalness, hopelessness, suicidality, violence, personality disturbance, and drug use problems.

REFERENCES:

1. Kendall-Tackett KA, Williams LM, Finkelhor D: Impact of sexual abuse on children: a review and synthesis of recent empirical studies. *Psychological Bull* 113:164-180, 1993.
2. Green AH: Child sexual abuse: immediate and long-term effects and intervention. *J Am Acad Child Adolesc Psychiatry* 32:890-902, 1993.

No. 79
ASSESSING CHILDHOOD ABUSE AND ADULT PSYCHOPATHOLOGY

Doreen L. Hughes, M.D., *Department of Psychiatry, Bowman Gray School of Medicine, Medical Center Boulevard, Winston-Salem NC 27157;* Stephen I. Kramer, M.D., Tracy T. Latz, M.D.

EDUCATIONAL OBJECTIVES:

To recognize potential biases in research on childhood sexual and physical abuse among adult psychiatric inpatients and appreciate the need for further clarifying work in this area.

SUMMARY:

Objectives: Childhood physical and sexual abuse are frequent findings in the histories of psychiatric patients, especially those with dissociative psychopathology. One study has reported an inverse correlation between age of onset of abuse and dissociative symptomatology. The present study evaluated childhood abuse histories in relation to dissociative symptomatology, other psychiatric diagnoses, and histories of incarceration among women admitted to a state hospital in a 5.5-month period.

Method: Participants completed the Dissociative Experiences Scale (DES) and the Dissociative Disorders Interview Schedule. Data on length of stay (LOS) and history of incarceration were collected also. Of 421 women admitted (483 consecutive admissions) 121 were discharged prior to assessment, 64 were excluded, 60 declined participation, 176 enrolled in the study, and 175 completed the study protocol.

Results: Reported frequency of childhood abuse was 67% (n = 118): physical only 7% (13); sexual only 17% (29); both 43% (77). Mean scores on the DES differed significantly by abuse status (mean +/–SD: both 34.8+/–26.5, sexual only 26.3+/–20.2, physical only 14.9+/–19.6, no abuse 19.6+/–14; $F = 8.89$, $df = 3$, $p = 0.0001$), though there was sizable overlap. However, there was no significant difference in mean scores in relation to age of onset of abuse. The coexistence of major depression, somatization disorder, any dissociative disorder, and borderline personality disorder was significantly greater in those with both types of abuse when compared with those with no abuse (all $p \leq 0.013$). Histories of incarceration, coexisting substance abuse, and LOS were not significantly different among the groups.

Conclusions: The relationship of abuse severity factors (such as age of onset) to dissociative symptomatology remains to be delineated fully. Potential biases due to treatment setting and method of assessment must be recognized and minimized in studies focusing on childhood abuse and adult psychopathology.

REFERENCES:

1. Kirby JS, Chu JA, Dill DL: Correlates of dissociative symptomatology in patients with physical and sexual abuse histories. *Comprehensive Psychiatry* 34 (4):258-263, 1993.
2. Brown GR, Anderson B: Psychiatric morbidity in adult inpatients with childhood histories of sexual and physical abuse. *Am J Psychiatry* 148:55-61, 1991.

PAPER SESSION 27—ELECTRICAL ACTIVITY AND THE BRAIN

No. 80
USE OF ECT IN CALIFORNIA REVISITED: 1984-1994

Barry A. Kramer, M.D., *Department of Psychiatry, USC University Hospital, 1500 San Pablo Street, 3rd Flr, Los Angeles CA 90033*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss factors limiting access to ECT in order to continue to have this treatment modality available for patients. Demographic and complication statistics should enable the practitioner to discuss the misleading media reports of ECT with patients and colleagues.

SUMMARY:

Objective: The use of ECT in California was examined from 1984 to 1994 and compared with a previous study examining use from 1977 to 1983.

Methods: Data were collected from legally required reports submitted to the state for all ECT performed.

Results: A total of 28,437 patients (mean = 2585.18 per year) received a total of 160,847 treatments with a mean rate of 0.90 patients/10,000 population. The rate in 1984 (1.15) was similar to the mean rate for 1977-1983 (1.12). The rate dropped in 1986 (0.92) and again in 1991 (0.74). There were 821 patients (2.89% of total) who were judged to be incapable of giving informed consent and received ECT after a court review. This is similar to the rate of 3% for 1977 to 1983. The number of counties where ECT was available increased from 15 in 1983 to 19 in 1991 and returned to 15 in 1994. The number of facilities providing ECT increased from 62 in 1983 to 83 in 1990 and decreased to 69 in 1994. White patients comprised 91.5% of ECT recipients. Three deaths were reported for a rate of 0.19 deaths/10,000 treatments.

Conclusions: Despite its safety, the availability of ECT in California continues to remain limited geographically and socioeconomically. The rate of its use has declined. A possible relationship of this decline to the introduction of new antidepressants and the rapid expansion of managed care will be discussed. Other potential causes and implications of ECT's limited availability will also be discussed.

REFERENCES:

1. Kramer BA: Use of ECT in California, 1977-1983. *Am J Psychiatry* 142:1190-1192, 1985.
2. Kramer BA: ECT use in the public sector: California. *Psychiatric Quarterly* 61:97-103, 1990.

No. 81
PSYCHIATRIC DISORDERS TREATED WITH ECT

Richard C. Hermann, M.D., *Department of Psychiatry, Harvard Medical School, 115 Mill Street, Belmont MA 02178;* Robert A. Dorwart, M.D., Nancy Langman-Dorwart, M.P.H., Steven Kleinman, M.D., Jeff Bortle, B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to discuss how clinician consensus, underuse, and overuse may potentially contribute to the variation observed in ECT utilization rates. They will learn about use and limitations of claims data as a means of analyzing clinician practices.

SUMMARY:

Background and Objective: ECT is an effective and relatively safe treatment for specific psychiatric disorders. However, studies show that clinicians disagree about the procedure's value, and that across cities, ECT utilization rates vary much more than prevalence rates of disorders effectively treated by ECT. Little research has been conducted into the extent that ECT may be underused or overused. This study examines the extent to which ECT use is limited to disorders effectively treated with the procedure.

Method: Controlled trials and APA, NIMH, and AHCPR evaluations were reviewed to determine the psychiatric disorders in which efficacy of ECT has been established. Insurance claims were analyzed from all patients covered by Blue Cross-Blue Shield of Massachusetts who received ECT during 1994 and 1995. During this period, 936 patients received 1,532 courses of ECT, administered by 142 psychiatrists in 58 treatment facilities. Data were collected regarding patient diagnoses and psychiatrist and facility characteristics.

Results: Major depression, schizophrenia, bipolar disorder, and schizoaffective disorder have been shown to be effectively treated with ECT. A total of 85% of patients treated with ECT had one of these disorders; 11% had another psychiatric diagnosis; and 4% had incomplete records. Also, 59% of facilities (and 68% of psychiatrists) treated only patients with diagnoses within established indications for ECT; 10% of facilities (and 13% of psychiatrists) treated only patients with diagnoses outside established indications. Multivariate analyses will be presented examining facility and psychiatrist characteristics associated with use of ECT outside of established indications.

Conclusions: Most patients treated with ECT had diagnoses known to be effectively treated with the procedure. Treatment of disorders outside standard diagnostic indications was localized to a minority of facilities and psychiatrists. Multivariate analysis will allow for examination of psychiatrist and facility characteristics associated with such ECT use. Further study, using more clinically detailed sources of data, will be necessary to determine the appropriateness of ECT use.

REFERENCES:

1. Hermann RC, Dorwart RA, Hoover CW, Brody J: Variation in ECT use in the United States. *Am J Psychiatry* 152:869-875, 1995.
2. Hermann RC: Variation in psychiatric practices: implications for health care policy and financing. *Harvard Review of Psychiatry*, 4:98-101, 1996.

No. 82
QUANTITATIVE ELECTROENCEPHALOGRAM FINDINGS IN SELF-INJURIOUS PATIENTS WITH BPD

Mark J. Russ, M.D., *Hillside Hospital, 75-59 263rd Street, Glen Oaks NY 11004;* Scott S. Campbell, Ph.D., Tatsuyuki Kakuma, Ph.D., K. Harrison, R.N., E. Zanine, B.A.

EDUCATIONAL OBJECTIVES:

To understand the association among pain report, dissociation, and quantitative EEG findings in self-injurious patients with borderline personality disorder, patients with major depression, and normal subjects.

SUMMARY:

Objective: This study explores the use of quantitative EEG as a physiological correlate of pain report during the cold pressor test in women with borderline personality disorder who experience analgesia during self-injury (n = 19), similar patients who report pain during self-injury (n = 21), women with major depression (n = 15), and normal controls (n = 20). This study extends our previous findings of decreased pain report in the analgesic group compared with the "pain-feeling" borderlines and normal controls.

Method: Four experimental groups as defined above underwent a 10°C cold pressor test with 16-channel EEG monitoring before, during, and after the procedure. Group and phase effects were assessed for delta, theta, alpha, beta 1, and beta 2 power.

Results: The analgesic group of borderline patients exhibited significantly higher theta activity before, during, and after the cold pressor test than the other three groups ($F(3) = 17.1$, $p < 0.0001$). Theta activity was significantly correlated with dissociation score ($r = 0.32$, $p < 0.0001$) and pain rating ($r = 0.42$, $p < 0.0001$).

Conclusions: This pattern of increased theta activity has been reported in highly hypnotizable subjects and in experienced fire walkers and fakirs who engage in ritualistic self-injury. Increased

theta activity may be related to decreased pain sensitivity and dissociation in self-injurious borderline patients.

REFERENCES:

1. Russ MJ, Roth S, Lerman A, Kakuma T, et al: Pain perception in self-injurious patients with borderline personality disorder. *Biological Psychiatry* 32:501511, 1992.
2. Russ MJ, Clark WC, Cross LW, et al: Pain and self-injury in borderline patients: sensory decision theory analysis, coping strategies, and loss of control. *Psychiatry Research* 63:57-65, 1996.

PAPER SESSION 28—RISK FACTORS IN ALCOHOL AND SUBSTANCE ABUSE

No. 83
PERSONALITY AND ADOLESCENT SUBSTANCE MISUSE

Stewart Gabel, M.D., *Department of Psychiatry, Childrens Hospital, 1056 East 19th Avenue, Denver CO 80218;* Michael C. Stallings, Ph.D., Stephanie Schmitz, M.A., Susan E. Young, M.A., Thomas J. Crowley, M.D., David W. Fulker, Ph.D.

EDUCATIONAL OBJECTIVES:

To demonstrate an awareness of the relationship between personality dimensions and alcohol and/or substance dependence in adults; to recognize that personality dimensions in parents may predict alcohol and/or substance dependence symptoms in their adolescent offspring; and to recognize that novelty seeking in adolescents predicts their own alcohol and/or substance dependence symptoms.

SUMMARY:

Objective: To assess whether personality dimensions in mothers and sons predict alcohol and/or substance misuse (ASM) in adolescent boys from largely father-absent homes.

Method: Forty-two adolescent male treatment probands and their mothers were studied. The youths' mean age was 15.8 years. All were in a residential center and all had conduct disorder diagnoses by DSM-III-R criteria. Eighty-six percent met DSM-III-R criteria for substance dependence. Alcohol and substance use and criminality were assessed through direct interview, self report, and family interview. Maternal and adolescent personality dimensions were assessed through an abbreviated version of Cloninger's Tri-Dimensional Personality Questionnaire (TPQ; Cloninger, 1987).

Results: Maternal novelty seeking (NS) predicted adolescent alcohol and drug symptoms, but was not significantly related to the mother's own ASM. Probands' NS predicted their own alcohol and drug dependence symptoms. In general, maternal ASM, maternal NS, and proband NS all played some role in proband ASM. At the most severe level of adolescent drug dependence, the adolescent's own NS, when coupled with high maternal NS, rendered the youth most vulnerable to increased alcohol-dependent and drug-dependent symptoms.

Conclusion: The assessment of personality dimensions adds new perspectives to the study of families of adolescents with ASM.

REFERENCES:

1. Cloninger CR: *The Tridimensional Personality Questionnaire. Version IV.* St. Louis, MO: Washington University School of Medicine, 1987.
2. Young SE, Mikulich SK, Goodwin MB, et al: Treated delinquent boys' substance use: onset, pattern, relationship to conduct and mood disorders. *Drug Alcohol Dependence*, 37:149-162, 1995.

No. 84
REMISSION FROM ACUTE MANIA WITH SUBSTANCE ABUSE

Joseph F. Goldberg, M.D., *Department of Psychiatry, Payne Whitney Clinic, 525 East 68th Street, New York NY 10021;* Jessica L. Garno, B.S., Andrew C. Leon, Ph.D., James H. Kocsis, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be familiar with new data on the prevalence, clinical features, differential treatment, and time course to remission in hospitalized manic patients with vs. without comorbid substance abuse.

SUMMARY:

Objective: Bipolar disorders frequently co-occur with alcohol and drug abuse, and their dual presentation may worsen treatment outcome and relapse. This study examined the prevalence and impact of substance abuse over a five-year period for acute manic inpatients. Clinical features and time to remission were compared for patients with and without substance abuse histories.

Method: Records were reviewed for 211 patients consecutively hospitalized from 1991-1995 for DSM-III-R bipolar I disorder at the Payne Whitney Clinic. Current and past substance abuse was assessed on admission by interview and urine toxicology screens. Affective symptoms and medication data were rated from daily progress notes using standardized criteria. Baseline severity and weekly improvement were rated using Clinical Global Improvement (CGI) scales. Time to remission, defined by CGI ratings, was estimated for patients with vs. without substance abuse using Kaplan-Meier survival analyses.

Results: 1) Alcohol or other drug abuse was evident among 35% of bipolars; 2) Among dual-diagnosis patients, alcoholism was most common (82%), followed by cocaine (30%), marijuana (29%), and opiates (13%); 3) Prior suicide attempts and treatment noncompliance were more common among bipolars with than without substance abuse ($p < .05$); 4) Remission during hospitalization was less common for patients abusing two or more drugs than those using one or none ($p < .05$) Remission did not occur faster among non-substance-abusing bipolars.

Conclusions: Substance abuse is common among bipolar patients and may be linked with higher rates of suicidality. Poly-substance abuse mitigates against affective remission. However, enforced inpatient abstinence may eliminate the adverse effects of substance abuse on immediate outcome for many dual-diagnosis patients, allowing remission from mania to occur as swiftly for substance-abusing as non-abusing bipolar patients.

REFERENCES:

1. Brady KT, Sonne SC: The relationship between substance abuse and bipolar disorder. *J. Clin. Psychiatry* 56(3):19-24, 1995.
2. Nunes EV, McGrath PJ, Wager S, et al: Lithium treatment for cocaine abusers with bipolar spectrum disorders. *Am. J. Psychiatry* 147:655-657, 1990.

No. 85
MORTALITY RELATED TO ALCOHOLISM

Brian L. Cook, D.O., *Department of Psychiatry, University of Iowa, 18 Oak Park Drive, NE, Iowa City IA 52240;* George Winokur, M.D., Alberto Abreu,

EDUCATIONAL OBJECTIVES:

To recognize the excessive mortality rates associated with alcoholism, and identify specific alcoholism subtypes that are most at risk. Participants will also be able to recognize specific causes of death that differ between alcoholism subtypes.

SUMMARY:

Objectives: This study evaluates long-term mortality rates in alcoholism. The main objective of this report is to demonstrate differential mortality rates across three previously defined alcoholic subtypes.

Method: Probands were selected from a consecutive series of veterans admitted between July 1, 1975 and March 1, 1977. The original sample consisted of 445 veterans. Subjects were administered a structured psychiatric interview. The alcoholics were divided into those with primary alcoholism (N = 128), alcoholism associated with antisocial personality disorder (N = 50), and alcoholism that was secondary to some other psychiatric disorder (N = 46); 221 subjects had no alcoholism. In this follow-up, definitive status has been determined for 217 of the original 224 alcoholics. Seven alcoholic subjects had data dropped from their index evaluation that precluded their follow-up, leaving 97% of the original cohort for analysis. The follow-up period is between 19 and 21 years.

Results: 55% of the alcoholic probands were dead at the time of follow-up, compared with 26% of the nonalcoholic probands. Alcoholic mortality was highest in the primary group and lowest in the antisocial group (60% v. 40%). The alcoholics lost on average 17.05 years of potential life and died at a rate over three times that of age- and sex-matched population controls. Survival analysis techniques clearly demonstrate that the antisocial group had a prolonged survival curve compared with the other groups, and appeared nearly identical to the nonalcoholic survival functions. Causes of death varied significantly by alcoholic subtype.

Conclusions: Alcoholism mortality is markedly elevated compared with population controls and nonalcoholic psychiatric patients, and differs across alcoholic subtype in terms of rates and causes. This study provides a long-term view of mortality related to alcoholism.

REFERENCES:

1. Cook BL, Winokur G: Classification of alcoholism with reference to comorbidity. *Comp Psychiatry* 35(3):165-170, 1994.
2. CDC: Alcohol-related mortality and years of potential life lost—United States, 1987. *MMWR* 39:173-178, 1990.

PAPER SESSION 29—CLINICAL RESEARCH ON EATING DISORDERS: AN UPDATE

No. 86
EATING DISORDERS IN SEVERE OBESITY

L.K. George Hsu, M.D., *Department of Psychiatry, New England Medical Center, 750 Washington St., Box 1007, Boston MA 02111;* Peter N. Benotti, M.D.

EDUCATIONAL OBJECTIVES:

To recognize the occurrence of eating disturbances such as binge eating in severe obesity; to recognize the effect of eating disturbances on outcome of gastric bypass.

SUMMARY:

Introduction: Severe obesity defined as body mass index ≥ 40 kg/m^2, carries significant morbidity and mortality. Gastric bypass is increasingly utilized to treat severe obesity, because nonsurgical treatments are usually not effective.

Objective: To determine if eating disturbances such as binge eating and night eating affect outcome of gastric bypass (GBP).

Method: 27 female severely obese patients were interviewed 20.8 ± 11.0 months after GBP by the Eating Disorder Examination.

Results: (1) Pre-GBP binge eating, bulimia nervosa, night eating, and drinking excessive fluids were present in 82% of patients; (2) Pre-GBP eating disturbance significantly predicted (a) recurrence of eating disturbances after GBP, (b) weight regain of 10 lbs or more after initial weight loss; (3) Weight regain and eating disturbances typically occurred at two years after GBP; (4) The Eating Disorder Examination profiles of post-GBP patients resembled those of "restrained eaters."

Conclusions: (1) Eating disturbances are very common in severe obesity; (2) They are persistent and tended to recur after GBP leading to weight regain; (3) GBP probably increases "restraint" but does not change the eating disturbance in severe obesity; (4) Research targeting eating disturbances is urgently needed for treatment of severe obesity.

REFERENCES:

1. Sugerman HJ, Starkey JV, Birkenhauer R: A randomized prospective trial of gastric bypass versus vertical banded gastroplasty for morbid obesity and their effects on sweets versus non-sweets eaters. *Am Surg* 205:613-624, 1987.
2. Fairburn CG, Wilson GT (Eds): *Binge Eating: Nature, Assessment, and Treatment.* New York, Guilford Press, 1993.

No. 87
BULIMIA NERVOSA, PTSD, AND AMNESIA: A NATIONAL STUDY

Timothy D. Brewerton, M.D., *Department of Psychiatry, Medical University of SC, 171 Ashley Ave, Charleston SC 29425-0002;* Bonnie S. Dansky, Ph.D., Dean G. Kilpatrick, Ph.D., Patrick M. O'Neil, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation the participant should be able to recognize the important role that victimization and subsequent PTSD and psychogenic amnesia have on the pathogenesis and maintenance of bulimia nervosa.

SUMMARY:

Objective: In the National Women's Study (NWS) we found that victimization experiences (rape, molestation, aggravated assault) were significantly more common in respondents with bulimia nervosa (BN) than in nonbulimic respondents. Prior studies have not simultaneously assessed the presence of post-traumatic stress disorder (PTSD) and related symptoms.

Method: We analyzed data from the NWS (n = 3,006), a representative sample from four stratified U.S. regions, in order to determine frequencies of lifetime and current PTSD and associated psychogenic amnesia (PA) (based on DSM-III-R criteria) in relationship to BN and binge eating disorder (BED). Respondents were designated as having PA if they endorsed ever forgetting parts of their distressing experiences on structured interview.

Results: BN subjects had significantly more lifetime (37%) and current PTSD (21%) than the non-BN/non-BED subjects (12% lifetime, 4% current, $p < 0.001$). BED respondents also had higher rates of lifetime (21%, $p < 0.01$), but not current PTSD (2%). BN respondents endorsed PA 2.5 times more often than non-BN/non-BED respondents (27% v. 11%, $p < 0.001$), and there was a trend for a similar difference between BN and BED (11%, $p < 0.09$). PTSD diagnosis with PA was associated with significantly higher rates of sexual and physical assault, as well as BN diagnosis and symptomatology, compared with PTSD diagnosis without PA. BN subjects with PA endorsed significantly higher frequencies of rape, childhood rape, aggravated assault, and laxative/diuretic abuse, as well as significantly higher current and maximum BMI's than BN subjects without PA.

Conclusions: These data suggest that bulimic behaviors, particularly those involving purging, are maladaptive mechanisms with psychobiological underpinnings that facilitate avoiding, numbing, and forgetting traumatic memories.

REFERENCES:

1. Dansky BS, Brewerton TD, Kilpatrick DG, O'Neil PM: (in press) The National Women's Study: relationship of victimization and PTSD to bulimia nervosa. *International Journal of Eating Disorders.*
2. Resnick HS, Kilpatrick DG, Dansky BS, et al: Prevalence of civilian trauma and post-traumatic stress disorder in a representative national sample of women. *J Cons. Clin. Psychology* 61:984-991, 1993.

No. 88
PREDICTORS OF RELAPSE IN BULIMIA NERVOSA

Marion P. Olmsted, Ph.D., *Department of Psychiatry, Toronto General Hospital, CW1-311, 200 Elizabeth Street, Toronto ON M5G 2C4, Canada;* Allan S. Kaplan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should have a preliminary understanding of some of the factors related to relapse in bulimia nervosa and should be aware that treatment may be more effective in the long term if these issues are addressed.

SUMMARY:

Objectives: The aim of this study was to identify vulnerability factors that predict relapse in women with remitted bulimia nervosa (BN).

Method: Patients who had successfully completed inpatient, outpatient, or day hospital treatment at the Toronto Hospital were asked to participate in a follow-up study. The study followed a prospective, longitudinal design with patients' psychosocial functioning and eating assessed every three months for up to 24 months.

Results: Data based on 46 BN patients who were remitted at admission to the study indicated a 42% relapse rate within the first six months and only three additional relapses after that point. The pattern of symptoms was variable across patients, with a subgroup moving in and out of symptom control over time. Low-level residual symptoms at baseline were associated ($p < .05$) with subsequent relapse. At the last assessment prior to relapse, patients who would relapse over the next three months had higher scores on the Restraint subscale of the Eating Disorder Examination ($p < .02$) and higher scores on the Wishful Thinking subscale of the Coping Strategies Inventory ($p < .03$).

Conclusions: These findings suggest that patients who relapsed had a more tenuous grasp on symptom control, were more likely to return to dieting, and did not confront and resolve difficulties when they arose. All of these dimensions may be amenable to clinical intervention, suggesting that maintenance therapies may play a critical role in the treatment of bulimia nervosa.

REFERENCES:

1. Olmsted MP, Kaplan AS, Rockert W: Rate and prediction of relapse in bulimia nervosa. *Am J Psychiatry*, 151:738-743, 1994.
2. Mitchell J, Davis L, Goff G: The process of relapse in patients with bulimia. *International Journal of Eating Disorders*, 4:457-463, 1985.

PAPER SESSION 30—POLITICAL INSTABILITY AND PSYCHIATRIC MORBIDITY IN EASTERN EUROPE

No. 89
TESTIMONY PSYCHOTHERAPY WITH BOSNIAN REFUGEES

Alma D. Kulenovic, M.D., *University of IL at Chicago, 1601 West Taylor, Room 423S, Chicago IL 60612;* Stevan M. Weine, M.D., Ivan Pavkovic, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be able to understand the clinical benefits of testimony psychotherapy in the treatment of trauma-related psychiatric sequelae of human rights violations.

SUMMARY:

Objective: To describe the clinical effectiveness of the testimony method of psychotherapy as a treatment intervention in a pilot study with a group of adult, traumatized refugees from genocide from Bosnia and Herzegovina who have been resettled in Chicago.

Method: 17 Bosnian refugees (seven women and 10 men), mean age 45.4, who gave informed consent, participated in testimony psychotherapy averaging six sessions. They received standardized assessments with the PTSD Symptoms Scale, the Beck Depression Inventory, the Communal Traumatic Events Inventory, and the Global Assessment of Functioning.

Results: Post-treatment and two-month follow-up assessments demonstrated statistically significant decreases in the rate of PTSD diagnosis (100% to 76% to 54%), PTSD symptom severity (32.5 to 20.5 to 11.0), as well as re-experiencing, avoidance, and hyperarousal symptoms severity. Depressive symptoms also demonstrated a significant decrease (16.18 to 10.12 to 5.65). There was a statistically significant increase in GAF (63.53 to 72.83 to 79.42). Six-month follow-up assessments demonstrated the continuation of the same trend of decrease in PTSD and depression symptoms and an increase in GAF.

Conclusions: This pilot study with Bosnian survivors of genocidal trauma resettled in the U.S. suggests that testimony psychotherapy may lead to substantial improvements in PTSD symptoms and depression symptoms, as well as to a substantial improvement in functioning. For these subjects, it appears that by joining with "witnessing professionals" to tell and document their trauma story in all its enormity and complexity, survivors can advance on their path toward recovery. Further study with more subjects is warranted.

REFERENCES:

1. Cienfuegos AJ, Monelli C: The testimony of political repression as a therapeutic instrument, *Am J Orthopsychiatry* 53(1), 43-51, 1983.
2. Weine S, Becker D, McGlashan T, et al: The psychiatric consequences of 'ethnic cleansing': clinical assessments and testimony of Bosnian refugees recently resettled in America, *Am J Psychiatry*, 152:536-542, 1995.

No. 90
THE CLINICAL EFFECTIVENESS OF SSRI'S IN REFUGEE TRAUMA

Amer Smajic, M.D., *University of IL at Chicago, 1601 West Taylor, Room 423S, Chicago IL 60612;* Stevan M. Weine, M.D., Zvezdana Bijedic, M.D., Esad Boskailo, M.D., Ivan Pavkovic, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the clinical utility of SSRIs in the treatment of refugee trauma and other related psychiatric conditions.

SUMMARY:

Objective: To describe the clinical effectiveness of serotonin selective reuptake inhibitors in treating PTSD and depression in a group of adult Bosnian refugees from "ethnic cleansing."

Method: The subjects are 33 Bosnian refugees who presented for treatment of mental health consequences of surviving ethnic cleansing. Ages ranged from 24 to 63 years, with 18 females and 15 males. None had any known history of psychiatric illness prior to their traumatic experiences of the war. Subjects received standardized

evaluations for PTSD (Edna Foa's PTSS scale) and depression (Beck Depression Inventory) as well as the GAF. Assessments were done at intake, at two weeks, and at six weeks after initiating therapy. Thirty-three subjects received open trials of venlafaxine (5), sertraline (15), or paroxetine (13) with standard clinical doses.

Results: Overall, SSRIs yielded statistically significant improvement at six weeks in the total PTSD symptom severity (39.6 to 29.0, p = .000) and in each symptom cluster (reexperiencing, avoidance, and hyperarousal). SSRIs also led to improvement in the depression score (31.1 to 22.7, p = .000) and in the GAF (50.3 to 63.9, p = .000). Venlafaxine was discontinued in eight subjects due to adverse effects. Otherwise, there was no appreciable difference between SSRIs.

Conclusion: This study provides the first empirical evidence that SSRIs are effective in treating PTSD and depression in traumatized refugees. Sertraline and paroxetine may be more clinically useful due to the high rate of side effects of venlafaxine.

REFERENCES:

1. Weine S, Becker D, McGlashan T, et al: The psychiatric consequences of 'ethnic cleansing': clinical assessments and testimony of Bosnian refugees recently resettled in America, *Am J Psychiatry*, 152:4:536-542, 1995.
2. van der Kolk BA, Dreyfuss D, Berkowitz R, et al: Fluoxetine in post traumatic stress. *J Clin Psychiatry* 55:12:517-522, 1994.

No. 91
AN INDEPENDENT LATVIA: WORLD RECORD IN SUICIDES

Elmars Rancans, M.D., *Mental Health Care Center, Raina Bulv. 27, Riga LV 1359, Latvia;* Santa Zeibote, M.D.

EDUCATIONAL OBJECTIVES:

To discuss the dramatic increase in the suicide rate in Latvia between 1990-1995 as well as the possible underlying reasons and outcomes.

SUMMARY:

The problem of suicide affects every country in the world. It is one of the most frequent causes of death in many countries. During the Soviet occupation of Latvia, the number of suicides in Latvia was close to the average number throughout the world, according to official statistics. After the restoration of Latvia's independence in 1990, we observed a dramatic increase of suicides, which increased by 200% from 22.1 cases per 100,000 inhabitants in 1990 to 40.6 per 100,000 inhabitants in 1995. This increase was especially pronounced in those aged from 40 to 59 years. It placed us in one of the "leading" positions as far as suicide rates in the world. This significant increase created a great resonance among mental health care professionals and caused considerable alarm about the general mental health of the society. Therefore, we established a specialized unit for research into suicide problems in Latvia. Preliminary data allow us to hypothesize that freedom itself does not cause this skyrocketing rate of suicide. We should, instead, more deeply analyze all available data and possible influencing factors for this particular period of time. Results of our study and outcome predictions will be discussed in this paper with potential input from other suicide experts.

REFERENCES:

1. R. Andresina, et al: *Mental Health Care in Latvia - History and Present.* MacAbols, Latvia, 1996.
2. Chiles J, Strosahl K: *The Suicidal Patient: Principles of Assessment, Treatment, and Case Management.* American Psychiatric Press, Washington, D.C., 1995.

PAPER SESSION 31—CURRENT USES OF GROUP THERAPY

No. 92
COMBINED MEDICATION AND GROUP THERAPY FOR DYSTHYMIA

David J. Hellerstein, M.D., *Department of Psychiatry, Beth Israel Medical Center, 1st Ave & 16th Street, Pos 2-B, New York NY 10003-2992;* Suzanne A.S. Little, M.A., Lisa W. Samstag, M.A., J. Christopher Muran, Ph.D., Arnold Winston, M.D., Richard N. Rosenthal, M.D.

EDUCATIONAL OBJECTIVES:

To describe issues related to developing group therapy for medication-treated patients with dysthymia, including therapeutic interventions targeted at alleviating residual symptoms and dysfunctional cognitive and interpersonal patterns.

SUMMARY:

Clinical studies of dysthymia have demonstrated that medication treatment is effective in alleviating many, though not all, symptoms of chronic depression (1). Psychotherapy has shown some promise (2), but there are few studies of combined medication and psychotherapy for dysthymia. In the Beth Israel Medical Center Mood Disorders Research Program, we have developed a manualized group therapy model for medication-treated dysthymic patients. The goal is to address residual symptoms of dysthymia (such as social isolation, avoidance, cognitive distortions, etc.) that may interfere with full recovery. Our 16-session group treatment model emphasizes: 1) psychoeducation; 2) mindfulness training; 3) interpersonal learning about adaptive behaviors; and 4) relapse prevention. We hypothesize that patients who are informed about depressive illness, biological vulnerabilities, and symptom precipitants will be more active in recovery; that training in mindfulness can reduce stress; that maladaptive behaviors can more effectively be addressed in the group rather than individual setting; and that relapse may be averted by early use of coping strategies. To date, 32 patients have entered a prospective 48-week randomized study comparing medication (fluoxetine) treatment alone with combined medication-group therapy. Preliminary findings show high retention rates in patients randomized to the combined treatment. We will discuss issues related to treatment development and clinical care in this setting.

REFERENCES:

1. Hellerstein DJ, Yanowitch P, Rosenthal J, et al: A randomized double-blind study of fluoxetine versus placebo in treatment of dysthymia. *Am J Psychiatry* 150:1169-1175, 1993.
2. Markowitz J: Psychotherapy of dysthymia. *Am J Psychiatry* 151:1114-1121, 1994.

No. 93
GROUP THERAPY IN THE TREATMENT OF INJURED WORKERS

C. Donald Williams, M.D., *402 East Yakima Avenue, Ste330, Yakima WA 98901-1143*

EDUCATIONAL OBJECTIVES:

At the conclusion of this paper, the participant should be able to utilize a developmentally based understanding in the assessment and

treatment of patients with workplace injuries, and be able to explain group therapy as a primary treatment modality in this patient population.

SUMMARY:

The results of psychiatric treatment of injured workers has often been disappointing. Conventional wisdom holds that a failure to return patients to work within six months results in treatment failure. The purpose of this review is to present a rationale for utilizing group therapy as a more effective treatment alternative and to present data supporting longer-term treatment. Data for this study were obtained from patients referred for treatment to a private psychiatric practice in a rural community. Diagnoses were tabulated and were corroborated by independent medical evaluation. In 60 consecutive, blue-collar, worker's compensation patients treated in a private practice, anxiety disorders were diagnosed in 24, or 39%; major depression or dysthymia was present in 56 (91%); pain disorder was diagnosed in 16 (26%) of patients. Injured workers had coexisting Axis II diagnoses in 50 (81%) of all patients referred for psychiatric care, although only 40% of independent evaluators rendered an Axis II diagnosis.

Group psychotherapy in combination with appropriate pharmacotherapy enabled 40% of the patients in this sample to return to work, sometimes as long as four years after beginning therapy. It brings to therapy the factors of peer influence and confrontation, without antitherapeutic humiliation.

REFERENCES:

1. Azima F: Group Psychotherapy with Personality Disorders. Kaplan and Sadock, eds, *Comprehensive Group Psychotherapy*, Third Ed., Baltimore, Williams and Wilkins., pp. 393-406, 1993.
2. Oldham JM, et al: Comorbidity of axis I and axis II disorders. *Am J Psychiatry* 152:571-578, 1995.

No. 94
IMPACT OF AN INPATIENT COGNITIVE-BEHAVIOR THERAPY MOOD-MANAGEMENT GROUP

Louis R. Alvarez, M.D., *Department of Psychiatry, Harvard Medical School, 221 Longwood Avenue, Boston MA 02115;* John R. McQuaid, Ph.D., Barbara A. Belk, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the efficacy of a cognitive-behavioral mood-management group in reducing depression in psychotic and nonpsychotic patients, and the potential of an inpatient cognitive-behavioral group to improve outpatient follow-up and decrease the likelihood of relapse and rehospitalization.

SUMMARY:

Objective: This study was undertaken to assess the efficacy of a cognitive-behavioral mood-management group in reducing depression in psychotic (n = 14) and nonpsychotic (n = 30) inpatients. The two objectives were to determine if there was a correlation between the group subjects and 1) follow-up after discharge; 2) mental health costs incurred 60 days after discharge.

Method: 44 patients at San Francisco General Hospital were enrolled in study and randomly assigned to either the control (n = 20) or the intervention group (n = 24), which consisted of nine one-hour sessions. Outcome measures used were the HDRS and BDI.

Results: While patients improved substantially with the group intervention, there were no significant effects between the group subjects and controls. A significant effect (p = .01) was noted in follow-up after discharge (18 of 24 group patients vs. seven of 20 controls). Also significant (p = .03) was the number of patients presenting in crisis after discharge (three of 24 group subjects vs. eight of 20 controls). There was a nonsignificant trend for subjects to incur less 60-day mean costs than controls ($3,776 vs. $6,119).

Conclusions: A cognitive-behavioral mood-management group was found to reduce depression scores in a heterogeneous inpatient population. A significant effect between group subjects and controls was observed in those patients following-up and presenting in acute states after discharge.

REFERENCES:

1. Kingdon DG, Turkington D: *Cognitive-Behavioral Therapy of Schizophrenia.* New York, The Guilford Press, 1994.
2. Wright JH, Thase ME, Beck AT: *Cognitive Therapy with Inpatients.* New York, The Guilford Press, 1993.

PAPER SESSION 32—COST-EFFECTIVENESS IN THE USE OF ANTIPSYCHOTIC MEDICATION

No. 95
CLOZAPINE: EFFICACY AND COST-EFFECTIVENESS

Maria R. Urbano, M.D., *Department of Psychiatry, Eastern Virginia Med. Sch., 825 Fairfax Avenue, Norfolk VA 23505;* Mahmood A. Khan, M.D., Tobin Jones, M.D., Sally Chewning, R.N., Lisa Fore-Arcand, Ed.D.

EDUCATIONAL OBJECTIVES:

The participant should be able to recognize the cost-effectiveness of clozapine and its superior clinical efficacy in schizophrenia, schizoaffective disorder, and bipolar disorder.

SUMMARY:

The number of inpatient hospital days and the number of hospitalizations were compared before and after the institution of clozapine as the only drug treatment. Records of 28 patients with schizophrenia, schizoaffective disorder, or bipolar disorder who had been on clozapine for at least one year continuously were reviewed. Equal time periods before and after clozapine was started were compared with regard to number of inpatient days and hospitalizations with an average time span of three years. The dosage range was 400-600 mg. Cost of care was calculated based on these findings.

The mean inpatient days for each subject prior to clozapine was 189 days per year, which was reduced to 41 days with a mean reduction of 148 days per year per subject. This finding was statistically significant with a T value of 5.48 and a P value of .0001. The total number of hospitalizations was 75 in the three years prior to initiation of clozapine, with a reduction to 10 hospitalizations after clozapine was started. The mean reduction was 2.32 hospitalizations per subject, which was statistically significant with a T value of 7.97 and a P value of .0001. The mean expenditure was reduced from $52,480 to $15,435 with a mean savings of $37,055 per patient per year. This calculation was based on the cost of inpatient hospital days, physician visits, blood draws, therapy sessions, and medication.

Therefore, a dramatic reduction in inpatient hospital days and number of hospitalizations was noted in an aggregate of diagnoses after the institution of clozapine, with a significant reduction in the cost of psychiatric care and with superior clinical efficacy. There was no incidence of agranulocytosis, EPS, or tardive dyskinesia. Leukopenia was noted (7%), as was hypersalivation (50%), sedation (46%), tachycardia (11%), weight gain (32%), myoclonus (3.5%), and orthostatic hypotension (3.5%).

REFERENCES:

1. Meltzer HY: Cost-effectiveness of clozapine in neuroleptic-resistant schizophrenia. *Am J Psychiatry,* 150:1630-1638, 1993.
2. Baldessarini RJ: Clozapine: a novel antipsychotic agent. *New England Journal of Medicine*, 324:746-754, 1991.

No. 96
REDUCED HOSPITAL DAYS WITH RISPERIDONE TREATMENT

Mahmood A. Khan, M.D., *Department of Psychiatry, Hampton VAMC, 100 Emancipation Drive, Hampton VA 23667;* Jorge A. Cortina, M.D., Alaa-Eldin M. Mahmoud, M.D., Joseph P. San Clemente, M.D., Lisa Fore-Arcand, Ed.D.

EDUCATIONAL OBJECTIVES:

After this presentation, the participant will be able to recognize the potential of risperidone therapy to reduce hospitalization for patients with a variety of psychotic illnesses, including schizophrenia, schizoaffective disorder, and bipolar disorder with psychotic features.

SUMMARY:

Objective: In order to assess the effect of risperidone treatment on inpatient utilization by patients with a variety of psychotic disorders, a retrospective analysis of the hospitalization of individuals converted to this medication was conducted.

Method: Records of the 24 patients with schizophrenia, schizoaffective disorder, and psychotic mood disorders who had been converted from typical antipsychotic therapy to treatment with risperidone at least six months prior to initiation of this study were analyzed. Excluding the hospitalizations in which risperidone treatment was initiated, the number of hospital days utilized after conversion to risperidone was compared with the number of hospital days utilized in the equivalent period preceding the change in medication.

Results: The combined total of hospital days before conversion to risperidone was 313, and after conversion the total was 228. On average, patients were treated with risperidone for 13 months, so the number of yearly hospital days per patient was reduced 27%, from 11.8 to 8.6. Overall, the total number of hospitalizations was reduced 25%, from 28 to 21.

Conclusion: Conversion of patients with a variety of psychotic disorders to antipsychotic therapy with risperidone was associated with a significant decrease in hospitalization.

REFERENCES:

1. Davis JM, Janicak PG: Risperidone: a new, novel (and better?) antipsychotic. *Psychiatric Annals* 26:78-87, 1996.
2. Marder SR, Meibach RC: Risperidone in the treatment of schizophrenia. *Am J Psychiatry* 151:825-835, 1994.

No. 97
HALOPERIDOL BLOOD LEVELS AND EFFECTS IN SCHIZOPHRENIA

Jan Volavka, M.D., *Clinical Research, Nathan S. Kline Institute, 140 Old Orangeburg Road, Orangeburg NY 10962;* Thomas B. Cooper, M.A., Pal Czobor, Ph.D., Jean-Pierre Lindenmayer, M.D., Leslie L. Citrome, M.D., Pavel Mohr, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize that long-term high doses of haloperidol treatment in many chronic schizophrenic or schizoaffective inpatients can be reduced without causing clinically significant adverse consequences.

SUMMARY:

We aimed to identify schizophrenic and schizoaffective inpatients receiving long-term high-dose haloperidol treatment, reduce their plasma levels, and determine the effects of that reduction.

The subjects were schizophrenic or schizoaffective inpatients at three New York State facilities with haloperidol plasma levels greater than 15 ng/ml and consistently ill for at least 18 months. Patients were randomly assigned to one of two groups. In the first group their doses were reduced over a period of 12 weeks; the target plasma level was 10 ng/ml. That level was maintained for the subsequent 16 weeks. The patients in the continuation group were maintained on their original level for 28 weeks. Repeated evaluations included haloperidol plasma levels, PANSS, CGI, NOSIE, AIMS, and Simpson-Angus Scale. So far, 23 patients have been enrolled in the study and nine were randomized: four to continue on their dose, and five to a dose reduction.

There were no relapses in the reduced group, but there was one in the nonreduced group.

We report preliminary results of an ongoing study. So far, our findings support our hypothesis: in chronic schizophrenic and schizoaffective inpatients, doses of haloperidol can be reduced without causing clinically important adverse consequences. Updated results will be reported.

REFERENCES:

1. Volavka J, Cooper TB, Czobor P, Meisner M: Plasma haloperidol levels and clinical effects in schizophrenia and schizoaffective disorder. *Arch Gen Psychiatry* 52:837-845, 1995.
2. Krakowski MI, Kunz M, Czobor P, Volavka J: Long-term high-dose neuroleptic treatment: who gets it and why? *Hosp Community Psychiatry* 44:460-464, 1993.

PAPER SESSION 33—CONSULTATION/ LIAISON PSYCHIATRY: NEW ERA

No. 98
INTER-RATER RELIABILITY OF EMERGENCY ASSESSMENTS

Bruce B. Way, M.A., *75 New Scotland Avenue, Unit B, Albany NY 12208;* Michael H. Allen, M.D., Jeryl Mumpower, Ph.D., Thomas Stewart, Ph.D., Steven Banks, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participants should begin to understand the areas of unreliability in emergency psychiatric assessments. Further, the presentation might stimulate the participants to consider the variables they use to decide disposition.

SUMMARY:

Objective: To study the inter-rater reliability of assessments conducted in psychiatric emergency services.

Method: Thirty videotapes of psychiatric assessments conducted by physicians in four urban psychiatric emergency services were subsequently rated by eight senior emergency service physicians, two from each hospital. The doctors rated the videotaped assessments on 14 eight-point Likert scales such as danger to self, psychopathology, depression, psychosis, benefit of inpatient treatment, and recommended disposition (discharge/admission).

Results: The 14 judgments varied in their reliability, with client differences explaining more of the variation in psychosis (68.4%), substance abuse (64.9%), and social support (55.2%), and less in impulse control (30.6%), psychopathology (31.1%), and danger to self (32.9%). Six or more of the eight reviewing doctors agreed on recommended disposition (dichomtomized in the middle of the eight-

point scale) for 17 of the 30 interviews, while for remaining the 13 interviews the doctors were more divided. None of the correlations between doctors' recommendations for disposition and actual disposition given by the treating psychiatrist were significant. Analysis of recommended disposition suggested that each doctor relied on a unique set of variables and weights in making dispositions.

Conclusions: Reliability varied among the concepts used in emergency psychiatric assessments. Doctors disagreed with each other as to which patients should be admitted and disagreed with the treating psychiatrist. This suggests a need for clarification of underlying emergency psychiatric concepts and of when an inpatient admission is required.

REFERENCES:

1. Way BB, Evans ME, Banks SM: Factors predicting inpatient admission and referral to outpatient services of patients presenting to psychiatric emergency services. *Hospital and Community Psychiatry* 43:703-708, 1992.
2. Rabinowitz J, Slyuzberg M, Salamon I, et al.: A method for understanding admission decision making in a psychiatric emergency room. *Psychiatric Services* 46:1055-1060, 1995.

No. 99
MANAGED CARE PARADIGM SHIFTS AND CONSULTATION-LIAISON OPPORTUNITIES

Troy L. Thompson II, M.D., *Department of Psychiatry, Jefferson Medical College, 1025 Walnut Street, Suite 320, Philadelphia PA 19107-5005;* David G. Folks, M.D., Joel J. Silverman, M.D.

EDUCATIONAL OBJECTIVES:

To recognize six managed care paradigm shifts that affect C-L psychiatry and understand adaptive approaches to make each an opportunity for C-L psychiatrists.

SUMMARY:

Objective: To recognize six paradigm shifts due to managed care that affect C-L psychiatry and to understand adaptive approaches to make each shift an opportunity for C-L psychiatrists.

Methods: The authors, who are academic psychiatry chairs and former C-L division directors, evaluated their centers and discussed managed care mediated changes affecting C-L with other chairs, administrators, and C-L and other psychiatrists.

Results: Six paradigm shifts were identified: 1) Health care financing negotiations have shifted much more to the payor, with cost risks being shifted to the provider. 2) The focus is more on preventive medicine for populations rather than heroic interventions. 3) Consumer and advocacy groups have empowered patients. 4) Strong incentives favor outpatient vs. inpatient care. 5) Physicians have become members of interdisciplinary groups, with team work and resource management as key goals. and 6) Nonphysician professionals are playing greater roles in care.

Conclusions: Psychiatrists should become aware of these changes and the opportunities they present for C-L to develop effective proactive approaches to engage the managed care system to protect future patient care, education, and research. Also, C-L psychiatrists must repeatedly demonstrate empirically and educate decision makers and the public about the clinical efficacy (access, quality, and satisfaction) and cost-effectiveness of C-L interventions, and that C-L should play a key role in health care planning if quality care is to consistently result. Increased linkages to primary care are key to facilitating successful adaptation to these changes.

REFERENCES:

1. Rivo ML, Mays HL, Katzoff J, et al: Managed health care: implications for the physician work force and medical education. *JAMA* 274-712-715, 1995.
2. Saravay SM, Strain JJ: APM task force on funding implications of consultation-liaison outcome studies—special series introduction: a review of outcome studies. *Psychosomatics* 35:227-232, 1994.

No. 100
RENAL DIALYSIS AND END-OF-LIFE DECISIONS

Lewis M. Cohen, M.D., *Department of Psychiatry, Baystate Medical Center, 759 Chestnut Street, Springfield MA 01199;* Michael Germain, M.D., Anne Woods, L.C.S.W., Steven V. Fischel, M.D., Jack D. McCue, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the psychiatric aspects of patients who are considering termination of the life-support treatment of dialysis. Participants should be able to assist nephrologists in making these difficult determinations.

SUMMARY:

Objective: The life-support treatment of dialysis offers a model to explore the psychiatric aspects of end-of-life decisions. Little is known about the history of depression, psychiatric treatment, and suicide attempts in these patients, and whether they change their minds about stopping therapy.

Method: After completing three related studies, we are conducting a three-year, prospective study of patients who discontinue dialysis at 10 programs in the United States and Canada. Patients and families are interviewed at the time of the decision to terminate treatment, and the palliative care and quality of dying are observed until death ensues. More than 30 subjects have been enrolled.

Results: Few patients have an individual or family history of psychiatric contact or suicide attempts. Ambivalence was evident in the pilot research (N = 11) where three subjects had a history of previously stopping dialysis, while a fourth subject chose to resume dialysis treatment, but died on the following day. Denial of dying on the part of patients and dialysis staff was also apparent in previous studies and continues to be manifest during the current investigation.

Conclusions: Major psychiatric disorders, such as depression, and self-destructive behaviors, such as suicidal attempts, play only minor roles. More attention should be paid to the phenomena of denial and ambivalence in the decision to terminate life support.

REFERENCES:

1. Cohen LM, Germain M, Woods A, et al: Patient attitudes and psychological considerations in dialysis discontinuation. *Psychosom* 34:395-401, 1993.
2. Weisman AD: *On Dying and Denying: A Psychiatric Study of Terminality.* Behavioral Publications, Inc. New York, 1972.

PAPER SESSION 34—COMORBIDITY FACTORS IN ANXIETY DISORDERS

No. 101
COMORBIDITY OF PANIC DISORDER AND PERSONALITY DISORDER

Eric D. Peselow, M.D., *Department of Psychiatry, NYU School of Medicine, 32 Bassett Avenue, Brooklyn NY 11234;* Sunil D. Khushalani, M.D., R. Sandlin Lowe III, M.D., Mary T. Guardino, Wieslawa Tomaszewska, M.D.

EDUCATIONAL OBJECTIVES:

To evaluate the comorbidity of panic disorder and personality disorder during periods of acute panic symptoms and during periods when panic free in order to understand the importance of state-trait issues and timing of assessment

SUMMARY:

Objective: The purpose of this report is to evaluate frequency of DSM-IV personality disorders in patients with panic disorder as well as to determine the frequency of comorbid conditions such as generalized anxiety disorder (GAD), agoraphobia, obsessive-compulsive disorder (OCD), social and specific phobia, depression, and DSM-IV personality disorders.

Method: To date we have evaluated 58 patients with panic disorder who were diagnosed using a modified symptom checklist adapted from the SCID during the acute stage of the illness and following clinical recovery (defined as being free from a full-blown panic attack for at least one month) 12-16 weeks later. To assess personality disorders the SIDP for DSM-IV was used both during the acute phase of the illness and upon clinical recovery. From the SIDP we were able to assess both dimensional personality traits and categorical diagnosis. In addition, using the modified SCID, at baseline we also determined whether the patients met DSM-IV criteria for GAD, agoraphobia, social and specific phobia, OCD, or depression.

Results: At baseline, 37 of the 58 patients (64%) met criteria for at least one DSM-IV personality disorder, with the two most frequent being avoidant (41%) and dependent (38%). However, upon clinical recovery, only 26 of the 58 patients (45%) met criteria for at least one DSM-IV personality disorder, and the frequency of meeting criteria for a DSM-IV personality disorder as well as the dimensional trait score with respect to the Cluster A and Cluster C traits decreased to a significant level when the panic attacks ceased. Panic patients with a greater comorbidity of other anxiety disorders tended to retain the personality disorder diagnosis.

Conclusion: Assessment of Axis II pathology is confounded by active psychopathology, but even during symptom free periods there is high comorbidity between panic disorders and DSM-IV personality disorders.

REFERENCES:

1. Green MA, Curtis GC: Personality disorders in panic patients: response to termination of antipanic medication. *Journal of Personality Disorders* 2:303-314, 1988.
2. Reich J, Troughton E: Frequency of DSM-III personality disorders in recovered depressed and panic disorder patients. *Psychiatry Research* 26:89-100, 1987.

No. 102
PANIC DISORDER: COMORBIDITY AND PHENOMENOLOGY

Sunil D. Khushalani, M.D., *Department of Psychiatry, New York University, 211 East 35th Street, New York NY 10016;* Eric D. Peselow, M.D., Wieslawa Tomaszewska, M.D., R. Sandlin Lowe III, M.D., Mary T. Guardino,

EDUCATIONAL OBJECTIVES:

To evaluate comorbidity and the relationship of specific clinical symptoms of panic disorder to help the clinician better understand, diagnose, and treat panic disorder.

SUMMARY:

Objective: The purpose of this report is to evaluate the types of symptoms one most frequently sees in patients with panic disorder and to determine the frequency of comorbid conditions in panic disorder.

Method: To date we have evaluated 162 patients with panic disorder using a modified symptom checklist adapted from the SCID. On this modified SCID we also determined whether the patients met DSM-IV criteria for GAD, agoraphobia, social and specific phobia, OCD, or depression. To assess the specific panic symptoms, the panic inventory was given. To assess personality disorders, the SIDP for DSM-IV was used.

Results: From the panic inventory, the most frequent symptoms that the panic-disordered patients had were palpitations (85.8%) followed by fear of dying (80.2%) and dizziness (74.7%). The three least frequent symptoms were hot and cold flashes (38.3%), paresthesias (39.5%), and nausea (42.0%). There was a high degree of comorbidity associated with panic disorder, as only 34/162 patients (21.0%) met criteria for panic alone. Overall, 71.6% of panic patients had depression as a comorbid feature, and 99/162 (61.1%) panic patients had GAD as a comorbid feature. Also, 59/162 (36.4%) of the panic patients had agoraphobia. Overall the comorbidity of OCD, specific phobia and social phobia was 25.3%, 11.7%, and 10.3%, respectively. Of 77 patients who received the SIDP for DSM-IV personality disorders, 52 (67.5%) met criteria for at least one DSM-IV personality disorder; the two most frequent were avoidant and dependent.

Conclusion: In panic disorder patients comorbidity is more of a rule than an exception. In addition, panic disorder is quite varied in its manifestation. Treatment has to be guided by keeping that in perspective. The overall response to treatment in panic-disorder patients with Axis I and Axis II comorbidity will be discussed.

REFERENCES:

1. Shear MK, Maser JD: Standardized assessment for panic disorder research. *Archives of General Psychiatry* 51:346-354, 1994.
2. Briggs AC, Stretch DD, Brandon S: Subtyping of panic disorder by symptom profile. *British Journal of Psychiatry* 163:201-209, 1993.

No. 103
INCIDENCE OF DEPRESSION AND ANXIETY SPECTRUM DISORDERS IN A CARDIOLOGY CLINIC

Wieslawa Tomaszewska, M.D., *Department of Psychiatry, NYU Medical School, 312 East 30th Street, #9A, New York NY 10016;* Eric D. Peselow, M.D., Sunil D. Khushalani, M.D.

EDUCATIONAL OBJECTIVES:

To assess incidence and frequency of untreated depressive and anxiety spectrum disorders in a cardiology clinic to allow nonpsychiatric physicians to understand the magnitude of the problem and the relationship between cardiac illness and psychopathology.

SUMMARY:

Objective: To study patients who attend a cardiology clinic who have documented cardiac pathology and to examine the frequency of depressive and anxiety spectrum disorders in this sample.

Method: To date we have evaluated 107 patients who attend a cardiology clinic. The patients who were screened were not in psychiatric treatment at the time of the evaluation. We evaluated patients for the study using a modified symptom checklist adapted from the SCID. Using the modified SCID, we also determined whether the patients met DSM-IV criteria for GAD, agoraphobia, panic disorder, or depression. To assess the specific symptoms, we evaluated all patients using the Montgomery-Asberg Depression Scale, Hamilton Anxiety Scale, Panic Inventory, and CGI.

Results: 43 of the 107 patients (40.2%) who were not currently in treatment met criteria for at least one of the four disorders, with 24 (22.4%) meeting criteria for major depression and one of the anxiety spectrum disorders. In addition, of the 64 who did not meet criteria for one of the DSM-IV diagnoses studied, 25 had at least

subsyndromal pathology that caused them some distress (Hamilton Anxiety Score >8, Montgomery-Asberg Depression score >8, Panic Inventory showing limited symptom attacks). Patients who had evidence of depressive or anxious symptoms had statistically higher numbers of visits to medical clinics over the preceding year than those who had no psychiatric pathology.

Conclusion: Approximately 60% of individuals attending a cardiology clinic and who were not in psychiatric treatment had some evidence of depressive or anxious symptoms. Six- to 12-month follow-up data on these patients will be presented, as will a discussion of the implications for patients with psychiatric illness treated in a medical clinic.

REFERENCES:

1. Farsure-Smith N, et al: Depression following myocardial infarction-impact on 6 month survival. *JAMA* 270:1819-1825, 1993.
2. Coryell W, Noyes R, House JD: Mortality among outpatients with panic disorder. *Am J Psychiatry* 143:508-510, 1986.

SYMPOSIUM 1—CAREGIVING IN THE NINETIES: SUPPORTING THE DOCTOR, SPOUSE AND FAMILY
APA Auxiliary

No. 1A
WHO ARE THE CAREGIVERS?

Paul Jay Fink, M.D. *One Belmont Avenue, Suite 523, Bala Cynwyd, PA 19004*

No. 1B
THE INCIDENCE OF PTSD IN BREAST CANCER PATIENTS AND THEIR WITNESSES

Douglas M. Lanes, *1361 Elm Street, Suite 202, Mainchester, NH 03101-1323*

No. 1C
CAREGIVING ISSUES FOR RESIDENTS AND MEDICAL STUDENTS

Carol A. Bernstein, M.D., *Department of Psychiatry New York University Medical Center, 550 First Avenue, NB 20N11, New York, NY 10016*

No. 1D
FORMAL AND INFORMAL CAREGIVERS: ALLIES IN THE HELPING PROCESS

John D. Nottingham, M.D., *18333 Egret Bay Blvd., Suite 305, Houston, TX 77058-3266*

No. 1E
NATIONAL QUALITY CAREGIVERS CONSORTIUM

Mrs. Rosalynn Carter, *Post Office Box 350, Plains, GA 31780-0350*

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to recognize and cope with their complex feelings as a caregiver. Strategies for promoting better communication with the doctor and family will be discussed. Suggestions on patient care, using love, common sense, and healing techniques will be addressed.

OVERALL SUMMARY:

This session will depart from the usual symposium format. Instead of each participant presenting a paper there will be a panel of participants, each making brief presentations, then the session will be devoted to open discussion about caregiving in the nineties.

Caregiving in the Nineties includes a complex series of events over time. Caregivers in the recent past have taken on the role of healing and nurturing. In the medical family, the burdens of truth and responsibility about medical conditions are shared with the family unit. Changing times have effected the practice and philosophy of medicine, therefore bringing about drastic changes in health care thrusting additional emotional and financial pressures on patients and their families. The result is a new type of health care provider, and in the case of a medical family a professional or spouse or other family member is recruited by necessity to care for a patient. This role has intensified due to the cost-shifting from health care institutions back to family and community. Caregiving within the medical family requires the strength of a team effort that includes professional practices used in concert with multiple caregiving strategies and the healing tool of love and compassion. The Presenters of this symposium will address these issues and offer solutions to these problems.

SYMPOSIUM 2—DANGER ZONE: PSYCHIATRY IN PEACEKEEPING OPERATIONS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, participants whould be able to

1) Describe the six phases of peacekeeping operations and the stressors particular to each.

2) Describe the psychiatric consultation issues pertinent to each phase of operations.

3) Describe typical military community interventions which reduce the rate of psychiatric morbidity.

4) Discuss the typical challenges facing the psychiatrist-commander and the supports needed by her/him.

No. 2A
OUTPATIENT MENTAL HEALTH: OPERATION JOINT ENDEAVOR

David M. Benedek, M.D., *Department of Psychiatry, First Armor Division USA, CMR 438/Box 2177/APO AE 09111, Bad Kreuznach, Germany;* Simon H. Pincus, M.D.

SUMMARY:

Introduction: Army divisions deploy with organic mental health assets to identify and treat stress reactions and other mental disorders.

Objective: This report summarizes the range of mental health care programs available to U.S. soldiers deployed to the former Yugoslavia.

Methods: Challenges of delivering mental health care in an austere environment to a population particularly concerned with the stigma of seeking care are examined, and mission-specific stressors are defined. Division mental health service actions to increase access and reduce stigma are discussed and referral rates, return-to-duty rates, suicide rates, and medical evacuation rates are compared to those of other recent military deployments.

Results: Operational stress resulting from workload, harsh environment, actual and perceived threat, and prolonged family separation was comparable to other recent deployments. Psychiatric evacuation rate (4%) and suicide rate (0%) were lower, while return-to-duty rate (96%) was higher than predicted by previous deployment experience.

Conclusions: Mental health service activities to obtain command support for, promote, and implement a broad range of programs permitted early intervention, reduced morbidity, and may serve as a model for future deployments.

No. 2B
COMBAT STRESS CONTROL IN OPERATION JOINT ENDEAVOR

Simon H. Pincus, M.D., *Department of Psychiatry, US Army, 625 Robinglen Court, Colorado Springs CO 80906-6808;* David M. Benedek, M.D.

SUMMARY:

Introduction: The military has developed specialized mental health units to evaluate soldiers diagnosed with stress reactions or neuropsychiatric disorders.

Objective: This paper presents lessons learned during the year-long peace enforcement mission to Bosnia-Herzegovina.

Methods: Austere weather and dangerous physical conditions present unique challenges to the delivery of mental health care. Promoting access to care is emphasized. Decreasing stigma is achieved through thoughtful use of media. Prevention of post-traumatic stress is effected through early critical incident stress debriefings. Field expedient restorative services are used in lieu of traditional inpatient care, high-risk soldiers are evacuated by air to a tertiary setting.

Results: Demographics and operational stressors are examined. Return-to-duty rates (85%) following restorative care and air evacuation (15%) are comparable with previous deployment experience. Suicide rates (0%) are significantly lower.

Conclusions: Credibility with leaders, chaplains, and medical personnel was achieved through successful marketing strategies and prevention classes. At risk soldiers were readily identified and referred for evaluation. Lessons learned will prove valuable for improving mental health care delivery in future military deployments.

No. 2C
PSYCHIATRIC SERVICES IN MILITARY PEACEKEEPING

Donald P. Hall, Jr., M.D., *Department of Psychiatry, Walter Reed AMC, Washington DC 20307*

SUMMARY:

Review of clinical data and published reports from recent U.S. humanitarian missions to Somalia, Haiti, and Cuba reveals that soldiers and civilians who served during these missions faced different stressors and patterns of maladjustment than individuals who served in previous, traditionally combat, military operations. Clinical data indicate that post-traumatic stress disorder and illnesses historically referred to as battle fatigue are less common among affected civilians and rare among soldiers. Analysis of data from Operation Uphold Democracy (Haiti) reveals two specific findings: First, a distinct pattern of high psychiatric acuity, lasting approximately six weeks, was observed during the initial phase of the mission. Second, in comparison to recent missions to Somalia and the Persian Gulf, a high rate of psychiatric morbidity and mortality marked the initial weeks of the operation in Haiti. During the first 30 days, 13 soldiers were diagnosed with major DSM-IV-defined Axis I disorders and 3 servicemen committed suicide. Over the next 60 days, 6 soldiers were diagnosed with major Axis I disorders and no service personnel committed suicide. Psychodynamic factors and health service organizational principles may be employed to understand these events and guide mental health interventions provided on future peacekeeping missions.

No. 2D
UNIT FACTORS AND OPERATIONAL STRESS CASUALTIES

Gregory L. Belenky, M.D., *Neuropsychiatry, WRAIR, Washington DC 20307;* Paul Bliese, Ph.D., Ronald Halverson, Ph.D., Robert Gifford, Ph.D.

SUMMARY:

Combat stress control teams working with Army units in operational settings focus on the prevention and treatment of operational stress casualties. In evaluating and treating stress casualties, the clinician is often at a loss as to whether the person he/she is seeing is simply a distressed individual or represents the tip of the iceberg of a dysfunctional unit. The question is important as the combat stress control teams have the capacity to conduct command consultations and unit level interventions as well as the responsibility to treat individual cases. Human dimensions research began as a research tool to evaluate unit and organizational climate through surveying unit members, their well-being, and health symptoms. In both the U.S. Army deployments to Haiti and to Bosnia, human dimensions research surveys have been analyzed in-theater and the results fed back to unit commanders and combat stress control teams within 7 days of completing collection. This has provided commanders and combat stress control teams with information on the well-being and health symptoms of soldiers and their units in near-real-time, and facilitated treatment of individual cases through better appreciation of the unit matrix from which the individual comes and suggested fruitful command consultations and unit level interventions.

No. 2E
PSYCHIATRIST IN COMMAND

Linton S. Holsenbeck III, M.D., *Colorado Health Networks, 201 West 8th Street, Suite 380, Pueblo CO 81003*

SUMMARY:

Military organizations have increasingly recognized the role of psychological and physical stress in combat breakdown, at both individual and organizational levels. Specific training is directed toward seasoning service members against stress and a variety of social supports have been developed to sustain men and women in stressful operations. The manipulation of stresses on the opposing force has become a critical talent in the art of war. In response to the growing recognition of the role of stress in warfare, military organizations have fashioned important roles for mental health providers. The U.S. Army, in particular, has fielded a number of "combat stress control" organizations. Psychiatrists have been deemed most appropriate to command such units. However, the roles of psychiatric physician and military commander are antitheses in many ways. The qualities and, in many cases, values typifying the "good psychiatrist" are significantly at odds with those typifying the "good commander." The psychiatrist is a representative of the "Healer" culture. The commander is a representative of the "Warrior" culture. The integration of the two cultures in the psychiatric-commander is difficult, stressful, and often alienating. The personal and professional challenges facing psychiatrist-commanders are explored. Some parallels are drawn to related culture conflicts facing psychiatrist-executives.

No. 2F
MENTAL HEALTH SUPPORT TO MENTAL HEALTH PROVIDERS

Theodore S. Nam, M.D., *Department of Psychiatry, LRMC, CMR 402/Box 444, APO AE 09180-0444*

SUMMARY:

Introduction: Deployed mental health care providers provide mental health care to the command, soldiers, and health care providers. Currently, there is no doctrine or directive ensuring a systematic provision of preventive mental health to the deployed mental health providers.

Objectives: This presentation describes an attempt in establishing and providing mental health support to the two leaders of the mental health teams deployed during the Operation Joint Endeavor (OJE), a peacekeeping mission to a war-torn Bosnia and Herzegovina.

Method: Direct person-to-person, telephonic, and E-mail communications are examined during the six phases of OJE: 1) predeploy-

ment, 2) deployment, 3) sustainment, 4) pre-redeployment, 5) redeployment, and 6) postdeployment.

Results: The two leaders of the mental health care teams developed an effective working alliance, and delivered compassionate care exemplified by the sharing of the limited resources, high rates of return to duty, and low rates of air evacuations, suicides, and homicides.

Conclusion: The effectiveness of the mental health care providers can be enhanced by consistent mental health support throughout the deployment.

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SYMPOSIUM 3—THE EXPERT CONSENSUS: TREATMENT OF BIPOLAR DISORDER

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to identify the crucial points in the disease management of bipolar disorder and implement expert consensus guidelines for dealing with them.

No. 3A
EXPERT CONSENSUS GUIDELINES METHODOLOGY

Daniel Carpenter, Ph.D., *Department of Psychology, New York Hospital/Cornell, 21 Bloomingdale Road, White Plains NY 10605*

SUMMARY:

The Bipolar Treatment Guideline presented in this symposium is based on a new method of establishing expert consensus. The first step in this process was to develop a model for the clinical management of bipolar disorder with key decision points identified where the clinical trials literature is scant or absent. A questionnaire was then developed, which systematically queried experts as to the appropriateness of several treatment options given a series of clinical situations. The questionnaire was then mailed to 68 nationally known experts in the treatment of bipolar disorder, and 60 responded. A second survey was mailed subsequently to elucidate the earlier findings. A total of 61 of the original 68 responded. Statistics of agreement and analyses aimed at identifying patterns of random responding were used to quantify areas where the experts reached a consensus. Summary statistics for each treatment option were calculated including the mean and 95% confidence interval. The rating of the experts was defined according to where the confidence interval fell on the 9-point scale. Once the consensus of the experts was quantified, the results were used to inform a practice guideline based on the consensus of the experts.

No. 3B
BIPOLAR DISORDER EXPERT CONSENSUS SURVEY RESULTS

David A. Kahn, M.D., *Department of Psychiatry, Columbia Univ/ Presbyterian Hos, 180 Ft Wash Ave/Harness 236, New York NY 10032*

SUMMARY:

Sixty-eight nationally recognized psychopharmacology research experts on bipolar disorder were surveyed on approximately 80 key treatment decisions. Responses were received from 59 (85%). Using both continuous and categorical analyses of appropriateness ratings on a 9-point scale, treatment recommendations were derived. There was excellent agreement on many items, yielding recommendations consistent with other current guidelines, but more specific with respect to choices of first-line and second-line options. For acute-phase treatment of mania, lithium was the treatment of choice for classic "euphoric" mania, with valproate the first-line alternative. Valproate was the treatment of choice for mixed and rapid-cycling mania, with lithium the first-line alternative for mixed mania, and lithium or carbamazepine the first-line alternatives for rapid-cycling. Subsequent pathways for treatment resistance to initial mood stabilizers and for adjunctive medications were identified. For acute-phase treatment of bipolar depression, buproprion and SSRI's were first-line, in conjunction with specific, differential pathways for use of more stabilizers, psychotherapy, antipsychotics and ECT in bipolar I and II disorders, with and without psychosis. A number of recommendations also emerged for various patterns or relapse during maintenance treatment.

No. 3C
THE IMPLEMENTATION OF BIPOLAR TREATMENT GUIDELINES

John P. Docherty, M.D., *Department of Psychiatry, New York Hospital/Cornell, 21 Bloomingdale Road, New York NY 10605*

SUMMARY:

Although approximately 2,000 guidelines currently exist, current data suggest that very few of these are actually used. Two major problems appear to be responsible for this lack of use: the nature and quality of the guidelines themselves, and the lack of integration of the guidelines as part of an overall health delivery system. We will review an approach to guidelines that attempts to rectify these two problems. First, this approach involves a novel process for the development of more useful guidelines. Usefulness is defined as guidelines which are impartial, representative, practical, quantitatively derived, verifiable, and modifiable during use. Second, it involves a program of implementation that follows a public health model. Level one of the intervention entails a systematic process for developing awareness and broad acceptance of the guidelines among the stakeholders in the treatment process, including policymakers, administrators, providers of care, patients, and their families. The second level consists of a program of effective education involving both didactic presentation and the opportunity for paradigmatic "hands-on" experience in the use of the guidelines. Level three involves a program for sustained involvement of the providers in the use of the guidelines, by using "network" technology. This entails an interactive process in which data on the use of the guidelines provide information regarding their feasibility and validity, and support a continuous process of modification and refinement. This network is supported through the use of tools appropriate to the particular guidelines, including paper and pencil forms as well as closed-loop computer systems. Specific issues arising in this implementation program for bipolar disorder will be discussed.

No. 3D
PATIENT ADVOCACY PERSPECTIVE IN BIPOLAR GUIDELINES

Arthur O. Anselmo, *National Depressive and Manic-Depressive Assoc. 730 North Franklin, Suite 501, Chicago IL 60610*

SUMMARY:

Bipolar disorder is a lifelong, recurrent illness that affects 2.2 million Americans. If left untreated, the illness often causes damage to many aspects of an individual's life, including relationships, employment, education, and finances. Although treatment is safe and highly effective, many people with the illness do not seek treatment, are misdiagnosed, or do not receive adequate treatment. A survey conducted by the National Depressive and Manic-Depressive Association found that patients received a correct diagnosis of the illness an average of eight years after originally seeking treatment. On average, patients saw 3.3 medical doctors before receiving a correct diagnosis. While most individuals experience significant improvement following treatment, many undergo recurring episodes of the illness. Therefore, the development of precise treatment guidelines is essential for the accurate diagnosis and effective treatment of bipolar disorder. Guidelines must cover a wide range of patient symptoms and behaviors, and provide a number of treatment options. In addition, patients and their families can do many things to reduce the frequency and severity of episodes. Treatment guidelines that include actions for patients and families can serve as an effective tool in minimizing the devastating effects of bipolar disorder.

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SYMPOSIUM 4—DELAYED TRAUMATIC RECALL IN PSYCHIATRY AND THE LAW
Joint Session with the American Academy of Psychiatry and the Law's Committee on Adult Recovered Memory

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation participants will understand different types of memory, including traumatic, differing presumptions and priorities within clinical and forensic practice, uses and hazards of recovered memory in psychotherapy, effects of hypnosis and suggestion, relevant neurobiology, and guidelines for managing traumatic recall in clinical and forensic psychiatric practice.

No. 4A
TYPES OF MEMORY: ISSUES IN ASSESSMENT AND TREATMENT

John O. Beahrs, M.D., *Department of Psychiatry, Oregon Health Sciences Univ, PO Box 1036, Portland OR 97207*

SUMMARY:

Distinct memory systems are known. "Declarative" memory refers to memory of events and factual content that can be described in language. Gradual acquisition of new skills is termed "procedural" memory. Conditioned avoidance to aversive stimuli, sometimes termed "emotional" memory, underlies the rigidified patterns of avoidance and re-enactment that often follow traumatic experience. Only declarative recall is relevant to questions of factual truth. Remembered traumatic events are sometimes true, false, and/or distorted. Pitfalls in assessment include confusion of patterns of conditioned avoidance with declarative content, and of content not accessible to voluntary retrieval with non-declarative memory. Declarative content is more likely to be altered by suggestion in individuals with high hypnotizability and dissociative potential, in settings of mutual social influence, and when incoming information bypasses conscious scrutiny. Overall, it is important to differentiate experiential and substantive realities. Effective treatment requires empathic respect for patients' experience, and determination of factual truth requires external corroboration through tangible data.

No. 4B
DELAYED TRAUMATIC RECALL IN PSYCHOTHERAPY

Thomas G. Gutheil, M.D., *Department of Psychiatry, Massachusetts Mental Hlth Cntr, 74 Fenwood Road, Boston MA 02115*

SUMMARY:

Amid the confusion and anxiety surrounding legal wranglings about recovered memories, the clinical facts remain unchanged: normal therapeutic practice all over the world has continously revealed recovery of lost memory data. This segment of the symposium will address dynamic aspects of the recovery of memory in psychotherapy and its relevance to ideas of repression, forgetting, and related matters.

No. 4C
HYPNOSIS AND SUGGESTION IN TRAUMA-FOCUSED PSYCHOTHERAPY

David Spiegel, M.D., *Department of Psychiatry, Stanford Medical School, 401 Quarry Road, Room 2325, Stanford CA 94305-5544*

SUMMARY:

Hypnosis has been viewed as both the cause of and the cure for memory distortion. The special characteristics of the hypnotic state and the unusual attributes of those high in the trait of hypnotizability provide opportunities for exploration of memory distortion and retrieval. Trauma seems to elicit dissociation, with accompanying distortions in memory. Hypnosis has repeatedly been used to reverse dissociative amnesia and treat other aftereffects of trauma. Yet hypnosis and the enhanced suggestibility associated with it have been linked in the laboratory with increased productivity of memory retrieval at the expense of accuracy, often with a false sense of certainty that the memories produced are correct. Studies of the effects of hypnosis on memory retrieval will be reviewed. Effects of hypnosis and suggestion on the memory processes of encoding, storage, and retrieval will be examined, and the ways in which they may shape information perceived, the way in which it is stored, and how it is retrieved. Hypnosis is one useful technique for bridging amnesia, especially that resulting from traumatic experience. It may also be used to produce amnesia, and it may influence both the content and assessment of the accuracy of memory retrieval. Hypnosis is neither simply a solution nor a contaminant of memory processes, but rather an interesting if complicating factor in the understanding of memory, especially in relation to traumatic events.

No. 4D
THE NEUROBIOLOGY OF DELAYED TRAUMATIC RECALL

Angela M. Hegarty, M.D., *Department of Psychiatry, New York University, First Avenue and 27th Street, New York NY 10017*

SUMMARY:

The purpose of this presentation is to review the impact of the neurotransmitter and neuroendocrine changes associated with psychological trauma on brainstem-limbic-cortical networks that mediate delayed or impaired recall of traumatic events.

Neurocognitive assessment of patients exposed to severe trauma, reveals a pattern of impairments that may be attributable to dysfunction in both the hippocampal memory system, (formation and retrieval of conscious episodic memories), and frontal memory systems, (which organize both input to, and output from, the hippocampal system). The deficits include incomplete recall with impaired temporal sequencing, and contextual placement of memories retrieved, in response to internal and external trauma-related cues.

Neurocognitive assessment of patients exposed to repeated trauma reveal a pattern of perceptual, cognitive/associative, behavioral, and autonomic changes that may be associated with alterations in the septo-hippocampal and amygdaloid complex systems. Activation of these systems has been shown to impair frontal lobe functioning which may manifest clinically with confabulations, in which accurately remembered events are combined with other events, without regard to their internal consistency or plausibility.

The implications of these studies for the evaluation and management of traumatic memories elicited in therapy, and for the "false memory syndrome" debate, will be discussed in detail.

No. 4E
PSYCHIATRISTS' ROLE IN DELAYED RECALL LITIGATION

John J. Cannell, M.D., *1032 Leff Street, San Luis Obispo CA 93401-4444*

SUMMARY:

Many states now begin tolling the statute of limitations for child abuse not at the time of an alleged incident, but when it was first recalled. This has led to a wave of litigation over accusations of abusive events allegedly recovered in psychotherapy after years of amnesia, and in turn, to a backlash against psychotherapists for allegedly implanting false memories. This presentation will cover how to avoid such legal difficulties in clinical practice, and propose guidelines for psychiatric evaluators in the forensic arena. Evaluators should be separate from treating clinicians, and able to assure objective neutrality. Thorough diagnostic evaluation is mandatory. Current symptoms that suggest prior trauma do not constitute evidence for a specific past event. Independent evidence is required. Altered recall occurs more often in suggestible individuals, and through suggestive social influence both inside and outside of therapy. All of these variables should be assessed. It is helpful to document how contending parties' recall, assessments, and symptom patterns have evolved over time. Whenever possible, third parties should be interviewed and past health, school, and police records reviewed. Key principles will be illustrated through well-known past and contemporary legal cases.

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SYMPOSIUM 5—ADOLESCENT SEXUALITY: ISSUES OF NORMAL DEVELOPMENT AND CLINICAL PRACTICE
Joint Session with the American Academy of Child and Adolescent Psychiatry's Committees on HIV and Homosexual Issues

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to

1. Describe normal adolescent sexual development for males and females and expectable problems.
2. Know the methods and format of appropriate sexual history taking.
3. Recognize the sexual issues facing medically ill teens and adolescent parents.

No. 5A
NORMAL SEXUAL DEVELOPMENT

Alayne Yates, M.D., *Department of Psychiatry, Burns Medical School, 1319 Punahou, Honolulu HI 96826*

SUMMARY:

Objective: To develop perspective on normal sexual development.

Method: Presentation begins with a critical examination of sexual development in other eras and cultures. Findings on children's contemporary sexual behavior and development are presented. Sociocultural changes that affect children's perception of sexuality are described, with emphasis on sexual abuse prevention programs, AIDS, family relationships and rules, single parent sexual role modeling, abstinence based sex education, and exposure to prime time television. Sexual expression in childhood or adolescence is currently associated with pathology and deemed one of several high-risk or externalizing behaviors.

Results: Depression, sexual confusion, guilt, and gender identity issues are commonly reported. Conflicts about sexuality are evident in masturbation attitudes and behaviors. Sexual aversion, inhibition of desire, and cognitive distortions about sexuality are frequently found among adolescents.

Conclusions: Current limitations on data collection are noted and future directions for research are suggested.

No. 5B
FEMALE ADOLESCENT SEXUAL DEVELOPMENT

Elizabeth M. Tully, M.D., *Department of Psychiatry, Sutter Medical Group, 7700 Folsom Boulevard, Sacramento CA 95826*

SUMMARY:

Objective: The purpose of this paper is to examine the nature of sexuality in girls, with an emphasis on its relationship to the biopsychosocial transitions surrounding puberty. Although the sequence of the endocrinologic changes of puberty is related to chronologic age, there is a wide variation in the rate of sexual maturation between individuals. The relationship between sexual maturation and the adolescent growth spurt is examined, in addition to population differences. Breast development and menstruation have a powerful impact on the young adolescent girl and her body image. These changes combined with social stereotypes and cultural messages frequently result in negative self-appraisal.

Results: Extensive literature review indicates that the sexual behavior of female adolescents has changed over the past several decades in the United States. The factors that account for these changes are complex and interwoven. More research will be needed to determine how developmental and sociocultural factors may mediate the nature of girls' sexuality, and which interventions are most effective in promoting healthy behaviors in this age group.

No. 5C
MALE ADOLESCENT SEXUAL DEVELOPMENT

William M. Womack, M.D., *Department of Psychiatry, Children's Hospital & Med Ctr, PO Box C5371-CH13, Seattle WA 98105*

SUMMARY:

Objective: To develop a contemporary perspective on male adolescent sexual development.

Method: The presentation begins with a discussion of the physical and psychological changes that accompany male adolescence and how these changes influence sexual development. Issues such as how gender role behaviors and early sexual experiences are influenced by changing sociocultural factors such as media images of sexuality (TV, cinema, music), shifting family patterns, socioeconomic factors, and the absence of positive role models for the expression of sexuality, will be explored. Sexual orientation will be discussed from the perspective of how males experience conflict because of uncertainty regarding patterns of sexual arousal toward persons of the same and/or opposite gender, and how the primary care physician/psychiatrist can be helpful in supporting behaviors which allow for personal choice, individual responsibility, and healthy sexual expression. Included in this discussion will be an overview of homosexual identity development to help understand this normal variant of sexual expression.

Results: Cultural pressures put the adolescent male at risk for STD's, homophobia, depression, and sex-linked violence.

Conclusion: Understanding the parameters of normal adolescent sexual development can assist the physician to become an informed advocate for the promotion of healthy sexual behaviors and sexual expression.

No. 5D
SEXUAL HISTORY-TAKING: FOCUS ON ADOLESCENTS

Lynn E. Ponton, M.D., *Department of Psychiatry, University of CA at SF, 206 Edgewood Avenue, San Francisco CA 94117-3715*

SUMMARY:

Sexual history taking is an area of child and adolescent psychiatry that has the potential to benefit significantly from research advances in a variety of areas over the past ten years. Increasing knowledge about developmental changes associated with puberty (Irwin & Shafer, 1991), about the biological aspects of sexuality in younger children and its future impact on adolescents (Phibbs, 1987), about how adolescents make decisions about experimenting with new sexual activities, about the perceived role of the peer group, and about how culture affects sexuality (Ponton, 1993) can and should be effectively employed in clinical interviews. A standard interview format for adolescents and their parents, which includes aspects of sexual development, identity, and spectrum of behaviors—including relation to risk—will be discussed. Variations on sexual history taking for consideration of sexual molestation and harassment will also be discussed. The presentation will address important basic principles regarding sexual history taking and make recommendations regarding clinical research in this area.

No. 5E
IMPACT OF MEDICAL ILLNESS ON SEXUAL DEVELOPMENT

James D. Lock, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, RM 1120, Palo Alto CA 94304*

SUMMARY:

Purpose: To discuss the clinical and research literature related to sexuality and medical illness in adolescents.

Methods: Literature search of Medline and related periodicals.

Results: Physical illnesses have an impact on sexual development and behavior including physical, social, and emotional components. For the physically ill child in the early phase of adolescence concern with sexual issues is governed in large measure by the impact that their illness or its treatment has on their pubertal development. In the middle phase sexual problems arise as a result of impediments to developing peer groups. This leads to difficulties in sexual development in the medically ill because of increased dependency on family members and institutions, increased periods of isolation from peers due to physical illness, decreased capacities for sexual interaction due to acute or chronic health limitations, and increased shame around illness and its impact on psychosocial functioning. Key sexual issues for the medically ill adolescent during later adolescence are concerns about decreased life span, fertility, transferring dependency needs from families onto intimate partners, and the potential for genetic transmission of illness.

Conclusions: Clinicians working with medically ill teens should attend to the impact of their illness and its treatment on sexual development.

No. 5F
ADOLESCENT PREGNANCY AND PARENTHOOD

Larry K. Brown, M.D., *Department of Psychiatry, Brown University, 593 Eddy Street/RI Hospital, Providence RI 02903*

SUMMARY:

Objective: This presentation will review the literature concerning the consequences and correlates of adolescent pregnancy. It will also report on an ongoing HIV prevention program within an urban teen-tot clinic.

Methods: Clinical reports suggest both positive and negative impacts of adolescent parenthood on self-esteem, identity formation, and parental behaviors. The HIV prevention project surveyed 60 young mothers regarding their sexual behavior and attitudes.

Results: Cross-sectional research finds problematic outcomes for young parents. Young adolescent parents are at risk for further child bearing (40% within 18 months) and STD's (40%). Longer-term studies are more optimistic and note the positive impact of intervention and education. The survey finds that sexual behavior is largely unrelated to risk perceptions and most associated with perceptions of romantic relationships and cultural frameworks. Young fathers are often ignored by programs and tend to be skeptical of medical institutions.

Conclusions: Complex cultural and psychological forces impinge on young teens who are simultaneously adolescents and parents. Clinicians need to attend to these issues as they evaluate and treat young parents.

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SYMPOSIUM 6—TRAUMA AND RECOVERY IN VICTIMS OF THE BOSNIAN WAR

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to understand the nature of war-generated trauma and its impact on children and families. The participant will also learn how both individual clinicians and the public mental health system must adapt to meet the special challenges of war.

No. 6A
PSYCHOSOCIAL TRAUMA AND RESILIENCY IN CHILDREN

S. Arshad Husain, M.D., *Department of Psychiatry, University of Missouri, N119 Health Science Center, Columbia MO 65212-0001*

SUMMARY:

Objective: The aim of this paper is to acquaint the audience with the current findings on the effects of psychosocial trauma on children and the factors influencing vulnerability and resiliency.

Method: The author will report on a study he is conducting in Sarajevo of 791 children who have spent four years under siege enduring death and destruction caused by the war in the former Yugoslavia. These children often have been the deliberate target of grenade explosions and sniper fires. They lived with little food and water and passed four winters of sub-zero temperature without heat and electricity.

Results: Only 40% of children in this study met the DSM-IV criteria of PTSD.

Conclusion: Using data from his study, the author will discuss various theories explaining vulnerability and resiliency in children.

No. 6B
PUBLIC PSYCHIATRY: APPROACHES TO THE BOSNIAN WAR

Gordon L. Neligh III, M.D., *Department of Psychiatry, University of CO Hlth Sci Ctr, 4200 East 9th Avenue, Denver CO 80262*

SUMMARY:

One of the characteristics of the recent war in Bosnia is that it appears to have been fought in a way that produced maximum psychological consequences in the civilian population. It is perhaps telling that some of the leaders who produced these consequences were psychiatrists. Through a policy of constant shelling of cities such as Sarajevo, the intentional destruction of hospitals and the national library, random sniper fire, or the rape of Bosnian Muslim women, the population suffered severe psychological stress. A number of highly skilled clinicians from around the world were brought into Bosnia to help treat and prevent post-traumatic stress disorder. However, this author was brought in less to work with psychosocial trauma than to help reconstruct the public mental health system in Bosnia both during and after the war. The author worked with Bosnian psychiatrists and psychologists in restructuring psychiatric services out of the heavily shelled hospital and into the community. He worked with a project to teach social workers in Sarajevo about working with people with comorbid conditions and severe and persistent mental illness. This presentation deals with the history of these developments and the current problems in trying to restructure a public mental health system in Bosnia.

No. 6C
SHORT-TERM TRAUMA-FOCUSED THERAPY IN CHILD WAR VICTIMS

Arthur H. Green, M.D., *Child Psychiatry, Presbyterian Hospital, 622 West 168th Street, New York NY 10032*

SUMMARY:

The author will report his experiences as a consultant to psychiatric clinics in Slovenia and Croatia treating a large influx of war refugee children from Bosnia. Many children were interviewed directly, and the treatment protocols of numerous other children were reviewed with their therapists.

Results: The children had been exposed to the following categories of war-related trauma: a) Direct War Violence: Shelling and bombing resulting in the wounding and killing of people, b) Experience of Parental Loss and Separation, c) Resettlement as Refugees: Loss of attachment to families, peers, and school, and exposure to stressful conditions in refugee camps, and d) Stress Generated by Returning to Post-War Bosnia: Fear of renewed violence and exacerbation of traumatic reminders.

The most common symptoms encountered in the children were PTSD, depression, suicidal behavior, and generalized anxiety. Many children displayed psychosomatic symptoms, tics, and stuttering. Verbalization of traumatic memories and the expression of painful affects in a supportive milieu produced marked improvement in two months.

No. 6D
POSTWAR INTERVENTION WITH TRAUMATIZED CHILDREN AND ADOLESCENTS

Robert S. Pynoos, M.D., *Department of Psychiatry, UCLA, 300 Medical Center Plaza #2235, Los Angeles CA 90024*

SUMMARY:

This presentation will focus on issues in the organization and delivery of war-related psychosocial services for children, adolescents, and their families during the key transition from war-time to the post-war period. These issues encompass assessment instruments, the use of population surveys, strategies of mental health triage, prevention and intervention, the training and utilization of mental health and other health and academic personnel, and the development of necessary infrastructure and intersystem collaborations. The use of a developmental model of traumatic stress will be illustrated. Such a model indicates the importance of traumatic experiences, secondary adversities and traumatic reminders, as well as the bimodal expression in developmental disturbances and psychopathology (including comorbidity). This discussion is based on the experiences of the UCLA Trauma Psychiatry Program in consulting with UNICEF, especially in regard to the UNICEF Psychosocial Program for the ex-Yugoslavia region.

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1. Pynoos, et al: A developmental model of childhood traumatic Stress. In *Manual of Developmental Psychopathology Vol 2, Risk, Disorder, and Adaptation.* D. Cicchetti and Cohen (eds) New York: John Wiley, 72-95, 1995.
2. Kuterovac, et al: Children in war: A silent majority under stress. *British J Med Psychology* 67:363-375, 1994.
3. Leavitt, LA, Fox, NA (eds): *The Psychological Effects of War and Violence on Children.* Hillsdale, New Jersey: Lawrence Enbaum, 1993.
4. Yehuda R, Resnick B, Kahana B, Giller E: Long-lasting hormonal alterations to extreme stress in humans: Normative or maladaptive? *Psychosomatic Medicine,* 55:287-297, 1993.

SYMPOSIUM 7—SERVICE MODELS FOR FAMILIES OF PERSONS WITH SERIOUS MENTAL ILLNESS: CHARACTERISTICS AND OUTCOMES

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to understand the characteristics, strengths and weaknesses, effectiveness research, and obstacles to implementation of different models for providing services to families of persons with severe mental illness.

No. 7A
OUTCOME IN MULTIPLE FAMILY GROUPS: PATIENT RECOVERY AND FAMILY RELIEF

William R. McFarlane, M.D., *Department of Psychiatry, Maine Medical Center, 22 Bramhall Street, Portland ME 04102;* Robert Dushay, Ph.D.

SUMMARY:

This presentation reviews the distinctive aspects of psychoeducational multiple family groups (PEMFGs) and four trials in 350 cases with psychotic (Axis I) disorders.

The approach provides extensive support to families of patients with the primary goal being the clinical and functional recovery of the patient. It includes (1) engagement of the family as a partner in treatment, (2) in-depth education in the psychobiology of mental disorders and their pharmacological and social management, (3) a long-term PEMFG emphasizing problem-solving, (4) a social support network for patient and family, and (5) the group leaders serving as the patients' therapists and case managers.

Two studies compared single- and multi-family forms of psychoeducation, one in a four-year, small sample experiment and another at six public hospitals with a large sample (n = 172), with relapse as the primary outcome measure. A third compared clinical (relapse) and functional outcomes (employment) in assertive community treatment (ACT) with and without PEMFGs. The most recent compared employment outcomes in ACT combined with PEMFG to standard vocational rehabilitation. The multi-family approach was significantly superior to single-family intervention or ACT without family involvement.

Accumulated evidence suggests that this approach is the most cost-effective psychosocial treatment yet developed for high-risk schizophrenic patients. Also, family burden is significantly reduced by participation. Qualitative measures demonstrate that the approach is highly valued by participants.

No. 7B
OUTCOMES OF TWO BRIEF FAMILY EDUCATION PROGRAMS

Phyllis L. Solomon, Ph.D., *Social Work, University of Pennsylvania, 3701 Locust Walk, Philadelphia PA 19104*

SUMMARY:

There has been a recent development of family education programs for families of adults with severe mental illness. These programs are independent of treatment, and frequently, grass-root efforts. In contrast to the treatment oriented psychoeducation programs, there is limited research on the effectiveness of these family education programs to date. This presenter will discuss the research on family education that has been done to date, with particular emphasis on a study recently conducted by the presenter. The results of a random clinical trial of two short-term family education programs, a 10-week group workshop and individual family consultation, compared to a waitlist control will be presented. A unique aspect of these interventions is they were developed, supervised, and executed collaboratively by professionals and trained family members. The outcomes are family focused, including assessing reductions in family burden, stress, grief, and improvement in coping behaviors and self-efficacy. Secondary benefits to the ill relative such as decreased hospitalizations and symptomatology, and improved attitudes toward medication compliance, functioning, and quality of life were also assessed.

No. 7C
WHAT ARE THE CRITICAL ELEMENTS OF PSYCHOEDUCATION?

Nina R. Schooler, Ph.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh PA 15213*

SUMMARY:

Two study designs have been used to examine the value of family psychoeducation in schizophrenia—one comparing psychoeducation to treatments that do not engage families and one comparing more than one form of psychoeducation. The results of these studies are remarkably consistent. Treatments involving families are superior to treatments that do not. However, when one family treatment is

compared to another, there are no differences between them. This presentation will seek to identify the elements that are common to family psychoeducation approaches and outline both a minimal set of elements and a program that provides a broader range of family services. We will also address the question of which families may benefit from particular approaches within an overall psychoeducation model.

No. 7D
PROFESSIONAL VERSUS FAMILY-LED SUPPORT GROUPS: EXPLORING THE DIFFERENCES

Susan A. Pickett, Ph.D., *Department of Psychiatry, University of IL at Chicago, 104 South Michigan, Suite 900, Chicago IL 60603;* Tamar Heller, Ph.D., Judith A. Cook, Ph.D.

SUMMARY:

Recent research has begun to examine the effectiveness of psychoeducational support groups for families of persons with severe mental illness. One question in particular is whether groups led by other family members may provide greater emotional support and information than those led by mental health professionals. This study compares the psychological well-being and group appraisals made by individuals participating in support groups led by family members (N = 105) to those of individuals participating in support groups led by mental health professionals (N = 41). T-test analyses found few differences between the groups, with one important exception: family members who attended groups run by professionals reported greater benefits such as feeling more optimistic about their ill relative, feeling less isolated, and having more information regarding the various treatments for mental illness than did individuals who attended groups led by other family members. Discussion of study findings will include implications regarding group structure, family needs, and determing the most useful family-support group fit.

No. 7E
JOURNEY OF HOPE FAMILY EDUCATION PROGRAM

Joyce Burland, Ph.D., *8 Park Place, Brattleboro VT 05301*

SUMMARY:

The Journey of Hope Family Education Program is a new peer model in family education operating nationally in 32 states. The 12-week course is offered free in hundreds of communities across the country, with classes taught by trained family members working in co-leader pairs. In three years, the program has grown rapidly and spontaneously as a result of the exceedingly positive experience family members have in these classes. The program is sponsored by the National Alliance for the Mentally Ill and is forging new ground as an effective answer to the pressing need for education and support among families of individuals with severe and persistent brain disorders.

This presentation will explore the unique strengths of this new peer program: What properties does this self-help model possess that may account for its popularity among families? What can this peer program possibly "do better" than professional programs? What does this level of engagement among family member teachers say about their development as legitimate paraprofessionals in family education? How can this new family initiative be endorsed by mental health professionals? The presentation makes a compelling case for the acceptance and encouragement of peer education programs among providers in the mental health community.

REFERENCES:

1. McFarlane WR, Lukens E, Link B, et al: Multiple family groups and psychoeducation in the treatment of schizophrenia. *Archives of General Psychiatry*, 52:679-688, 1995.
2. Solomon P, Draine J, Mannion E, Meisel M: Impact of brief family psychoeducation on self-efficacy. *Schizophrenia Bulletin* 22:41-50, 1996.
3. Schooler NR, Keith SF, Severe JB, et al: Relapse and rehospitalization during maintenance treatment of schizophrenia: The effects of dose reduction and family treatment. *Archives of General Psychiatry*, In Press, 1996.
4. Pickett SA, Cook JA, Cohler BJ: Caregiving burden experienced by parents of offspring with severe mental illness: The impact of off-timedness. *Journal of Applied Social Sciences*, 18, 2; 199-207, 1994.
5. Journey of Hope Family Education & Support, Louisiana Alliance for the Mentally Ill, July 1995.

SYMPOSIUM 8—RESEARCH ON PSYCHOSOCIAL TREATMENT FOR ADDICTION
Joint Session with the American Academy of Addiction Psychiatry

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The purpose of this symposium is 1) To provide an overview of major recent research in psychosocial modalities developed for treatment of the substance abusing patient; 2) To offer related information useful to clinicians in their practice; 3) To acquaint the audience with the research methodology employing behavioral research on addiction treatment.

No. 8A
NIDA's BEHAVIORAL THERAPIES DEVELOPMENT PROGRAM

Jack D. Blaine, M.D., *Treatment Research, NIDA, 5600 Fishers Lane, Room 10A-10, Rockville MD 20857;* Lisa S. Onken, Ph.D.

SUMMARY:

The Behavioral Therapies Development Program (BTDP) was established by NIDA's Treatment Research Branch to develop new and enhance the efficacy of existing behavioral treatments for drug abuse and dependence. Objectives of this program are to develop and establish the efficacy of promising behavioral therapies for the treatment of drug addiction and abuse, to determine how and why a particular behavioral intervention is effective, to develop and test behavioral interventions to reduce AIDS risk behaviors in drug treatment populations, and, to ultimately disseminate efficacious behavioral interventions to practitioners in the field. The Behavioral Therapies Development Program consists of the following three stages of research, each representing a distinct stage of development: stage I - therapy development, stage II - efficacy testing, and stage III - transferability to the community. Psychotherapies, behavior therapies, cognitive therapies, family therapies, and counseling strategies are among the approaches currently being studied under this program. Specific therapies being developed and tested will be discussed.

No. 8B
THE NIAAA PROJECT MATCHING ALCOHOLISM TREATMENTS TO CLIENT HETEROGENITY (MATCH)

Richard K. Fuller, M.D., *DCPR, NIAAA, 6000 Executive Boulevard, #505, Bethesda MD 20892-7003*

SUMMARY:

Project MATCH is a multisite study of 1,726 alcohol-dependent patients designed to study whether tailoring treatments to patients improves treatment outcome. This large complex study was undertaken because 1) the small-scale studies indicated that patient-treatment matching enhanced treatment effectiveness and 2) policymakers were very interested in this issue. Three treatments differing in philosophy and practice were offered. These three treatments were a 12-session Twelve-Step Facilitation Therapy designed to help patients become engaged in the fellowship of Alcoholic Anonymous, a 12-session Cognitive-Behavioral Therapy designed to teach patients coping skills to prevent relapse to drinking, and a four-session Motivational Enhancement Therapy spread over 12 weeks designed to increase motivation for and commitment to change. *A priori* matching predictions were made based on 10 patient characteristics. The patient-treatment matches were tested in parallel studies in two settings, outpatient and aftercare. There were 952 outpatients (28% female) and 774 patients in aftercare (20% females). Compliance with the treatments was excellent. Patients, on the average, attended over two-thirds of the scheduled sessions. The methodologic rigor of the study was outstanding. Videotapes of the treatment sessions showed that the treatments were delivered as designed. More than 90% of the patients provided data for the five follow-up points spanning 15 months after entry into the study, and blood tests and interviews with patients' family and friends confirmed patients' reports of the absence or presence of their drinking. There was a substantial reduction in drinking during the 12-week treatment period and during the one year following treatment.

No. 8C
INTENSIVE OUTPATIENT TREATMENT FOR COCAINE ABUSE

Edward Gottheil, M.D., *Department of Psychiatry, Jefferson Medical College, 1201 Chestnut Street, #1505, Philadelphia PA 19107-4123*

SUMMARY:

Volunteers for this study were recruited from among first admissions to an inner-city, publicly funded clinic, conducted according to policies and procedures common to public sector outpatient substance abuse programs. In-treatment, end of treatment, and nine-month follow-up assessments were compared for participants randomly assigned for 12 weeks to (a) once weekly individual outpatient therapy, (b) once weekly individual plus one weekly group session, or (c) a newly designed intensive group treatment program consisting of three hours of group, three days per week.

For those patients who completed the program, there was significant improvement from intake to end-of-treatment on ASI, Beck, and SCL-90 scores. At the independent nine-month follow-up, patients who had remained in treatment longer were found to be doing better than those leaving earlier in terms of having fewer drug problems, a smaller proportion of dirty urines, a better employment status, and fewer psychological problems. They were also more likely to be attending self-help meetings, continuing in outpatient treatment, or returning to school. However, for the 447 patients assigned to the three conditions, there were no significant differences found among the treatment modalities on any of the variables at nine-month follow-up.

No. 8D
SUBSTANCE ABUSE AND SCHIZOPHRENIA: NEW TREATMENT MODELS

Richard N. Rosenthal, M.D., *Department of Psychiatry, Beth Israel Medical Center, First Ave at 16th Street, New York NY 10003*

SUMMARY:

The high prevalence of comorbid substance use disorders and schizophrenia has been documented through epidemiologic methods. However, only recently has increasing attention been directed to the problems associated with the clinical treatment of this group. Care of these patients has often been an amalgam of treatments taken from the schizophrenia and substance abuse fields, without real specificity for these patients. Our evolving clinical practice demands more specific treatments for specific disorders. This paper will present findings by several groups of investigators who are examining the specific contributions of comorbidity to the clinical picture in substance-using schizophrenia patients, and using these data to inform novel approaches to inpatient and outpatient treatment. Major areas that will be addressed are: a) effects of integrating mental health and addiction services, b) severity of illness as a predictor of type and intensity of services received and the relationship to adverse outcomes, c) the contribution of schizophrenia syndromes to capacity for treatment engagement and to outcome, d) the role of motivation in capacity for treatment, and e) effects of adding targeted assertive outreach. We will describe clinical advances and potential new treatments derived from these areas of investigation.

No. 8E
FAMILY THERAPY FOR ALCOHOLISM

Peter J. Steinglass, M.D., *Ackerman Institute, 149 East 78th Street, New York NY 10021-0405*

SUMMARY:

The research literature on family factors and alcoholism points not only to compelling evidence of a familial predisposition regarding development of alcoholism, but also to the significant role that family environmental factors play in influencing the differential course of alcoholism in its chronic phase. An unbiased reading of this literature suggests that active involvement of families, especially spouses, in comprehensive approaches to alcoholism treatment has solid conceptual grounding.

This presentation focuses on a meta-analysis carried out of the methodologically most substantial reports of the use of family therapy in controlled clinical trials of alcoholism treatment. The analysis suggested that the impact of family therapy approaches on treatment outcome was substantial, perhaps mediated by its powerful effect on increasing motivation for treatment. At the same time, very little data are yet available about the impact of family involvement in improving relapse prevention outcomes, although early evidence suggests that the picture here may be more complex with family therapy being effective only for certain subtypes of chronic alcoholism.

These findings will be discussed in terms of what it is about family involvement that might contribute to more versus less effective therapy outcomes at the different phases of treatment.

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1. Washton AM: Structured outpatient group therapy with alcohol and substance abusers. In *Substance Abuse: A Comprehensive Textbook, 2nd ed.* JH Lowinson, P Ruiz, RB Millman and JG Langrad (eds.) Baltimore, Williams and Wilkins, pp 508-519, 1992.

2. Hellerstein DJ, Rosenthal RN, Miner CR: A prospective study of outpatient treatment for substance-abusing patients with schizophrenia. *Am J Addict* 4:33-42, 1995.
3. Edwards ME, Steinglass P: Family therapy treatment outcomes for alcoholism. *J Marr Fam Ther* 21:475-509, 1995.
4. Wallace BC: Crack cocaine: What constitutes state of the art treatment? *Journal of Addictive Diseases* 11:79-95, 1991.

SYMPOSIUM 9—PSYCHIATRISTS, PSYCHOANALYSTS AND DIPLOMATS
Joint Session with the American Psychoanalytic Association

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this program, the participant should have a greatly enhanced understanding of the interplay of conscious and unconscious factors that underlie ethnic and international conflicts, and how psychoanalytic and psychodynamic concepts and techniques can be utilized to mediate and mitigate those conflicts.

No. 9A
ANGOLA ON THE COUCH

Harvey L. Rich, M.D., *2101 Connecticut Avenue, NW, #8, Washington DC 20012*

SUMMARY:

Dr. Rich will describe his mission to Angola for the World Bank to assess the level of war damage to the culture which is impeding productivity and to recommend corrective actions at the cultural level.

No. 9B
NEGOTIATING ETHNO-NATIONAL CONFLICTS IN ESTONIA

Maurice Apprey, Ph.D., *Human Interaction, University of VA Center, Drawer A, Blue Ridge Hospital, Charlottesville VA 22901*

SUMMARY:

Professor Apprey will illustrate how psychoanalytic concepts can be utilized in international conflict in a practice analogous to preventive medicine. He will describe a series of group meetings among Russian and Estonian diplomats, legislators, and others.

No. 9C
IN THE WAKE OF THE STORM: SOCIETAL TRAUMA IN KUWAIT

Ambassador W. Nathaniel Howell, Ph.D., *Human Interaction, University of VA Center, Drawer A, Blue Ridge Hospital, Charlottesville VA 22901*

SUMMARY:

Ambassador Howell will present data from 150 in-depth interviews with Kuwaitis soon after the Iraqi occupation to illustrate the social/political processes, both conscious and unconscious, that were initiated as the result of this shared trauma.

No. 9D
BOSNIA: ANCIENT FUEL FOR A MURDER INFERNO

Vamik D. Volkan, M.D., *Human Interaction, University of VA Center, Drawer A, Blue Ridge Hospital, Charlottesville VA 22901*

SUMMARY:

Dr. Volkan will describe the concept of chosen trauma: the mental representation of a shared event which has led to helplessness and victimization. He will show how the Serbs' chosen trauma of 600 years ago inflames the current situation in Bosnia and has played a significant role in the atrocities and systematic rapes there.

REFERENCES:

1. Twemlow SW, Sacco FC: Peacekeeping and peacemaking: The conceptual foundations of a plan to reduce violence and improve the quality of life in a midsized community in Jamaica *Psychiatry,* Vol. 59, May 1996.
2. Apprey MA: Heuristic steps for negotiating ethno-national conflicts: Vignettes from Estonia *New Literary History,* 27, 199-212, 1996.
3. Howell WN: The evil that men do...: Societal effects of the Iraqi occupation of Kuwait *Mind & Human Interaction,* Vol. 6: No. 9, pp. 150, Nov. 1995.
4. Volkan VD: The Need to Have Enemies and Allies: From Clinical Practice to International Relationships Jason Aronson, 1988.

SYMPOSIUM 10—HWABYUNG AND ANGER SYNDROMES: A NOSOLOGICAL CHALLENGE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The purpose of this symposium is (1) to inform participants about recent research findings relevant to hwabyung among Koreans; (2) to expand the understanding of participants on the role of anger in relation to psychiatric morbidity; (3) to examine crosscultural differences and similarities in the manifestation of psychiatric symptoms.

No. 10A
HWABYUNG: A SYNDROME ASSOCIATED WITH CHRONIC ANGER

Sung Kil Min, M.D., *Department of Psychiatry, Yonsei U College of Med, CPO Box 8044, Seoul 120 00172, Korea*

SUMMARY:

Objective: The purpose of this study is to identify clinical manifestation of hwabyung, a culture-related syndrome in Korea, which is known to be associated with chronically suppressed and accumulated anger in the psychosociocultural context of Korea.

Method: A group of normal healthy volunteers and patients with depressive disorders, anxiety disorders, and somatization disorders were assessed with the Korean version of DIS-III, Bond's questionnaire of defense style, and a self-rating scale of hwabyung and symptoms.

Results: Hwabyung was diagnostically a mixed form of depression and somatization with frequent anxiety attacks. The symptoms were characterized as chronic depressive mood, multiple pains, physical weakness, culture-related somatic expressions such as heat sensation, respiratory stifling, palpitation, sighing, epigastric mass, and a sensation of pushing-up in the body. Behaviorally, impulsiveness and

frequent going-outs (roaming) were exhibited. The major defense styles were suppression-inhibition-withdrawal, somatization, eating, avoidance, and help-seeking complaining. Hwabyung were found to be closely related with the psychology of hahn, a unique culture-related emotional condition of Koreans.

Conclusion: Hwabyung is found to be a mixed depression-somatization syndrome with characteristic anger-related somatic and behavioral symptoms.

No. 10B
CLINICAL COURSE OF HWABYUNG

Si-Hyung Lee, M.D., *Department of Psychiatry, Kangbuk Samsung Hospital, 108 Pyung-Dong Jong No-Ku, 110 Seoul 100634, Korea;* Jin Hak Kim, M.D., So Hee Lee, M.D.

SUMMARY:

Hwabyung (HB) or Wool-hwa-byung, described as one of the culture bound syndromes in DSM-IV, is a chronic illness usually found in late middle-aged women. It ensues when people are trapped in an inescapable situation that results in anger and frustration. In this situation, the coping mechanism of HB patients is culturally unique, and the clinical pictures they present through its course are also characteristic accordingly. The course of HB is like a volcanic activity, switching over time from active (eruption of burning rage toward the responsible person with intense hatred and resentment, Won-han) to dormant (calmer outwardly, fireball remains), owing to partial suppression. Roughly the clinical course of HB could be divided into three stages, i.e., impact, conflict, and resignation, although the impact stage is not apparent in the case of gradual onset. At the end stage the patients project it onto supernatural beings, or attribute it to their own fate. We would like to discuss the general course of hwabyung in terms of Hwa-ki (fire element) vs. Wool-ki (stuffy element), Won-han (resentment) vs. Haan, acceptance as one's fate vs. nonacceptance and the prospective outcome of Haan. Some discussion about diagnostic aspects will also be made.

No. 10C
HAAN AND HWABYUNG

Luke I.C. Kim, M.D., *Department of Psychiatry, UC Davis School of Medicine, 1301 Brown Drive, Davis CA 95616-0801*

SUMMARY:

The relationship between hwabyung and the concept of "haan" is explored. A primary etiological contribution to the development of hwabyung is considered to be the psychological state of haan (sometimes spelled hahn), a unique Korean folk term describing chronic anger, or in a more psychiatric term, a psychological, affective state of chronic suppressed anger. Haan is represented by feelings (not openly and overtly, but silently and internally) of anger, resentment, grudges, indignation, a desire to get even with, and revenge against. Feelings of victimization associated with a sense of injustice and unfair treatment are strong. From the historical, geo-political and socio-economic point of view, Korea is located strategically as a bridge between powerful and at times aggressive neighboring countries, and in the process Korea has been trampled and victimized. Thus, the history of Korea is said to be a nation of haan contributing to the development of depression, anxiety, and other somatoform symptoms of hwabyung. The concept of haan will be further elaborated.

No. 10D
BIOLOGICAL MANIFESTATION OF HWABYUNG

Christopher K. Chung, M.D., *Department of Psychiatry, Harbor UCLA, 1000 West Carsons Street, Torrance CA 90509;* Russell Poland, Ph.D.

SUMMARY:

Patients self-labeled as suffering from "hwabyung" (HB), a Korean culture bound syndrome, present symptoms that typically overlap with a number of DSM-IV diagnoses, including major depression, panic disorder, generalized anxiety disorder, somatization and somatoform disorders. At the same time they also report symptoms that appear to be more culturally unique, including the "pushing up sensation in the chest," sensation and belief of a mass in the epigastric area, and the culturally specific beliefs related to HB including the importance of anger as well as "excessive heat" as precipitating factors. The status of HB thus represents a challenging issue for clinicians and researchers interested in psychiatric nosology as well as in the psychiatric care of Korean and Korean-American populations. As a way to clarify these issues, we have been examining the existence of biological markers of depression (shortened REM latency, increased REM density, cortisol hypersecretion, blunted TSH response to TRH) as well as those reported to associate with chronic fatigue (alpha intrusion during stages 3 and 4) in a group of HB patients and their normal controls. The results are currently being analyzed, and will be presented.

No. 10E
HWABYUNG, NEURASTHENIA AND CHRONIC FATIGUE SYNDROME

Keh-Ming Lin, M.D., *Department of Psychiatry, Harbor-UCLA Medical Center REI, 1124 West Carson Street, Torrance CA 90002*

SUMMARY:

We will report our recent findings on the clinical characteristics, diagnostic features, and psychosocial correlates of hwabyung, and compare them with neurasthenia and chronic fatigue syndrome (CFS). While none of hwabyung patients self-label as suffering from neurasthenia or CFS, all fulfill the ICD-10 criteria of neurasthenia, and one subject manifested symptom patterns compatible with a diagnosis of CFS according to the CDC criteria. When compared with Chinese neurasthenia patients diagnosed according to ICD-10 criteria and Caucasian patients suffering from CDC CFS, the clinical characteristics and psychosocial correlates are remarkably similar.

These findings are intriguing in light of current debates on the nosological status of the so-called "culture bound syndromes," including neurasthenia and hwabyung. Neurasthenia was originally a Western concept now rarely used in Western societies, but has become indiginized throughout Asia. In contrast, hwabyung has its roots in Korean cultural traditions. CFS, on the other hand, has been an exclusively Western phenomenon. The overlap and similarities among these three conditions suggest that they may be variants of a similar clinical condition that widely exists in many cultures but is still poorly understood and conceptualized as an entity in the contemporary psychiatric nosologic system.

No. 10F
HISPANIC AND KOREAN "ANGER SYNDROMES": A CROSS-CULTURAL COMPARISON OF NERVIUS AND HWABYUNG

Michael W. Smith, M.D., *Department of Psychiatry, Harbor-UCLA REI, 1124 West Carson Street/B4 S, Torrance CA 90502*

SUMMARY:

The pathological manifestations of unexpressed anger have become a topic of research interest in recent years. Fava (1993) described characteristic "anger attacks" in a group of North American Caucasians whose manifestations appear to be similar to two "culture bound syndromes" known as nervios and hwabyung. Nervios, an Hispanic syndrome, and hwabyung, a Korean syndrome, have been identified by Guarnaccia (1989) and Lin (1983) respectively, as being directly associated with suppressed anger.

This paper presents the similarities between these syndromes and suggests the possibility that they may not be as culture bound as previously believed but may be only cultural variants of the same anger syndrome. Additionally, the author suggests including anger as a diagnostic variant of panic and depressive disorder in the developing DSM-V.

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3. Kim L: Psychiatric care of Korean Americans. In Gaw A (ed): *Culture, Ethnicity and Mental Illness.* APA Press, Washington DC., 347-375, 1992.
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5. Lin KM: Asian-American perspectives. In Mezzich J, Kleinman A, Fabrega H Jr, and Parron D (eds): *Culture and Psychiatric Diagnosis.* American Psychiatric Press, Washington, D.C. 1996.
6. Fava M, Rosenbaum JF, Pava JA, et al: Anger attacks in unipolar depression, Part 1: Clinical correlates and response to fluoxetine treatment. *American Journal of Psychiatry,* 150(8):1158-63, Aug 1993.

SYMPOSIUM 11—TRAUMATIC MEMORY PROCESSES AND PTSD

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the end of this symposium attendees will have gained an understanding about the different ways that trauma affects memory processes, how traumatic memories are fundamentally different from memories of everyday life, how memory processing affects the development of PTSD, and how PTSD itself will affect subsequent memory processing.

No. 11A
TRAUMATIC MEMORY RECALL IN ADULT AND CHILDHOOD TRAUMA

Bessel A. van der Kolk, M.D., *HRI Trauma Center, 227 Babcock Street, Brookline MA 02146;* Jennifer Burbridge, M.A., Joji Suzuki, B.A., Rita Fisler, Ed.M.

SUMMARY:

This study looked at how adults with recent traumas process traumatic memories compared with adults with memories of childhood traumatic events. Data were collected from 34 adults who had been traumatized as children, and 29 who had been traumatized as adults.

Methods: All subjects met DSM-III-R diagnostic criteria for PTSD. All subjects were given the Traumatic Memory Inventory (TMI) which inquires about nature of the trauma(s), duration, when and where the subject became conscious of it, and sensory modalities in which memories were experienced including visual, tactile, olfactory, auditory, and affective.

Results: Most subjects in both groups remember their traumas in the form of visual images, as emotions, and a substantial number of subjects in both groups had olfactory and auditory flashbacks. The childhood onset group had significantly more pathological self-soothing behaviors than the adult onset group, including self-mutilation and binge eating.

Conclusions: This study supports the idea that it is in the very nature of traumatic memory to be initially stored as sensory fragments without a coherent semantic component. It appears that as people become aware of more and more elements of the traumatic experience, they construct a narrative that "explains" what happened to them. This study suggests that trauma interferes with the natural transcription of sensory elements of an experience into an autobiographical narrative, regardless of the age of the victim.

No. 11B
DISSOCIATION AND MEMORY IN AWARENESS-INDUCED PTSD

Janet E. Osterman, M.D., *Department of Psychiatry, Boston University Sch of Med, 720 Harrison Avenue, Ste 905, Boston MA 02118;* Bessel A. van der Kolk, M.D.

SUMMARY:

Awareness during anesthesia or waking up while undergoing surgery has been long recognized as a potential complication of general endotracheal anesthesia. There has been little recognition of the traumatic nature or sequelae, including PTSD, of this experience.

Patients with PTSD frequently have a variety of dissociative experiences including dissociation at the time of the trauma, dissociated memories of their trauma, and dissociation as a defense to encapsulate their traumatic experience. Patients with awareness-induced PTSD suffer these phenomena.

Awareness encompasses a variety of intraoperative experiences, including severe pain, which patients undergo in a state of helplessness due to medication-induced paralysis and intubation. Since patients are physically incapable of escaping, they may use dissociation to mentally leave their body.

Patients may have poorly integrated memory of waking up during surgery. They may re-experience their trauma as nightmares, flashbacks, or respond to implicit cues without having conscious awareness.

We will present data on 30 subjects and 30 controls comparing the nature of their memory. The role of peritraumatic dissociation and the use of dissociation on a day-to-day basis will be presented. The rate of PTSD and other traumatic sequelae, as well as the psychological effects, including effects on personality and post-surgical functioning, will be examined.

No. 11C
ACCURACY OF ADULTS' RECOLLECTIONS OF ABUSE

Linda M. Williams, Ph.D., *Stone Center, Wellesley College, 106 Central Avenue, Wellesley MA*

SUMMARY:

The current controversy about adults' memories of child sexual victimization raises important questions about the prevalence of repression of memories of child sexual abuse and the validity of memories recalled after a period of amnesia. Research and clinical experience suggest that a large proportion of adults who were sexually abused in childhood have had periods of amnesia for the abuse.

Some skeptics dismiss adults' accounts of previously forgotten sexual abuse as distortions based on fantasy or on suggestibility fostered by clinicians.

This session addresses this controversy and reports findings from a longitudinal study of women and men with documented evidence of sexual abuse in childhood. Upon reinterview in 1990-1992, a large proportion did not recall the abuse, which had been reported in the early 1970's. Of those who did recall the abuse, many reported prior periods during which the abuse was forgotten. Patterns of forgetting and remembering childhood trauma suggest that for some individuals such memories are affected by conscious processes of motivated forgetting and remembering, as well as the operation of selective inattention, distraction, and dissociation. The role of repression, cognitive development, and salience of the event in adult recollection of sexual abuse are examined. The accuracy of the adult memories of child sexual abuse is reported and legal, research, and clinical implications are discussed.

No. 11D
NATURE OF TRAUMATIC MEMORIES IN GULF WAR VETERANS

Steven M. Southwick, M.D., *Department of Psychiatry, Yale University, VAMC 116A, West Haven CT 06516;* Andrew Morgan, M.D., Andreas Nicolau, Ph.D., Dennis S. Charney, M.D.

SUMMARY:

The nature of traumatic memory is currently the subject of intense investigation. On the one hand memory for trauma is viewed as fixed or indelible. On the other hand it is seen as malleable and subject to substantial change. In a prospective follow along study of nontreatment-seeking Desert Storm veterans, we tested consistency of memory for traumatic events that had been experienced in the Gulf. Fifty-nine National Guard reservists completed the Mississippi Scale for Combat-Related PTSD and the Desert Storm Trauma Questionnaire one month and then again two years after returning from the Gulf. Responses were composed for consistency between the two time points and correlated with level of PTSD symptomatology. There were many instances of inconsistent recall for events that were highly traumatic and objective in nature. The data suggest that traumatic memories are not indelible or fixed. Further, in this sample of veterans memory for traumatic events tended to become amplified over time as PTSD symptomatology increased. These findings raise questions about the retrospectively determined correlations between degree of traumatic exposure and degree of PTSD symptomatology.

No. 11E
COGNITIVE ALTERATIONS IN PTSD: STATE OR TRAIT

Rachel Yehuda, Ph.D., *Department of Psychiatry, Mt. Sinai School of Medicine, 130 West Kingsbridge Road, Bronx NY 10468;* Julia A. Golier, M.D., Abbie Elkin, B.A., Philip D. Harvey, Ph.D.

SUMMARY:

Cognitive and memory-related alterations have been described in trauma survivors with PTSD, which have largely been attributed to the effects of trauma on learning, memory, and other related neuropsychological processes. However, since many of the observed deficits are not present in trauma-exposed individuals without PTSD, it is difficult to conclude that trauma alone accounts for all of the cognitive alterations reported to date. We recently used a battery of neuropsychological tests in order to examine trait-related characteristics such as source monitoring, development of associations, arousability, and perseveration in a large group of trauma survivors. For each test, trauma survivors were tested for performance using both neutral and personally valenced trauma-related stimuli. Both trauma survivors with, and trauma survivors without, PTSD were studied. This design allowed us to begin to differentiate between cognitive phenomena that might be a result of trauma exposure and phenomena that would more likely be associated with risk for developing PTSD. Data from our studies of Holocaust survivors, combat veterans, and other trauma groups will be presented. The findings demonstrate that trauma survivors do indeed processes traumatic stimuli differently from non-exposed individuals. However, although some types of alterations seem to result from trauma exposure, others appear to be associated with the development of chronic PTSD. The latter alterations may have predated trauma exposure, and may have been associated with aspects of vulnerability to PTSD.

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SYMPOSIUM 12—NARCISSISTIC PERSONALITY DISORDER: NEW FRONTIERS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant will be able to recognize problems in the diagnostic validity of the NPD category, diagnose the shy, covert NPD type, identify the differential diagnosis between NPD and psychopathic personality disorder, the diagnostic overlap between NPD and common Axis I disorders, and know principles for cognitive treatment of NPD.

No. 12A
NOSOLOGICAL STATUS OF NARCISSISTIC PERSONALITY

Leslie C. Morey, Ph.D., *Department of Psychology, Vanderbilt University, 301 Wilson Hall, Nashville TN 37240*

SUMMARY:

Determining whether narcissism represents a diagnostic entity or a range of personality pathology that is common to personality disorders is a difficult issue, both theoretically and empirically. The data from our research group suggest that, at least as defined by *DSM* criteria, the latter interpretation may be more accurate. First, the internal consistency of the diagnostic criteria for narcissistic personality is not particularly impressive. Second, the disorder is one of the worst in terms of diagnostic overlap with other Axis II disorders. Third, the criteria are not particularly coherent, with some more highly related to other disorders than to the parent NPD construct. Our data are consistent with a model that postulates a strong dimension of severity of narcissistic pathology that underlies the variation among the specific features of most if not all personality disorders. An analysis of the markers of this global dimension reveals a number of features, cutting across many disorders, that tap a general failure

in empathy and attachment that have been traditionally ascribed to the concept of "character disorder." It is proposed that this dimension reflects an overall dimension of narcissistic pathology, and that the severity of this pathology reflects an essential distinction among personality disordered patients that will have strong empirical relationship to etiology, course, and outcome. A unitary, dimensional classificatory approach is recommended, similar to that outlined for substance abuse problems in the DSM-III-R. At the same time, many of the more categorical features of the disorder could be retained with a consideration of a diagnostic construct of psychopathy.

No. 12B
ASSOCIATION BETWEEN PSYCHOPATHY AND NARCISSISM

Stephen D. Hart, Ph.D., *Department of Psychology, Simon Fraser University, Burnaby BC V5A 1S6, Canada*

SUMMARY:

Objectives: Many people, including psychodynamic theorists such as Kernberg and Meloy, have noted important similarities between narcissistic and psychopathic personality disorder (NPD and PPD, respectively). In this presentation, I review empirical research on the association between the two disorders.

Method: My analysis is based on a narrative-style review of published research on PPD and NPD.

Results: Several studies based on categorical diagnoses have found moderate levels of comorbidity between NPD and PPD. Similarly, studies that used dimensional measures have found PPD ratings to be correlated positively with ratings of NPD. Interestingly, the association between the disorders is limited to interpersonal and affective symptoms of PPD (glibness, grandiosity, deceitfulness, etc.) as opposed to antisocial behavior symptoms (impulsivity, irresponsibility, aggressivity, etc.).

Conclusion: The available evidence seems to suggest that NPD is robustly associated with PPD, albeit only with one facet of PPD symptomatology. I suggest directions for research that may help to determine the nature and causes of the association between NPD and PPD.

No. 12C
PATHOLOGICAL NARCISSISM AND MAJOR MENTAL ILLNESS

Elsa F. Ronningstam, Ph.D., *Psychosocial Department, McLean Hospital, 115 Mill Street, Belmont MA 02178*

SUMMARY:

Objective: To explore the relation between NPD/pathological narcissism and common Axis I disorders.

Method: Results from empirical studies of the prevalence of personality disorders in Axis I disordered patients, using structured interviews for Axis II personality disorders, and the rates of Axis I disorders in samples of narcissistic patients, were analyzed and compared with clinical and theoretical accounts on narcissistic pathology in these disorders.

Results: Higher prevalence rates of NPD were found in substance abuse (12, 38%) and bipolar disordered patients (4, 47%), and high rates of depression (42, 50%) were found in patients with NPD. There was no empirical support for the presence of a significant relation between NPD and any specific Axis I disorder. However, the clinical literature reported on the presence of substantial narcissistic pathology, including both covert (vulnerability, shame, insecurity) as well as overt (grandiosity, superiority, controlling/aggressive behavior) type of pathology, in bipolar, substance abuse, and eating disordered patients.

Conclusions: An integrating analysis suggests more complex interacting comorbidity between pathological narcissism and substance abuse disorder, bipolar disorder, depression, and anorexia nervosa.

No. 12D
THE SHY NARCISSIST

Salman Akhtar, M.D., *1201 Chestnut Street, Ste 1503, Philadelphia PA 19107*

SUMMARY:

Objective: This paper describes the less-recognized "covert," "diffident," or shy type of narcissistic personality and notes its distinctions from the usual, DSM-IV type of flamboyant narcissistic personality.

Methods: Combining the views implicit in the author's 1982 and 1989 portrayals of narcissistic personality with the pertinent literature since 1989 as well as with the author's observations from his psychotherapeutic and psychoanalytic practice, a clinical profile of the shy narcissist is developed.

Results: Like the ordinary narcissist, the shy narcissist is also omnipotence seeking and defective in his capacity for sustained deep object relations. Unlike the former, the shy narcissist has (1) his grandiosity hidden in a psychic corner, (2) strict conscience and less sociopathic tendencies, (3) vulnerability to shame not upon the exposure of blemishes but upon unmasking of his ambition, (4) a socially reticent, resilient, and nondemanding attitude, (5) less apparent dysfunction in marital and sexual life, and (6) a less glittering intellectual facade.

Conclusion: There exists a type of narcissistic personality that is not overtly grandiose, competitive, fascinating, and garrulous. Its recognition has significance for the differential diagnosis of personality disorders and might have treatment implications.

No. 12E
SCHEMA-FOCUSED THERAPY FOR NARCISSISM

Wendy T. Behary, M.S.W., *Cognitive Therapy Ctr of NJ, 47 Maple Street, Suite 401, Summit NJ 07901;* Jeffrey Young, Ph.D.

SUMMARY:

Objectives: An overview of Young's treatment model for NPD. Schema-focused therapy integrates cognitive, behavioral, experiential, and transference-based strategies. The conceptual model revolves around identifying and confronting *schema modes*, which are defined as separate facets of self that have not been fully integrated with each other. The narcissist is characterized by three modes: the lonely child, the self-aggrandizer, and the detached self-soother.

Methods: Individual treatment focuses on intimate connections, including the therapy relationship. Additionally, the use of imagery, and cognitive and behavioral techniques is integral in helping the narcissist value nurturing and empathy more than status and approval; combat entitled behavior; address the patient's devaluing of the therapist; access early feelings of deprivation and defectiveness; give up compulsive and addictive behaviors; and understand the therapist's own schemas in treating the narcissist.

Results: We observe an improved tolerance for the therapeutic experience, a reduction in schema-driven beliefs and coping modes, increased capacity for experiencing and nurturing feelings of loneliness, deprivation, and devaluation, greater adaptation to rules and reciprocity, achievement of healthier and more satisfying relationships, and more reasonable expectations of self and others.

Conclusion: Young's Schema-Focused Therapy seems to be an effective model in the treatment of narcissistic personality disorder.

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SYMPOSIUM 13—THE EFFICACY-EFFECTIVENESS GAP IN BIPOLAR DISORDER

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to (1) recognize the limits in general clinical practice of currently available medication treatments for bipolar disorder (the "efficacy-effectiveness gap"), (2) understand the psychosocial contributors to these limits, and (3) identify methods for improving outcome by addressing such psychosocial contributors.

No. 13A
IMPACT OF LITHIUM ON OUTCOME OF BIPOLAR DISORDER

Mario Maj, M.D., *Department of Psychiatry, Naples University, Largo Madonna Delle Grazie, Naples 80138, Italy;* Raffaele Pirozzi, M.D., Lorenza Magliano, M.D.

SUMMARY:

The impact of lithium prophylaxis on the outcome of bipolar disorder has become a controversial issue. This study provides information on all bipolar patients who started prophylaxis at a lithium clinic over more than 15 years. Until they remained on lithium, they were seen bi-monthly and evaluated by standardized instruments. Treatment surveillance was accurate. Five years after start of prophylaxis, all patients were contacted for a follow-up interview. Of the 390 patients who started prophylaxis, 11% were not available at follow-up, 28.5% were off lithium, 36.9% were on lithium having had at least one recurrence during prophylaxis (28.2% with a reduction of at least 50% of mean annual morbidity compared to pre-treatment period), and 23.6% were on lithium having had no recurrence. Patients who were off lithium had a significantly poorer outcome than those on lithium, but patients who were off all psychotropic drugs did not differ from those on lithium. These results demonstrate that acceptance of lithium prophylaxis is often poor and complete suppression of recurrences is not at all the most frequent outcome, even if treatment surveillance is adequate. Comparison of lithium-treated and nonlithium-treated patients in naturalistic studies is biased by the bidirectional relationship between outcome and treatment.

No. 13B
LIFE EVENTS, MEDICATIONS AND BIPOLAR DISORDER

Sheri L. Johnson, Ph.D., *Department of Psychology, University of Michigan, PO Box 249229, Coral Gables FL 33124;* Bjorn Meyer, B.A., Ivan J. Miller, Ph.D., Mark S. Bauer, M.D., Gabor I. Keitner, M.D., Christine E. Ryan, Ph.D., David A. Solomon, M.D.

SUMMARY:

The effects of life events and medication levels on recovery in bipolar disorder were examined longitudinally. Seventy-nine inpatients met the following criteria: (1) DSM-IV diagnosis of bipolar disorder, manic, or depressed episode using the SCID, (2) no organic brain syndrome, and (3) no current substance abuse. Monthly interviews were conducted for at least one year, and scores of below 8 on the MHRSD and 7 on the BRMS for at least two months defined recovery. Treatment adequacy was rated monthly using the Intensity of Somatotherapy for Bipolar Disorder Scale. The Bedford College Life Events and Difficulties Schedule was administered at two-, six-, and 12-month followups. Survival analysis with medication levels as a time-dependent covariate, followed by whether or not individuals had experienced a severe life event, revealed that higher medication levels were associated with faster recovery. After accounting for medication levels, the presence of life events was further associated strongly with longer time to recovery. Whereas the median period to recovery among individuals without a severe life event was only 133 days, this period exceeded one year for those with a severe life event. Clinical recommendations for individuals with severe life events will be discussed.

No. 13C
COGNITIVE BEHAVIOR THERAPY FOR BIPOLAR DISORDER

Monica R. Basco, Ph.D., *Department of Psychology, University of TX SWMC, 4104 Ambleside Court, Colleyville TX 76034;* Melanie M. Biggs, Ph.D., A. John Rush, M.D.

SUMMARY:

This presentation provides an overview of a new cognitive-behavioral intervention (CBT) for the maintenance treatment of bipolar disorder (Basco & Rush, 1996). CBT for bipolar disorder was developed to enhance medication management by helping patients improve their adherence to pharmacotherapy, identify subsyndromal symptoms for early intervention, combat subsyndromal symptoms of depression and mania, and cope with common psychosocial and interpersonal stressors.

The skills training component of the bipolar CBT treatment package (Basco & Rush, 1996) is delivered weekly over 6 months, with maintenance visits occurring monthly for an additional 6 months. Preliminary feasibility data show that in a small sample patients attended an average of 27 visits over an average of 37 weeks with 64% completing the full year of treatment. Ninety percent of visits were attended on time as scheduled. Seventy-five percent of homework assignments were completed in full, with an additional 12% completed in part. Patients rated the content of treatment sessions as very understandable and highly useful. Clinician ratings show that therapists were able to accomplish most session goals. Sessions receiving the lowest ratings led to modifications in the treatment manual. Symptom ratings remained low throughout the course of maintenance treatment.

No. 13D
ADJUNCTIVE FAMILY TREATMENT OF BIPOLAR DISORDER

Gabor I. Keitner, M.D., *Department of Psychiatry, Rhode Island Hospital, 593 Eddy Street, Providence RI 02903;* Ivan J. Miller, Ph.D., Christine E. Ryan, Ph.D.

SUMMARY:

Objective: We will present the results of two studies investigating the role of the family in bipolar disorder.

Method: In the first study, 24 patients and their families and a sample of matched control families completed a measure of family functioning.

Results: The results indicated that the families of bipolar patients manifested significant family dysfunction during the acute episode. A five-year follow-up of these patients indicated that bipolar families with high levels of family dysfunction had over twice the rate of rehospitalizations as those bipolar families with low levels of dysfunction.

The second study was a pilot study of family treatment of bipolar patients.

Method: 14 bipolar patients and their families were randomly assigned to receive standard treatment (pharmacotherapy + clinical management) or to family therapy + standard treatment. Treatments began in the hospital and continued for 18 weeks after discharge. A two-year follow-up was also completed.

Results: The results indicated that when compared to the standard treatment group, the family therapy group had a) lower rates of family separations, b) greater improvements in level of family functioning, c) higher rates of full recovery, and d) lower rates of rehospitalization for the two years after treatment.

Conclusions: The family needs to be taken into consideration when assessing and treating patients with bipolar disorder.

No. 13E
AN EASY-ACCESS PROGRAM FOR BIPOLAR DISORDER

Mark S. Bauer, M.D., *VA Medical Center/116A, 830 Chalkstone Avenue, Providence RI 02908;* Nancy Shea, R.N., Linda McBride, M.S.N., Christopher Gavin, B.S.

SUMMARY:

Objective: We hypothesized that easy access to ambulatory services for bipolar disorder would improve several important process and outcome variables. A program was developed that was exclusively clinic based without community outreach or extensive rehabilitation components. Core program components included (1) algorithm-driven somatotherapy, (2) standardized psychoeducation, and (3) easy access to a single primary nurse provider to enhance continuity of care.

Methods: An *a priori* study using mirror-image design was used to compare pre-program data under standard clinical care to data after one year in the experimental program. Data from the first 103 patients to complete one year are reported here.

Results: The program resulted in increased patient satisfaction and increased intensity of medication treatment without increasing side effects. While scheduled ambulatory clinic visits increased as expected, emergency room use and psychiatric triage use decreased significantly. For high utilizers, psychiatric hospital days and total mental health expenditures decreased significantly.

Conclusions: Easy access to ambulatory care may have beneficial effects on important process and outcome variables for bipolar disorder. Candidate mechanisms include on-demand access, continuity of care, and improved medication delivery. Conclusions indicate that *not* restricting ambulatory care for this population may improve outcome *and* reduce costs.

No. 13F
THERAPEUTIC ALLIANCE IN TREATMENT OUTCOME FOR DEPRESSION

Stuart M. Sotsky, M.D., *Department of Psychiatry, George Washington Medical Ctr, 2150 Pennsylvania Avenue, NW, Washington DC 20037-2396*

SUMMARY:

Objective: The relationship between the therapeutic alliance and treatment outcome was examined for depressed outpatients who received interpersonal psychotherapy, cognitive-behavior therapy, imipramine with clinical management, or placebo with clinical management as part of the NIMH Treatment of Depression Collaborative Research Program.

Methods: Clinical raters scored videotapes of early, middle, and late therapy sessions for 225 cases (619 sessions). Outcome was assessed from patients' and clinical evaluators' perspectives and from the perspective of depressive symptomatology.

Results: Therapeutic alliance was found to have a significant effect on clinical outcome for both psychotherapies and also for both active and placebo pharmacotherapy. Ratings of patient contribution to the alliance were significantly related to treatment outcome; ratings of therapist contribution to the alliance and outcome were not significantly linked.

Conclusions: These results indicate that the therapeutic alliance is a common factor with significant influence on outcome.

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SYMPOSIUM 14—PSYCHOSOCIAL CARE FOR WOMEN WITH BREAST CANCER

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to

1. Understand the emotional challenges facing the woman with breast cancer and her family.
2. Recognize possible psychological syndromes that can result from screening, diagnostic testing, and treatment of breast cancer.
3. Plan psychiatric and social work services for women with breast cancer and their families.

No. 14A
PSYCHOLOGICAL CONSEQUENCES OF DIAGNOSTIC TESTS

Debra L. Fertig, M.D., *Department of Psychiatry, University of Mass Medical Ctr, 55 Lake Avenue North, Worcester MA 01606;* Daniel P. Hayes, M.D.

SUMMARY:

In recent years there has been growing literature studying the psychological consequences of diagnostic medical testing in oncol-

ogy. This review will discuss studies on the emotional consequences of the following tests specific to breast cancer: 1) risk assessment for the BRCA1 gene, 2) screening mammography, 3) follow-up testing for recurrence of disease.

Patients tend to overestimate the utility of screening and diagnostic tests, and often incorrectly perceive the significance of a "normal" test. Individual variations in coping style appear to be a key factor in determining different psychological responses to receiving information. Prospective evaluations of quality of life and patients' perceptions of diagnostic interventions are needed, as well as physician training to assess and address the specific psychological needs of patients.

No. 14B
FERTILITY ISSUES IN WOMEN TREATED FOR BREAST CANCER

Randy S. Glassman, M.D., *Department of Psychiatry, Brigham & Women's Hospital, 75 Francis Street, Boston MA 02115;* Alison Fife, M.D.

SUMMARY:

For a woman of child-bearing age, a diagnosis of breast cancer carries both a physical and an emotional burden. The physical side effects of chemotherapy are numerous, and include potential effects on ovarian function, which affects fertility and sexual function, and may have implications for fetal anomalies. For example, female patients who have undergone bone marrow transplantation for acute myeloid leukemia have gone on to have successful pregnancies. Others developed ovarian failure and were unable to become pregnant. Infertility becomes an issue for these women, and carries with it the potential for comorbid psychological dysfunction for the patient, her partner, and family.

We review here the medical, ob-gyn, and psychiatric literature on fertility and the psychological and psychiatric issues in women who are anticipating or who have undergone treatment for breast cancer. The known effects of chemotherapy on ovarian function, and the available data on pregnancy outcomes will be reviewed. Additionally, the newer infertility treatments will be reviewed as they relate to decision making and psychological status. The potential for freezing embryos and possibly unfertilized eggs in the future will present women with new opportunities, but difficult and emotionally laden choices.

We will present information from interviews with women who have received chemotherapy for breast cancer, and who have either considered pregnancy or who have become pregnant. Psychiatric issues, comorbidity, and implications for treatment will be addressed.

No. 14C
MEASURING DEPRESSION IN WOMEN WITH BREAST CANCER

Mary Jane Massie, M.D., *Department of Psychiatry, Memorial Sloan-Kett, 1275 York Avenue, New York NY 10021-6007;* David K. Payne, Ph.D., Maria Theodoulou, M.D.

SUMMARY:

The most common types of psychological distress in women with breast cancer are depression and anxiety. Oncology staff members often ask consulting psychiatrists to recommend brief screening instruments that can be used to measure depression and anxiety and to assist them in learning how to rapidly identify patients most in need of psychiatric consultation. We have explored the use of two screening instruments (the Hospital Anxiety and Depression Scale [HADS] and a 100m visual analogue scale [VAS]) to measure psychological distress in 103 women with breast cancer and have explored correlations between patients' perceptions of their psychological distress and oncological staff members' perceptions of patients' psychological distress. The HADS tapped significant levels of distress that correlate with patients' subjective assessments of distress. The VAS correlated well with both the medical oncologist's and oncology nurse's ratings of the patients' distress, as well as with the HADS. The usefulness and limitations of brief screening measures to identify women with breast cancer who could benefit from psychiatric consultation will be described.

No. 14D
NEW RESEARCH IN PSYCHOSOCIAL INTERVENTIONS FOR WOMEN WITH EARLY-STAGE BREAST CANCER: THE BRIDGES STUDY

Ann O. Massion, M.D., *Department of Psychiatry, University of Mass Medical Ctr, 55 Lake Avenue North, Worcester MA 01655;* James R. Herbert, Sc.D., Lynn Clemow, Ph.D., M.D. Wertheimer, M.D., Jon Kabat-Zinn, Ph.D.

SUMMARY:

An increasing body of literature indicates that coping skills and psychosocial function can have an impact on quality of life and possibly recovery for women with breast cancer. There is a need to identify effective coping skills and cost-effective psychosocial interventions to facilitate coping with breast cancer. The BRIDGES study at the University of Massachusetts Medical Center was designed to address these issues. The study involves randomization to one of three arms: a meditation-based stress reduction intervention, a nutrition education intervention, and an individual approach group, which essentially is a usual-treatment group. Inclusion criteria are stage 1 or 2 breast cancer, age 65 or less, and within two years of diagnosis. Outcome variables include psychosocial measures (coping skills, quality of life, anxiety, and depression) and biological measures (immunological consisting of soluble Interleukin-2 receptor, Interleukin 4, and Interferon-gamma; and endocrinological consisting of the urinary melatonin metabolite, 6-sulphatoxymelatonin).

The presentation will include a brief literature review and presentation of preliminary data from the BRIDGES study (baseline and 4-month follow-up).

No. 14E
TREATING FAMILIES OF WOMEN WITH BREAST CANCER

Bonnie B. Greenberg, M.S.W., *Department of Social Work, Dana-Farber Cancer Institute, 44 Binney Street, Boston MA 02115*

SUMMARY:

Women being treated for breast cancer are faced with many challenges. Success in meeting these challenges is impacted by the reaction and involvement of the surrounding family/social system. This presentation will explore in detail the dimensions of family psychosocial assessment, unique breast cancer related issues, and appropriate psychosocial interventions.

A thorough, accurate assessment of the family's structure and dynamics is essential to effective intervention. Important areas of focus in assessing families with cancer include communication patterns, coping mechanisms, ability of members to support one another, individual and collective definitions of hope, potential role realignments, and pre-existing areas of family stress.

Family interventions should include the spouse/significant other, children, and/or parents/extended family, as much as is logistically possible. Treatment needs to be tailored to both the unique issues and developmental stages of the individual members as well as the

family unit as a whole. Interventions useful to the multidisciplinary health care team will be explored.

The crisis of breast cancer to a woman's sense of self can reawaken feelings of loss or abandonment. Dysfunctional marital or family relationships may be disclosed for the first time to a medical or psychosocial clinician. Sensitive, realistic interventions directed to deal with marital crises co-existing with breast cancer will be discussed.

No. 14F
WOMEN AT HIGH RISK FOR BREAST CANCER

David K. Wellisch, Ph.D., *Department of Psychiatry, UCLA School of Medicine, 740 Westwood Plaza, Los Angeles CA 90024*

SUMMARY:

This presentation will present data from both a community-based study and a high-risk clinic where this presenter has evaluated and treated women with a history of a first-degree relative with breast cancer. Findings from the community-based study showed such women to be similar to a well matched comparison group in most ways, but to differ in terms of: (1) more sexual problems; (2) more feelings of vulnerability to get breast cancer; and, (3) more knowledge of symptoms of breast cancer. The two groups did not differ in psychological symptomatology. A profile of the more psychologically vulnerable high-risk patient showed three variables to predict such vulnerability: (1) being an adolescent vs. pre-adolescent, or adult when mother was diagnosed; (2) having mother die (vs. survive) from breast cancer; and (3) making changes in the context of mother's breast cancer that permanently altered the daughter's life course.

In the high risk clinic we have enrolled 300 women in the last three years. We have found about 22% have depression symptoms in the clinical range at baseline, about 40% have anxiety symptoms at baseline, and about 80% have overestimated their vulnerability to get breast cancer in relation to their actual ("real") risk. All three of these variables reduce over time, with anxiety being most reduced.

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SYMPOSIUM 15—HIV DISEASE: IMMUNOBIOLOGY AND NEUROPSYCHIATRY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant will understand current concepts of HIV immunopathogenesis, new approaches to antiretroviral therapy, as well as the problems of viral resistance, the nature and neuropathological underpinnings of HIV-associated neurocognitive disorders and mood disorders, the promise and limitations of current approaches to prevention of HIV transmission.

No. 15A
THE IMMUNOBIOLOGY OF HIV

J. Allen McCutchan, M.D., *UCSD, 2760 Fifth Avenue, Suite 300, San Diego CA 92103*

SUMMARY:

Recently-developed techniques for direct measurement of the levels of HIV (RNA) in plasma, lymph nodes, and cerebrospinal fluids of infected patients have advanced understanding of HIV pathogenesis and patient management remarkably. This quantitative measure of "viral burden" combined with the advent of more potent antiretroviral drugs has permitted the first serious attempts to clear patients of all measurable replicating HIV. Recognition that some patients suppress HIV replication through their specific immune responses has fueled hope for both therapeutic and prophylactic vaccines. The impact of HIV and of opportunistic infections and tumors on the nervous system has been recognized and is being more effectively addressed. Continuing spread of HIV to new populations provides a powerful impetus for research and implementation of programs of behavioral intervention to reduce sexual and needle-related transmission. The complex interaction of social, psychologic, and biologic factors in the clinical manifestations and propagation of the HIV/AIDS epidemic provides a compelling opportunity for psychiatrists to lead in finding solutions to this global health problem.

No. 15B
NEUROCOGNITIVE COMPLICATIONS OF HIV

Igor Grant, M.D., *Department of Psychiatry, UCSD & VA Medical Center, 9500 Gilman Drive, La Jolla CA 92093-0680*

SUMMARY:

There are three levels of neurocognitive complications associated with HIV disease. These are neuropsychological impairment, mild neurocognitive disorder (MND, also known as minor cognitive motor disorder-MCMD), and HIV-associated dementia (HAD). Dementia is a severe complication occurring typically in the latter stages of AIDS, and afflicting approximately 5% of such patients. MND, a lesser neurocognitive syndrome, is observed in about 5% of medically asymptomatic, and 20% of persons with AIDS. The more subtle subclinical neuropsychological impairment is found in about 30% of medically asymptomatic persons. Although both neuropsychological impairment and MND can be subtle in nature, they can affect the individual's ability to work effectively, reduce quality of life, and are associated with earlier death. Neuronal damage (particularly dendritic loss) appears to be the substrate of neurocognitive disorder whose pathogenesis may include both direct toxic effects of viral products as well as indirect cytokine mechanisms. Implications for treatment and neuroprotection will be discussed.

No. 15C
PSYCHIATRIC ASPECTS OF HIV

J. Hampton Atkinson, Jr., M.D., *Department of Psychiatry, University of CA at San Diego, 9500 Gilman Drive, La Jolla CA 92093;* Thomas L. Patterson, Ph.D., Stephen J. Brown, M.D., Robert K. Heaton, M.D., John L. Chandler, M.D., Igor Grant, M.D.

SUMMARY:

Lifetime (>30%) and annual incidence (10% to 15%) rates of both major depression and substance use disorders in HIV-infected individuals are elevated and exceed those of major anxiety (~5% overall) and psychotic (<1%) syndromes. Three models can be used to understand origins of psychiatric conditions observed in the course of HIV infection and disease. The transition model proposes that psychiatric disorder occurs at key points, such as seroconversion or

transition to AIDS. The biological model suggests that systemic or central nervous system disease leads to secondary mood disorders or psychoses. The background model proposes that pre-HIV psychiatric vulnerability is activated or that life adversity independent of HIV precipitates complicating psychiatric disorder. Little evidence links onset of major psychiatric disorder to HIV "transitions." Central nervous system disease may enhance risk of mood and psychotic disorders, but rapid systemic disease progression does not. Many HIV psychiatric "complications" or vulnerabilities may arise from premorbid psychiatric disorder, or HIV-independent life adversity. Treatment is relatively straightforward and success rates approach those seen in other non-HIV medical illnesses.

No. 15D
HIV PREVENTION: INTERVENTIONS FOR HIV-POSITIVE INDIVIDUALS

Thomas L. Patterson, Ph.D., *Department of Psychiatry, University of CA at San Diego, 9500 Gilman Drive, La Jolla CA 92093-0680;* Shirley Semple, Ph.D., Lydia R. Temoshok, Ph.D.

SUMMARY:

Efforts to slow the spread of HIV have focused almost exclusively on behavioral interventions to prevent infection among high-risk populations of HIV negative individuals. Few studies, however, have focused on the importance of HIV+ individuals to prevention efforts. Sexual transmission is the primary source of most new HIV infections. The purpose of this presentation is to: (1) review the efficacy of intervention studies designed to modify sexual risk behaviors; (2) present data that document the magnitude of high-risk sexual behaviors among HIV+ individuals; and (3) present an outline for an intervention to reduce high-risk sexual behaviors among HIV+ individuals. Data from our survey of sexual risk behaviors suggest the importance of focusing behavioral change efforts on condom use, negotiation of safer sex practices, and disclosure of HIV+ status to sex partners. We argue that interventions should be brief, target key problem behaviors, and of low cost in order to reach the greatest number of HIV+ individuals. We outline a number of theoretical and methodological issues including choice of appropriate theoretical model, definition of high-risk behavior, and stigmatization. The issues addressed are salient for clinicians, educators, and investigators working with at-risk groups.

No. 15E
NEW DEVELOPMENTS IN THE TREATMENT OF HIV INFECTION

Douglas D. Richman, M.D., *Pathology Department, University of CA at San Diego, 9500 Gilman Drive, La Jolla CA 92093*

SUMMARY:

New understanding of the pathogenesis of HIV infection, new assays to measure HIV RNA in blood, and new antiretroviral drugs have combined to yield dramatic improvements in the treatment of HIV infection. We now have the prospect of turning most patients into long-term nonprogressors, and conceivably of even eradicating infection altogether.

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3. Grant I, Atkinson JH: Psychiatric aspects of acquired immune deficiency syndrome. In *Comprehensive Textbook of Psychiatry/VI*, H.I., Kaplan and B.J. Sadock (eds.), Baltimore: Williams & Wilkins. 1644-1669, 1995.
4. Fisher JD, Fisher WA: Changing AIDS-risk behaviors. *Psychological Bulletin*, 111(3), 455-474, 1992.
5. Richman DD: HIV therapeutics. *Science* 272:1886-1888, 1996.

SYMPOSIUM 16—ETHICAL CONFLICTS IN MANAGED MENTAL HEALTH CARE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to identify potential effects of managed care decision making on the practice of psychiatry (specifically, on quality of care, medical ethics, the therapeutic alliance, and malpractice liability) and to discuss implementation of appropriate and effective responses by the individual clinician and by the profession.

No. 16A
FINANCIAL CONFLICTS OF INTEREST

Jeremy A. Lazarus, M.D., *Department of Psychiatry, Univ of CO, Hlth Sciences Ctr., 4200 East 9th Street, Denver CO 80220*

SUMMARY:

This paper reviews financial conflicts of interest from historical and present day point of view. Financial incentives, which are utilized by organized systems of care to assist physicians in appropriate utilization and sharing risk, are described in detail. The potentials for these financial incentives to create an incentive to provide less service than necessary is the predominant ethical concern. Attempts to mitigate against these conflicts and their effects will be described. Financial incentives more specific to psychiatry and their influence on the treatment relationship will be described in more detail. A series of proposals for either eliminating or limiting the ethical conflict will be presented in detail.

No. 16B
THE FUTURE OF MEDICAL ETHICS UNDER MANAGED CARE

Alan A. Stone, M.D., *Harvard University Law School, Hauser Hall, Room 400, Cambridge MA 02138-2996*

SUMMARY:

Throughout the health care industry, physicians are being presented with economic incentives to lower the cost of the health care they provide. Psychiatrists who fail to adapt to these new realities are unwelcome in organized provider settings that have been forced by health plans to lower costs in order to compete for patient referrals. The current *Principles of Medical Ethics* are not geared to this competitive market environment. Medical ethics have also fared badly in the courts and legislatures in recent decades. Lawmakers are increasingly dismissive of traditional medical ethics; law and medical regulation are replacing medical ethics. The physician's autonomy is being eroded on one side by economic incentives and on the other side by legal notions about the primacy of rights.

The economic reforms and the legal reforms are on a collision course and the ethical physician is trapped in the middle. The AMA's principles of medical ethics do not offer realistic solutions to this crisis. Health plans responding to market forces must be held liable for the consequences of their cost cutting. Physicians must establish that their professional autonomy and their standards of excellence are a "public good."

No. 16C
CAPITATION: NEW ETHICAL CHALLENGES FOR PSYCHIATRISTS

Paul S. Appelbaum, M.D., *Department of Psychiatry, University of Massachusetts, 55 Lake Avenue North, Worcester MA 01655*

SUMMARY:

Whatever ethical dilemmas may have arisen to date for psychiatrists as a result of managed care, they are likely to be dwarfed by problems resulting from the increasing assumption of capitated risk by providers. Capitation is designed to force clinicians to internalize the imperative to reduce costs, since providers are allocated a fixed sum of money to provide patient care. As economic pressures drive down capitation rates, clinicians will face more and more difficult decisions about allocating resources among their patients. Failure to hold in check the costs of care will threaten the financial stability of their practices, and their ability to treat the majority of the patients for whom they are responsible. The dilemmas that will arise relate to the criteria by which these choices are made, as well as the degree of involvement that patients will have in the decision making. To illustrate these issues, a case example will be presented of a "high-utilizing" patient in a capitated plan, whose treatment provoked conflict among clinicians and between clinicians and the patient's family. Mechanisms to address these dilemmas will be discussed.

No. 16D
WHO DETERMINES MEDICAL NECESSITY?

Harold J. Bursztajn, M.D., *Department of Psychiatry, Harvard Medial School, 96 Larchwood Drive, Cambridge MA 02138-4639*

SUMMARY:

Determining whether a clinical procedure is medically necessary requires a dialogue in which the physician's expertise interacts with the patient's experiences, feelings, and values. Giving this decision to a remote third-party reviewer who does not understand either the physician's or patient's perspective is problematic from a clinical, ethical, and legal standpoint. On the one hand, the disapproval of procedures considered necessary by both physician and patient may lead not only to ineffective care and bad outcomes, but also to feelings of helplessness and powerlessness on the part of both patient and physician. The patient's feelings of betrayal and abandonment may then be displaced onto the physician, leading to greater risk of malpractice liability. On the other hand, an economically motivated transfer of a patient from one facility to another may be considered an unwanted medical procedure. Such disruption may exacerbate the patient's pain and suffering, resulting in post-traumatic stress disorder and subsequent litigation. These dynamics are exacerbated in the context of mental health care, where continuity and trust in the therapeutic alliance are paramount. Exploration of the concept of "medical necessity" reveals that it is a social construct valid only when decision-making power resides in the physician and patient.

REFERENCES:

1. Lazarus JA, Sharfstein SS: Ethics and economics in health and mental health care, *Annual Review Of Psychiatry*, 13:389-413, 1994.
2. Stone AA: Paradigms, prc-emptions, & stages: Understanding the transformation of American psychiatry by managed care. 18 *International Journal of Law & Psychiatry* 353, 1995.
3. Appelbaum PS: Legal liability and managed care. *Am Psychol* 48:251-257, 1993.
4. Bursztajn HJ, Brodsky A: A new resource for managing malpractice risks in managed care. *Arch Int Med* (in press).

SYMPOSIUM 17—WOMEN AND CONTROVERSY: RESEARCH, EDUCATION AND PRACTICE
Joint Session with the Association of Women Psychiatrists and the APA's Committee on Women

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to identify the major controversies in women's health care and the role of psychiatrists in assessing and addressing their implications, both for individual patients and for the field.

No. 17A
THE SELLING OF WOMEN'S HEALTH

Donna E. Stewart, M.D., *Women's Health, Toronto Hospital, 200 Elizabeth Street, EN 1-222, Toronto ON M5G 2C4, Canada*

SUMMARY:

The underrepresentation of women in health research, coupled with gender differences in morbidity, mortality, and social determinants of health and access, have given rise to important social, ethical, and scientific questions. Some academic institutions are beginning to address these issues by developing chairs, professorships, educational, research, and clinical programs in women's health (WH). However, WH has also been identified as a powerful marketing tool. Women comprise 52% of the population, consume 70% of health care visits and prescriptions, and arrange health care for other family members. Women are also the target market for a wide range of personal hygiene, cosmetic, and hormone products. As women gradually gain access to more power through earning, advocacy, and inherited wealth, they become increasingly attractive as consumers, advocates, fund raisers, and donors. While some of these initiatives are helpful to WH, others are exploitative and thrive on misrepresentation, emotionalism, lobbying, and inferior health care. There is a danger in the new focus on WH, which may result in women receiving inappropriate or inadequate care and the necessary changes in research, education, and service delivery not being accomplished.

No. 17B
CAN WOMEN'S LEADERSHIP IMPROVE WOMEN'S HEALTH?

Carol C. Nadelson, M.D., *American Psychiatric Press, Inc, 1400 K Street, NW #1101, Washington DC 20005*

SUMMARY:

Historically, women have comprised most of the workers, but few of the leaders in health care. Although women are reported to place high priority on availability and access to health care, they have had relatively little influence on the determination of policy that can affect these priorities. Women physicians are increasing in number in all fields but especially in the primary care fields and psychiatry. They have not moved into leadership positions at the rate that could have been predicted from their early achievements and talents. There is also documentation that male and female physicians have different styles of interaction with their patients. They evoke different health behaviors, especially in areas that are gender specific, such as female

physicians' greater success in having their patients obtain mammograms. Women's more interactive and collaborative style of practice and leadership may be partly explanatory. This approach may also be better suited to emerging interactional, multidisciplinary modes of clinical practice. Regardless of whether we agree or disagree on whether discrimination limits womens' leadership roles in health care, we can agree that the energy, creativity, and perspective brought by diversity in leadership can foster progress.

No. 17C
WOMEN AND DIVERSITY

Margery S. Sved, M.D., *Adult Psychiatry, Dorothy Dix Hospital, South Boylan Avenue, Raleigh NC 27603-2176*

SUMMARY:

Research, education, and practice, as they relate to women as patients and women as psychiatrists, may also be affected by other aspects of diversity in addition to gender. Who are we discussing? What are the effects of race, ethnicity, age, sexual orientation, family structure and roles, professional identity, national origin, disability? How do these various aspects of diversity interact? What are the effects on women of membership in more than one minority group? How do we collect information and study what truly is relevant for the women who are receiving or need to receive psychiatric care? How do we collect information and study what is truly relevant for the women who are working or training as psychiatrists? Little information is available to begin to answer these questions. An overview of the types of diversity that need to be addressed will be given.

No. 17D
ABUSE OF PSYCHIATRY: SPECIAL CONCERNS FOR WOMEN

Margaret F. Jensvold, M.D., *IRWH, 1616 18th Street, NW, Ste 109, Washington DC 20009*

SUMMARY:

A commonly held misconception is that abuse and misuse of psychiatry occurred in the former Soviet Union and other countries but not in the U.S. The presenter, chairperson of the APA's Committee on Abuse and Misuse of Psychiatry in the U.S., will briefly summarize definitions of abuse and misuse of psychiatry, characteristics and nature of U.S. cases, and international comparisons. Although the topic of abuse and misuse of psychiatry is usually discussed in gender-neutral terms, there are ways in which sex (male vs. female), gender (biopsychosocially-defined construct), and sexuality (sexual thoughts, feelings, and behaviors) affect the motivations behind and nature of cases of abuse and misuse of psychiatry.

A number of cases have been reported in the media in recent years, for example, 40 cases of forced fitness-for-duty psychiatric examinations at the Library of Congress involving women and male homosexuals; female CIA employees who filed a class action lawsuit claiming they were forced to undergo psychiatric examinations when they reported sexual harassment, etc. Issues currently of concern within the U.S. psychiatric community include how and whether psychiatric ethics standards should be changed to improve protection for patients dealing with abuse and misuse of psychiatry; should organizational positions on aspects of abuse and misuse of psychiatry be formalized as position statements, etc.

Such current issues and their relationships to sex, gender, sexuality, and women's health will be discussed.

No. 17E
IS IT A CHOICE OR A BABY? PSYCHIATRISTS AND ABORTION

Nada L. Stotland, M.D., *Department of Psychiatry, Illinois Masonic, 5511 South Kenwood Avenue, Chicago IL 60637;*

The APA's position supporting reproductive choice, including abortion, continues to provoke controversy among APA members. Does abortion violate the most fundamental tenets of medicine, to do no harm and to preserve life? Or is access to safe and legal abortion a philosophical and physical essential for the protection and autonomy of women? Should the APA have a position on this issue? What do psychiatrists and psychiatry have to do with abortion, anyway? This presentation traces the history of abortion and psychiatric involvement in it, and the implications of reduced access to abortion for psychiatrists and psychiatric patients. Psychiatric illness may require treatment with medications and dosages unwise for a pregnant patient, or interfere with the capacity for parenting, so that a woman's infants are repeatedly and painfully removed from her custody. The birth of an additional child to a psychiatrically ill woman barely coping with ongoing parental responsibilities may jeopardize her well-being and the welfare of her existing children. Anti-abortion groups have alleged that abortion itself leads to adverse psychiatric sequelae. All psychiatrists must be aware of the relative psychiatric risks of abortion and childbirth.

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2. Dickstein L, Nadelson CC, (eds): *Women Physicians in Leadership Roles*. Washington, D.C., American Psychiatric Press, Inc., 1986.
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4. Jensvold MF: Potential for misuse and abuse of psychiatry in workplace sexual harassment. In: Shrier DK (ed.): *Sexual Harassment in the Workplace and Academia: Psychiatric Issues.* Washington, D.C.: American Psychiatric Press 153-180.
5. Stotland NL (ed): *Psychiatric Aspects of Abortion.* Washington, D.C., American Psychiatric Press, Inc., 1991.

SYMPOSIUM 18—ABORTION AND WOMEN

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to appreciate more fully the scientific basis for abortion.

No. 18A
ABORTION AND WOMEN: SIGNS OF THE TIMES

E. Joanne Angelo, M.D., *403 Commonwealth Avenue, Boston MA 02215-2326*

SUMMARY:

This paper chronicles 20 years of experience with women who sought out psychotherapy after abortion. The metamorphosis of a neon sign at a nearby club from "LUCIFER" to "NARCISSUS" to "CELEBRATIONS" is used to illustrate how cultural developments over that period of time relate to focal issues for these women in therapy. Several case vignettes demonstrate various constellations of symptoms that women describe as stemming from their abortion experience, as well as psychotherapeutic and other interventions that

proved to be more or less successful. Implications of these findings for long-term research studies are discussed.

No. 18B
MENTAL HEALTH AND ABORTION: A NEUTRAL STANCE

Philip G. Ney, M.D., *Family Practice, University of B.C., PO Box 27103, Colwood Corners, Victoria BC V9B 5S4, Canada*

SUMMARY:

Before 1940, most all indications for therapeutic abortion were medical. By the 1950's, psychiatric reasons accounted for more than 50% of all abortions. Today, where physicians are required to stipulate the reasons for abortion, over 90% are for so-called psychiatric reasons. However, standard texts state that there are no psychiatric indications, that is, "psychiatric indications for therapeutic abortion did not stand the test for scrutiny." "Patients who were sicker before abortions had more serious post-abortion problems." The Canadian Psychiatric Association has stated that, "Justification of a decision to terminate a pregnancy under pseudo-psychiatric rubrics is to be deplored." There are no studies that show psychiatric benefit from abortion, and all but a few show that there are psychiatric hazards. The best evidence is that psychiatric illness is a contraindication for abortion. Our research shows that all kinds of unresolved pregnancy loss have a deleterious effect on women's general health and that abortion does significantly more damage than miscarriages, etc. Until such time as benefit and safety are proven, official organizations must take a neutral stance on abortion.

No. 18C
PREDICTIVE FACTORS OF POSTABORTION MALADJUSTMENT

David C. Reardon, Ph.D., *Elliot Institute, PO Box 7348, Springfield IL 62707*

SUMMARY:

This paper is developed around a review of the literature describing individual characteristics and situational factors found to be predictive of psychological maladjustment following an abortion. The following are included among the most widely accepted predisposing risk factors: abortion of a planned pregnancy, feelings of being pressured into an unwanted abortion, negative religious attitudes about abortion, emotional instability, a history of multiple abortions, a late trimester abortion, and lack of support from meaningful others.

From the premise that predictive risk factors do exist and can be identified, it is argued that these factors define specific ethical and legal duties that counselors and attending physicians owe to their patients. Attention is paid to the special issues raised in counseling a patient who is predictively known to be at heightened risk compared to the "normal" client. Civil liability for adequate screening, full disclosure of risks, and negligent medical recommendations are also discussed. Finally, the issue of the circumstances in which a physician may have a right, or even a duty, to refuse to perform a contraindicated abortion will also be discussed.

No. 18D
MEDICAL ABORTION IN THE UNITED STATES: PROMISE AND PROSPECTS

Linda J. Beckman, Ph.D., *CSPP, 1000 South Fremont, Alhambra CA 91803;* S. Marie Harvey, Dr.P.H.

SUMMARY:

This presentation discusses the characteristics and recent history of medical abortion in the U.S. Emphasis is placed on method characteristics and contextual factors that may influence method acceptability and effects of the abortion experience. Medical abortion is not a "magic bullet," but it has the potential to increase access to abortion services for underserved groups. The authors recently conducted two studies on the acceptability of mifepristone/misoprostol abortion to American women. Using focus group interviews, the first examined what women knew about mifepristone and the perceived advantages and disadvantages of this method. The second study sampled 262 women enrolled in a national clinical trial of medical abortion at three centers. Women chose medical abortion because they wanted to avoid surgery (63%), believed the method was safer than surgical abortion (56%), felt the mifepristone was a more natural method (41%), and wanted a method that could be used early in pregnancy (27%). The majority of women (73%) were very satisfied with their experience and 94% said they would recommend the method to a friend. Additional findings and implications for educating and counseling women about abortion methods will be presented.

No. 18E
ABORTION AND MENTAL HEALTH: ISSUES, FINDINGS

Nancy F. Russo, Ph.D., *Department of Psychology, AZ State University, Box 871104, Tempe AZ 85287-1104*

SUMMARY:

Approximately one out of five American women has experienced abortion. The idea that abortion has widespread and severe negative mental health effects among abortion patients continues to be advanced, including attempts to promote a "post-abortion syndrome" and to pass "informed consent" legislation mandating that doctors tell their patients that abortion can cause them to experience depression and other mental health problems. This presentation considers the empirical evidence for such claims, reporting findings on the relationship between abortion and depression from large national samples of women. Implications for practice and public policy will be discussed.

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2. Babikian HN. Abortion. In: Kaplan HI, Freedman AM, (eds.), *Comprehensive Handbook of Psychiatry, 2nd ed.* 1496-1500, 1975.
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SYMPOSIUM 19—PANIC DISORDER: RESEARCH AND PRACTICE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, participants will be thoroughly familiar with current information on diagnosis, course, etiol-

ogy, quality of life and economic issues, and available treatments for panic disorder.

No. 19A
PANIC DISORDER IN THE MEDICAL SETTING

Mark H. Pollack, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC-815, Boston MA 02114*

SUMMARY:

Panic disorder is highly prevalent among patients seen in medical settings. Most patients with panic disorder present for initial evaluation to the emergency room or other medical facilities, and many continue to receive ongoing care in these venues. Panic disorder is over-represented among high utilizers of medical services, and often goes unrecognized and untreated. Failure to recognize panic disorder results in overutilization of medical personnel and unnecessary and costly use of medical technology and other resources. The dramatic and varied array of somatic symptomatology associated with panic disorder may represent a significant source of diagnostic confusion. In this presentation we will review findings on the prevalence and characteristics of panic disorder in the medical setting with particular focus on patients presenting with cardiac, respiratory, gastrointestinal, and neurologic symptomatology.

No. 19B
THE SOCIAL AND ECONOMIC BURDEN OF PANIC DISORDER

Gregory E. Simon, M.D., *Group Health Coop., Center for Health Studies, 1730 Minor Avenue, Suite 1600, Seattle WA 98101-1404*

SUMMARY:

Community and primary care surveys document the large burden of panic disorder on the health care system and society in general. The "excess" medical utilization associated with panic disorder is even greater than that associated with somatization disorder and major depression. Panic disorder is common among "high utilizers" of outpatient medical services, especially those presenting with cardiovascular or autonomic symptoms. Panic attacks and panic disorder are consistently associated with significant functional impairment, lost productivity, and reliance on social welfare benefits. These indirect or social costs of panic disorder easily outweigh any direct medical costs required for improved recognition and more appropriate treatment. Observational data suggest that more appropriate treatment of panic disorder could result in significant economic benefit or cost offset by reducing both direct and indirect costs. While definitive proof of such a cost-offset effect may require further study, data on the burden of panic disorder do have implications for practicing clinicians. Appropriate public education, patient education, and outreach to medical colleagues can improve access to treatment.

No. 19C
NEUROBIOLOGY OF PANIC DISORDER

Jeremy D. Coplan, M.D., *Department of Psychiatry, Columbia University/Physicians, 722 West 168th Street, Unit 24, New York NY 10032;* Laszlo A. Papp, M.D., Daniel S. Pine, M.D., Donald F. Klein, M.D., Jack M. Gorman, M.D.

SUMMARY:

Much progress has been made in understanding the neuroanatomy, neurotransmitter, ventilatory physiology, cognitive psychology, and neuropsychopharmacology of panic disorder. However, this progress has prompted new questions, some of which may be addressed through preclinical primate models. Panic disorder appears to involve multiple levels of neuroanatomic (and neurotransmitter) dysfunction, although the precise site of primary dysfunction remains undetermined. From a caudal to rostral direction; the carotid body and other viscerosensory afferents conduct stimuli from a variety of laboratory panicogens (carbon dioxide, sodium lactate (D and D-L), isoproterenol and doxapram) via vagus to the medullary nucleus tractus solitarius (stimulated by CCK). Excitatory glutamatergic afferents from the nucleus paragigantocellularis (APGi) conduct such stimuli to the noradrenergic locus cerulcus, which is inhibited by norepinephrine, serotonin (5-HT) and GABA perhaps accounting for the therapeutic efficacy of the TCA's, SSRI's and benzodiazepines respectively, and the panicogenic/anxiogenic properties of yohimbine, flumazenil, mCPP and fenfluramine. Volatile NA firing stimulates the limbic system, particularly the central nucleus of the amygdala. Widespread caudal efferents mediated by CRF neurotransmission induce fear states, stimulate noradrenergic firing and provoke hyperventilation and cortisol release. Activation of these factors predisposes to lactate-induced panic. Besides the LC, 5-HT and GABA also inhibit the limbic system and the brainstem periqueductal grey (PAG), which is primed by the amygdala. When stimulated, the PAG produces profound escape and defense responses. Finally, the prefrontal cortex has powerful reciprocal connections with the amygdala, and also modifies medullary function, possibly explaining the efficacy of cognitive behavioral therapy. Unpredictable insecure early rearing, a putative contributor to adult panic, induces yohimbine hypersensitivity and high CRF in primates.

No. 19D
PANIC DISORDER: PHARMACOLOGICAL TREATMENT ADVANCES

R. Bruce Lydiard, M.D., *Department of Psychiatry, Medical University of SC, 171 Ashley Avenue, Charleston SC 29425*

SUMMARY:

Advances in the psychopharmacological and behavioral treatment of panic disorder have substantially increased our ability to provide effective short- and long-term treatments for the 8 to 10 million individuals who suffer from this severe, often debilitating anxiety disorder. This presentation, which will focus on pharmacological treatments, and will review the evidence for efficacy of the various classes of antipanic agents. The relative clinical advantages and disadvantages of the various treatment options will be highlighted. These include the tricyclics, monoamine oxidase inhibitors, benzodiazepines, and the newer selective serotonin reuptake inhibitor antidepressants and atypical agents.

It is increasingly evident that panic disorder often co-exists with other psychiatric disorders. Important treatment considerations for individuals suffering from both panic disorder and some commonly co-occurring psychiatric disorders (major depression, social phobia, alcoholism) will also be presented.

No. 19E
COGNITIVE-BEHAVIORAL THERAPY FOR PANIC DISORDER

Michael W. Otto, Ph.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, ACC-815, Boston MA 02114*

SUMMARY:

Cognitive-behavioral treatments (CBT) for panic disorder have accumulated an impressive amount of support for their short-term efficacy and ability to maintain treatment gains. In this presentation, a cognitive-behavioral model of panic disorder and its treatment will be presented. Elements of treatment, issues of treatment resistance,

and maintenance of treatment gains will be discussed. Attention will be placed on the relative efficacy and interactions between pharmacotherapy and cognitive-behavioral therapy, with emphasis on results from controlled trials. Strategies and cautions for combined treatment will be reviewed, with attention to issues associated with treatment choice, initiation, and discontinuation. Methods for maximizing the outcome of CBT will be discussed.

No. 19F
INTEGRATING PSYCHOTHERAPY AND PHARMACOTHERAPY IN THE TREATMENT OF PANIC DISORDER

M. Katherine Shear, M.D., *Dept. of Medical Anxiety, Univ Pittsburgh Med Cntr/WPIC, 3811 O'Hara Street, Pittsburgh PA 15213-2593*

SUMMARY:

Accumulating evidence suggests that combining medication and psychotherapeutic approaches to panic disorder may produce the greatest likelihood of treatment response and perhaps the best durability of response as well. This presentation will review existing evidence comparing medication and cognitive-behavioral treatment administered alone to results from combining the two. In order to provide this optimal treatment, administrative, strategic, and technical questions must be answered. These include questions such as who administers each treatment? Should psychiatrists be trained to do cognitive-behavioral treatments? If so, how should this be accomplished? Should the treatments be provided in tandem or in sequence? How should the treatment models be integrated? What are the specific goals for each treatment? How should maintenance treatment be conducted? Moreover, there is some evidence that other types of psychotherapy may be helpful for panic disorder patients, particularly when administered with medication. This presentation will provide answers to these questions about integrated psychotherapy and psychopharmacology for panic disorder.

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SYMPOSIUM 20—BLACK PSYCHIATRISTS: AMERICAN PSYCHIATRY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be cognizant and appreciative of the contributions of black psychiatrists to American psychiatry. In addition, attendees should experience increased awareness that the opinions held as lay persons shape their professional practices, and should be motivated to make use of new knowledge in their practices (as educators, clinicians, and researchers).

No. 20A
BLACK PSYCHIATRISTS: EARLY AND CONTEMPORARY PIONEERS

Jeanne Spurlock, M.D., *1628-B Beekman Place NW, Washington DC 20009*

SUMMARY:

This presentation will focus on biographical sketches of early and contemporary pioneers. These sketches are presented in parallel to brief vignettes of American history and the history of American psychiatry. A review of overlappings and blendings of various aspects of history serves to heighten awareness of the impediments, as well as opportunities, experienced by black psychiatrists in their search for professional achievement and the provision of competent psychiatric services for those in need of these services, especially the underserved.

No. 20B
BLACK PSYCHIATRISTS AND ACADEMIA

Irma J. Bland, M.D., *Department of Psychiatry, Louisiana State University, 1542 Tulane Avenue, New Orleans LA 70112-2865;* Bruce L. Ballard, M.D.

SUMMARY:

The results of a recent survey of black psychiatrists in academia are the focal points of this presentation. Their own efforts, coupled with institutional support, have earned great success for some respondents. Others have experienced a lack of institutional support in their efforts to advance in academic arenas. All have struggled with what they defined as institutional racism and sexism.

No. 20C
EXPERIENCES OF A BLACK IMG

Victor R. Adebimpe, M.D., *Mercy Psychiatric Institute, 320 Fort Duquesne Boulevard, Pittsburgh PA 15222*

SUMMARY:

This presentation focuses on the disquieting and challenging experiences of a black immigrant psychiatric resident in the United States. In the absence of answers to questions about mental differences between blacks and whites, the author turned his attention to research studies. Findings revealed nonscientific biases that are apparently held by some researchers. Correlations are made with certain conclusions.

No. 20D
BLACK PSYCHOANALYSTS

Ruth L. Fuller, M.D., *Department of Psychiatry, University of Colorado, 791 Locust Street, Denver CO 80220;* Jeanne Spurlock, M.D., Hugh F. Butts, M.D., Henry E. Edwards, M.D.

SUMMARY:

Responses from a survey of 23 black psychoanalysts are reviewed. Note is made of their contributions, especially as related to applied psychoanalysis. Attention is given to the "whys and wherefores"

of the very small number of black psychiatrists who have elected to pursue and complete psychoanalytic training. Various measures to increase the pool are suggested.

No. 20E
CURRENT MENTAL HEALTH ISSUES

Billy E. Jones, M.D., *56 Hamilton Terrace, New York NY 10031-6403*

SUMMARY:

This presentation focuses on contemporary issues affecting African Americans. The impact of health care reform on black patients and black psychiatrists is highlighted. Attention is also directed to the fact that some of the problems that are forecasted are not new. The waning of institutional racism in some areas and the waxing in other areas is also addressed.

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2. Wilson DE, Kaczmarek JR: The history of African American physicians and medicine in the U.S. *J Assoc. for Academic Minority Physicians Vol 4, No.3, pp 93-98, 1993.*
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SYMPOSIUM 21—NEW PSYCHOPHYSIOLOGICAL FINDINGS AND CURRENT MODELS OF PANIC DISORDER

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The purpose of this symposium is to demonstrate how latest research findings fit into current psychophysiological models of panic disorder. At the end of the symposium new models will be discussed and proposed.

No. 21A
RESPIRATORY PHYSIOLOGY OF PANIC

Laszlo A. Papp, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, Unit 24, New York NY 10032;* Jeremy D. Coplan, M.D., Donald F. Klein, M.D., Jack M. Gorman, M.D.

SUMMARY:

Respiratory abnormalities have been shown to differentiate panic patients from various comparison groups. Baseline differences in end-tidal and blood carbon dioxide (CO_2) levels, respiratory rate and tidal volume, and their variances indicate that at least a subgroup of panic patients are in a state of chronic respiratory alkalosis possibly due to chaotic breathing. High variance of minute ventilation has been confirmed in panic disorder patients using ambulatory respiratory monitor. CO_2 inhalation results in rapid increase in respiratory rate and continued rise in CO_2 levels in panic patients, while controls respond primarily with increased tidal volume and manage to stabilize CO_2 levels quickly. Following CO_2 inhalation, respiratory rates drop sharply while tidal volumes remain elevated longer in panic patients than controls. Since some respiratory abnormalities normalize following antipanic treatments, panic blockade may be related to direct effect on respiratory control. These findings are consistent with abnormal respiratory regulation in panic disorder patients and point to inefficient compensatory mechanisms as the possible pathophysiological explanation of panic attacks.

No. 21B
PHYSIOLOGICAL ASSESSMENT OF ANXIETY IN THE LABORATORY AND IN THE FIELD

Walton T. Roth, M.D., *Department of Psychiatry, Stanford, C 305, Stanford CA 94305*

SUMMARY:

Physiological recording adds a dimension to the assessment of anxiety and allows testing of specific anxiety theories. In one laboratory experiment, patients with panic disorder (PD), generalized anxiety disorder, and controls took deep breaths on signal and held them until they heard a release signal 30 seconds later. This was repeated 12 times. Neither patient group reacted with greater self-reported or physiological anxiety than controls, but PD patients had lower end-expiratory pCO_2s during the normal breathing periods. In a second laboratory experiment, PD patients and controls were asked to sit with their eyes closed for 10 minutes and to relax as much as possible. The only measure that declined substantially was conductance level (SCL). This decline was slower for PD patients who reported mini-panic attacks during relaxation. These patients also evidenced low frequency instability of SCL and heart rate. In the field we evaluated flight phobics and controls who were willing to take a short commercial flight. Subjects wore a light, compact monitor that recorded cardiovascular, electrodermal, and respiratory activity. Although the phobics reported substantial anxiety during the flight, they did not show increased respiratory rate or minute volume. Instead they paused longer after inspirations than did controls.

No. 21C
PSYCHOPHYSIOLOGY ASSESSMENT OF PANIC PATIENTS

Alexander Bystritsky, M.D., *Department of Psychiatry, UCLA, 300 UCLA Medical Plaza, #2200, Los Angeles CA 90095;* Emanuel Maidenberg, Ph.D.

SUMMARY:

Our current studies suggest panic attacks induced by CO_2 inhalation may be preceded by increase in systolic and diastolic blood pressure, blood pressure fluctuations, and irregular breathing with frequent pauses. In addition, we investigated the psychophysiological differences between those who panicked and others in response to structured tasks including mental arithmetic, knee bends, loud noises, etc. One of the tasks was to imagine a situation where panic attacks occurred most frequently (i.e. imagery exposure). Generally, our results replicated the findings of Walton Roth in that no significant differences in psychophysiological reactivity between panic and control subjects were found. Panic subjects and controls were also similar under baseline conditions. The only task that differentiated panic patients and controls was the imagery exposure. In summary, our current data seem to indicate that: (1) Differences at a "baseline" before a panic provoking experiment may be attributed to higher *anticipatory anxiety* of panic patients. (2) Panic patients do not exhibit higher psychophysiological reactivity to non-phobic stress tasks. (3) Panic patients may be physiologically reactive to imagery stimuli. Future research and clinical implications of these findings will be discussed.

No. 21D
RESPIRATORY PROVOCATION OF PANIC

George C. Curtis, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor MI 48109-0840;* James A. Abelson, M.D., John G. Weg, M.D., Randolph M. Nesse, M.D.

SUMMARY:

Doxapram induces hyperventilation by stimulating central and peripheral chemoreceptors. It lacks demonstrated effects on neurotransmitter receptors of psychiatric interest, such as those for noradrenalin, serotonin, GABA, etc. It can be administered as a simple, safe, small-volume, bolus injection. Doxapram may therefore be useful as a relatively clear probe for exploring possible respiratory dysregulation in panic disorder. Consistent with the hypothesis of a supersensitive suffocation alarm in panic disorder, we have found that doxapram at a dose of 0.5mg/kg provokes panic attacks and an excessive ventilatory response in patients with panic disorder, discriminating patients from controls approximately as effective as 7% carbon dioxide inhalation. A brief cognitive prophylaxis attenuated the doxapram-induced increase in respiratory rate and the frequency with which the experience was labeled as a panic attack. It did not attenuate the increase in tidal volume, the reported intensity of individual panic attack symptoms, nor the robust finding of respiratory irregularity in patients, which was present before, during, and after doxapram infusion. The findings to date are consistent with a biologically based respiratory dysregulation in panic disorder which is partially modifiable by cognitive factors.

No. 21E
PSYCHOPHYSIOLOGY OF NOCTURNAL PANIC ATTACKS

Michelle G. Craske, Ph.D., *Department of Psychology, Univ. of Calif., Los Angeles, 405 Hilgard Avenue, Los Angeles CA 90095*

SUMMARY:

Nocturnal panic, or waking abruptly from sleep in a state of panic, is a relatively common occurrence in patients with panic disorder (up to 33% of patients experience nocturnal panic regularly, and many more experience it occasionally). However, the study of nocturnal panic is relatively limited. The current report presents preliminary data from an ongoing investigation of the psychophysiology and cognitive aspects of nocturnal panic and its treatment. Three features of psychophysiological responding will be presented. The first is overall levels of autonomic arousal during sleep, measured via r-r interval, heart rate, and respiration rate and volume, gathered over the duration of sleep, from ambulatory recording equipment worn in the patients' home environment. Autonomic functioning during sleep is compared between patients who experience nocturnal panic attacks regularly and those who have never experienced nocturnal panic (data from approximately 15 of each group will be presented). Second, physiological profiles will be compared from intervals preceding nocturnal panic and matched intervals during sleep that were not followed by waking in a nocturnal panic. Third, physiological responding to an experimenter-controlled signal that ostensibly reflected heightened arousal during sleep will be compared across nocturnal patients who (1) expect the signal to occur, knowing that it reflects normal and harmless changes in arousal during sleep, or (2) do not expect the signal to occur. These data will be discussed in relation to a psychobiological conceptualization of nocturnal panic that recognizes the role of psychophysiological triggers and cognitive appraisals of bodily sensations as dangerous.

No. 21F
AUTONOMIC NERVOUS SYSTEM DYSFUNCTION IN PANIC?

Murray B. Stein, M.D., *Department of Psychiatry, Univ. of California, San Diego, 9500 Gilman Drive, #0985, La Jolla CA 92093-0985;* Gordon J. Asmundson, Ph.D.

SUMMARY:

Panic disorder is characterized by the paroxysmal occurrence of episodes of anxiety accompanied by tachycardia, palpitations, tremor, sweating, and other manifestations of autonomic hyperactivity. Despite this compelling clinical presentation, little empirical data exist to support the hypothesis of autonomic nervous system dysfunction in panic disorder. Although some studies of baseline heart rate or blood pressure find that panic disorder patients are elevated on these indices, this is in all likelihood attributable to anticipatory anxiety. Similarly, most studies that show enhanced autonomic response in panic do so in the context of anxiety-provoking challenges. In our work we have been able to demonstrate differences in autonomic nervous system responsivity between patients with panic disorder and controls when physiologic, nonanxiogenic challenges are employed. These findings suggest the presence of a heightened "danger-detector" in patients with panic disorder, but not autonomic hyperactivity per se.

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SYMPOSIUM 22—RECENT RESEARCH IN PSYCHODYNAMIC TREATMENTS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to demonstrate a familiarity with recent research on psychodynamic psychotherapy and psychoanalysis, specifically on rates of Axis I disorders as well as incidence of trauma and loss in these patient populations.

No. 22A
SURVEY OF PSYCHOANALYSIS IN THE USA

Norman Doidge, M.D., *Department of Psychothera, Clarke Institute, 250 College Street, Toronto ON, Canada;* Barry J. Simon, M.D., Lee D. Brauer, M.D.

SUMMARY:

The purpose of this study was to determine the demographics, treatment histories, childhood traumata, and DSM-III-R disorders diagnosed in patients in psychoanalysis in the U.S.

Method: A survey of practice was sent to every other active member of the American Psychoanalytic Association. Part one, consisting of questions on patterns of practice, was to be filled out by each

psychoanalyst. Part two, to be filled out on each patient, consisted of questions on demographics, childhood traumata, DSM-III-R diagnoses, indications for psychoanalysis, and changes in defenses and functioning.

Results: The response rate was 40%, with data on 940 patients. Fifty-two percent of patients were women, and 48% men. Eighty-one percent had attempted briefer forms of treatment, including briefer forms of psychotherapy and medication prior to analysis. Thirty-two percent had traumatic separations in childhood, 16.6% were sexually abused, 16.2% physically abused, 14.3% had a parent or sibling die in childhood, 13.7% had mothers or substitutes with a serious illness, and 10.1% had a serious childhood illness lasting longer than six months. The mean number of adult disorders was X = 4.69. Global functioning and defenses matured over the course of treatment. In the U.S. psychoanalytic patients have high rates of trauma and psychopathology, and have attempted other forms of briefer treatment before analysis.

No. 22B
AFFECTIVE AND ANXIETY DISORDERS IN DYNAMIC TREATMENT

Susan C. Vaughan, M.D., *Columbia University, NY State Psychiatric Institute, 722 West 168th Street, Box 63, New York NY 10032;* Steven P. Roose, M.D., Randall D. Marshall, M.D., Roger A. MacKinnon, M.D.

SUMMARY:

There is a common belief that Axis I disorders require medication while Axis II disorders require psychotherapy. Related to this is the notion that patients seeking long-term psychodynamic treatments have Axis II rather than Axis I pathology. SCID-I and II data from 45 patients in psychoanalysis (4x/week) and psychodynamic psychotherapy (2x/wk) suggest, contrary to usual clinical lore, that patients seeking long-term treatment: (1) have high rates of current Axis I disorders (60%), (2) have high rates of affective and anxiety disorders (75% and 17% of current Axis I disorders, respectively), and (3) have low rates of personality disorders alone (15%).

Follow-up data obtained on 16 patients after one year of dynamic treatment suggest that resolution of the pre-treatment Axis I disorder at one-year follow-up was strongly related to medication use (chi-square $p<.05$). In addition, an examination of the characteristics of patients who dropped out in the initial three months of psychotherapy showed that most had an active Axis I disorder not treated with medication. This raises the question of whether untreated Axis I pathology leads to patient dropout.

No. 22C
PSYCHODYNAMIC TREATMENT OF BPD PATIENTS

John F. Clarkin, Ph.D., *Department of Psychiatry, New York Hospital - CMC, 21 Bloomingdale Road, White Plains NY 10605;* Pamela Foelsch, Ph.D., James Hull, Ph.D.

SUMMARY:

There is a dearth of research on the psychotherapeutic treatment of patients with severe personality disorder. These patients constitute public health problems because of multiple hospitalizations, multiple suicide attempts and chronic dysfunction.

We report here on an intensive design investigation which applies a manualized psychodynamic treatment (Kernberg et al., 1989) to patients with borderline personality disorder (BPD) and recent parasuicidal behavior. This treatment development study (1R21-MH53705-01) had two aims: (1) to assess therapist adherence and competence in the delivery of a psychodynamic treatment for BPD patients, and (2) to assess preliminary indices of change in patients engaged in this treatment.

Ten patients were treated in individual psychodynamic treatment by five experienced therapists in two sessions a week for a duration of 12 months. This paper will present data on therapist adherence to a manualized psychodynamic treatment. In addition, patient rate of change on key variables such as urges to discontinue treatment and urges to self-harm are examined by the use of weekly self-report measures and random regression models.

No. 22D
NEW RESEARCH ON THE PATIENT/THERAPIST MATCH

Ann Dolinsky, M.D., *Department of Med Educ, New York State Psych Institute, 722 West 168th Street, New York NY 10032;* Susan C. Vaughan, M.D., Steven P. Roose, M.D., Lisa A. Mellman, M.D.

SUMMARY:

Patient/therapist match is a concept that has received much attention in recent years. The absence of a good match has been cited as the primary cause of dropout in psychotherapy treatment, whereas the presence of a good match contributes significantly to a favorable therapeutic outcome. However, there is no consensual definition of what constitutes patient/therapist match; it remains an intuitively defined and subjectively assessed construct. Moreover, whether patient/therapist match is an entity that exists independent from transference, counter-transference, or therapeutic alliance is unclear, and certainly the boundaries between these concepts have not been delineated.

In the hope of developing a definition of match and a method of assessment, we did a study in which therapist/patient pairs in twice weekly psychodynamic psychotherapy simultaneously filled out questionnaires that asked about personal demographic data, personality characteristics, and therapeutic alliance. Thirty-four therapists and 50 patients participated in this study. This presentation will report the results on the dyad evaluation of personality congruence, therapeutic alliance, and the perception of the "match."

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3. Kernberg OF, Selzer, MA, Koenigsberg HW, et al: *Psychodynamic Psychotherapy of Borderline Patients*. New York: Basic Books, 1989.
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SYMPOSIUM 23—BORDERLINE PERSONALITY: BEST TREATED UNDER OTHER NAMES?
Joint Session with the Association for Research on Personality Disorders

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

After attending this symposium the attendee should understand different relevant ways to understand borderline personality disorder including dialectic behavior therapy, pharmacological, and various

clinical epidemiological approaches. Understanding these different conceptualizations will lead to various related treatment approaches to the disorder.

No. 23A
ADDICTION: MORE IMPORTANT THAN BORDERLINE TRAITS?

Per Vaglum, M.D., *Behavioral Sciences, University of Oslo, PO Box 1111 Blindern, Oslo N-0317, Norway;* Edle Ravndal, Ph.D.

SUMMARY:

Substance abusers often report a high frequency of borderline traits. It is, however, still unclear whether addiction treatment should pay attention to these. Are they related to the course of substance abuse, overdoses or suicidal behaviour?

We explored these questions in a five-year, prospective study of 200 narcotic addicts who applied for treatment at Phoenix House, Oslo. We used MCMI at admittance, after one drug free inpatient year, and at five-year follow-up.

Borderline symptoms were significantly reduced after one abstinent year (in contrast to the other dramatic scales), and were significantly related to the suicidal behaviour during the follow-up period. Level of borderline symptoms were, however, not related to level or course of drug abuse, nor to drop out from Phoenix House or to the rate of overdoses.

The findings indicate that substance abusing patients with borderline traits should be treated as addicts in general. Such traits seem to identify a subgroup whose increased risk of suicidal attempts should be more clearly focused in the addiction therapy.

No. 23B
RELATIONSHIPS BETWEEN DRUG ABUSE AND BORDERLINE SYMPTOMS

Wim Van den Brink, M.D., *Addiction Research, Amsterdam Institute, Jacob Obrechstraat 92/1071 KR, Amsterdam, Netherlands;* Dirk J. Korf, M.D.

SUMMARY:

When standardized measures are used to detect personality disorder in substance abusing populations, it is not unusual for as much as 80% of patients to be diagnosed as having a personality disorder. Many of these are borderline personality disorders. A centralized treatment facility for substance and alcohol abuse in the Netherlands for a large geographic area has provided an unrivaled opportunity to study this population and its relationship to borderline personality disorder. Drawing from data from this population, as well as other literature, this presentation will discuss (1) Whether borderline personality disorder predisposes to various forms of drug abuse (2) How borderline personality disorder may affect the outcome of treatment for substance abuse, (3) Whether substance abuse causes symptoms that "mimic" borderline personality disorder, and (4) The effects of abstinence on the frequency and intensity of borderline personality disorder symptoms. Ways of distinguishing important different clinical subgroups which may share some borderline personality features will be discussed.

No. 23C
SUICIDE, BPD AND DEPRESSION

James H. Reich, M.D., *Department of Psychiatry, Harvard Medical School, 2255 North Point Street, #102, San Francisco CA 94123;* Nathalie Le Hir

SUMMARY:

Objectives: Suicide attempts have been associated in past work to both major depression and borderline personality disorder. However, it is also likely that suicide attempts have different characteristics in the two different populations. This report hypothesized that there would be significant clinical differences between psychiatric outpatients with major depression depending on whether they have a history of suicide attempt and if they have borderline personality disorder.

Methods: Psychiatric outpatients who had major depression were divided into three groups: No suicide or borderline (major depression), suicide and not borderline (depression plus suicide) and suicide and borderline (borderline.) Standardized measures of Axis I and Axis II variables were gathered by trained interviewers.

Results: In terms of pathological personality traits the borderline group was higher than all other groups. The depression plus suicide was significantly higher than all other groups in both anxiety and depression symptom measures. The depression plus suicide group differed from the borderline group by having a significantly lower level of familial GAD.

Conclusions: The presence of a history of suicide attempts in a major depressive group without borderline personality disorder appears to identify a group that is more symptomatically severe in Axis I symptoms and may require different treatments than borderline depressed patients or depressed patient without either suicide history or borderline personality. Implications of these findings are discussed.

No. 23D
BORDERLINE PERSONALITY: MORE TREATABLE UNDER DIFFERENT NAMES?

Hagop S. Akiskal, M.D., *Department of Psychiatry, Univ. of California, San Diego, 9500 Gilman Drive, La Jolla CA 92093-0603*

SUMMARY:

Borderline personality disorder (BPD) is currently classified as an Axis II disorder. Treatment research on BPD has conventionally focused on psychosocial and psychopharmacological interventions of the personality disorder itself. This paper presents the argument that treating BPD patients on the basis of Axis I diagnoses constitutes a more rational approach. For those BPD patients meeting the criteria for major depression with "atypical" and bipolar II features, an MAOI or buproprion with or without a mood stabilizer (such as lithium or valproate) represent optimal choices. Dysthymic BPD often responds to an SSRI (e.g. fluoxetine or sertraline). BPD patients meeting the criteria for panicagoraphobic or polyphobic ("pananxious and panneurotic") conditions would favorably respond to another SSRI (e.g. paroxetine) or even to a more traditional antidepressant agent (e.g. imipramine). Still others may suffer from ADHD and potentially benefit from stimulant medication. A small group of BPD have temporal lobe features where anticonvulsants such as carbamazepine often prove useful. Finally, for those with schizotypal features, a low dose neuroleptic has been found useful. In the author's opinion, such considerations which represent extrapolations of the existing psychopharmacological literature on BPD, provide greater prognostic hope.

No. 23E
BRIEF TREATMENT OF DELIBERATE SELF-HARM

Ulrike Schmidt, M.D., *Pace Team, Maudsley Hospital, 300, Ivy Dale Road, London SE15 3DG, Great Britain;* Jose Catalan, M.D., Kathryn Evans, Philip Tata, Sue Thornton, Peter Tyler, M.D.

SUMMARY:

Deliberate self harm (DSH) is a defining feature of personality disorder of the flamboyant type (borderline, histrionic, and antisocial.) We developed a manual-based cognitive behavioral approach for this group of patients incorporating elements of Linehan's Dialectic Behavioral Therapy. The manual contains modules on in-depth analysis of the act of DSH, problem solving, monitoring thoughts and feelings, learning to tolerate distress, and dealing with substance abuse. The manual is administered in graded amounts in the course of a small number of treatment sessions. A pilot project was undertaken with patients with repeated DSH. To enter the study a subject required a flamboyant personality disorder, having presented to the emergency room with an episode of DSH, and having a history of a DSH attempt within the last year. Patients were randomly assigned to manual-based treatment or "treatment as usual." The key outcome measures were time to next DSH episode and mean number of DSH episodes over a six-month period. Social and economic status of subjects were determined to assess their relationship to the outcome. A preliminary analysis of the first 20 patients suggests that manual-based treatment reduces DSH repetitions. Implications of these results for clinical practice and research will be discussed.

No. 23F
SUICIDE, PARASUICIDE AND DIALECTIC BEHAVIORAL THERAPY

Marsha M. Linehan, Ph.D., *Department of Psychology, University of Washington, P.O. Box 351525, Seattle WA 98195*

SUMMARY:

Dialectic Behavioral Therapy (DBT) views the borderline personality disorder from the perspective of treatment of key symptoms from a behavioral and skills development model. This presentation will give a quick overview of the conceptualization of borderline personality disorder from the DBT perspective and will explain why this conceptualization is so effective in the treatment of this disorder. It will also briefly cover some aspects of DBT important for the clinician, such as treatment of parasuicidal behavior and treatment interfering behaviors. This approach will be compared and contrasted with other treatment approaches. Since, by definition, DBT is a constantly evolving therapy, exciting new findings and developments in this therapy will be previewed, including suggestions on how this therapy model can be adapted to different treatment settings.

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SYMPOSIUM 24—THALAMUS IN SCHIZOPHRENIA AND OTHER DISORDERS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participants will learn about the most recent findings on the role of thalamus in schizophrenia, mood disorders, and other neuropsychiatric disorders involving language and cognition. The new research to be presented, much of it yet to be published, will include MRI, PET, and neuropsychological investigations. Implications of these findings to the pathophysiology and possibly of treatment of the major psychiatric disorders will also be considered.

No. 24A
THALAMIC MISCONNECTION SYNDROMES IN SCHIZOPHRENIA

Nancy C. Andreasen, M.D., *Department of Psychiatry, University of Iowa, 200 Hawkins Dr, MHCRC 2911 JPP, Iowa City IA 52242;* Daniel S. O'Leary, Ph.D., Laura L.B. Ponto, Ph.D., G. Leonard Watkins, Ph.D., Richard D. Hichwa, Ph.D.

SUMMARY:

The symptoms of schizophrenia encompass the entire range of psychological functions that characterize human beings. The conceptual challenge of schizophrenia is to postulate a neural mechanism that could explain this diversity of symptoms. A parsimonious contemporary model of the fundamental deficit in schizophrenia should posit an abnormality in a basic cognitive process that could explain the diverse symptoms of schizophrenia and that is mediated by specific neural circuits. We have proposed a theory of "cognitive dysmetria" that may implicate the thalamus and its related circuitry in the development of schizophrenia. The thalamus is a key relay nucleus that modulates both motor coordination and cognitive coordination. A defect in its ability to relay information from the cerebellum to cortical regions and back to the cerebellum through pontine nuclei could lead to the cognitive dysmetria that characterizes schizophrenia. This presentation will summarize data from a series of PET studies that explore episodic memory, semantic memory, and practiced and novel recall of complex narratives and word lists. Convergent evidence from these various memory studies suggests that patients suffering from schizophrenia have disruptions in thalamic-cortical-cerebellar circuitry when they perform a wide range of memory tasks.

No. 24B
THREE-DIMENSIONAL ANALYSIS OF THALAMIC METABOLIC RATE IN SCHIZOPHRENIA

Monte S. Buchsbaum, M.D., *Department of Psychiatry, Mt. Sinai Medical Center, One Gustave Levy Place, New York NY 10029;* Erin A. Hazlett, Ph.D., M. Mehmet Haznedar, M.D., Craig Geneve, B.S., Lina S. Shihabuddin, M.D.

SUMMARY:

Recent neuroimaging research has drawn attention to the thalamus as an area that is abnormal in schizophrenia. In the present study, magnetic resonance imaging (MRI) and positron emission tomography (PET) with ^{18}F-2-deoxyglucose (FDG) were used to study size and metabolic rate in the thalamus in 27 unmedicated schizophrenia patients and 32 age- and sex-matched normal controls. During the FDG uptake period, all subjects performed a modified version of

the California Verbal Learning Test. PET (30 slice, 3-4M counts/slice, 4.5 mm FWHM) and MRI images (TR 24, TE 5, flip angle 40 degrees, 1.2 mm thickness) were co-registered. Thalamus edges were outlined for each hemisphere on serial MRIs by tracers blind to diagnosis and a new radial warping program was used to conform all outlines to the average of the normal group. Proportional z-axis interpolation then yielded an exactly uniform volume for statistical parametric mapping in the three dimensions. Using 2-tailed t-values, we visualized a 3D cluster in the region of the mediodorsal nucleus within the 3D images of the thalamic surface. The cluster of pixels in the left thalamus indicates an area where patients had significantly lower relative metabolic rates than controls ($p<.03$, resampling methods). Volumetric and shape measures of the thalamus were also obtained. These data have important implications in schizophrenia because the mediodorsal nucleus is a major cortical relay from the limbic system and has connections to the prefrontal cortex.

No. 24C
THALAMUS AND LATE-LIFE SCHIZOPHRENIA

Dilip V. Jeste, M.D., *Department of Psychiatry, Veterans Affairs Medical Cntr., 3350 La Jolla Village Drive, San Diego CA 92161-0001;* Laura L. Symonds, Ph.D., Terry L. Jernigan, Ph.D., Julie Stout, Ph.D., David L. Braff, M.D., Robert K. Heaton, M.D.

SUMMARY:

Background: Most of the brain-imaging and neuropsychological studies in schizophrenia have been done in young adults.

Methods: We will present the results of investigations involving more than 120 middle-aged and elderly outpatients with DSM-III-R schizophrenia. The subjects received an expanded version of the Halstead-Reitan neuropsychological test battery, and a subsample had an MRI with computerized quantitative analysis of gray matter, white matter, and fluid volumes in different areas of the brain.

Results: Patients with late-onset schizophrenia (onset after age 45) had a significantly larger volume of thalamus and less impairment in learning than those with early-onset schizophrenia. Next, we examined the relationship of age of onset of schizophrenia to MRI and neuropsychological measures in a large group of patients including younger adults. The best statistical predictors of a later age of onset of schizophrenia were: larger volume of thalamus, smaller volume of lenticular nucleus, and less severe impairment of learning.

Comment: We will discuss these findings with reference to the cortico-striato-pallido-thalamic (CSPT) circuitry.

No. 24D
THALAMIC VOLUME IN MOOD DISORDER

Renee M. Dupont, M.D., *Department of Psychiatry, UCSD School of Medicine, 9500 Gilman Drive, 0603, La Jolla CA 92093;* Terry L. Jernigan, Ph.D., Thomine Wilson, M.A., John Hesselink, M.D., J. Christian Gillin, M.D.

SUMMARY:

We have previously reported an increase in thalamic volume in bipolar subjects compared with unipolar subjects. Additional data from a larger group of subjects suggest that the increased volume of thalamus as well as white matter abnormalities define subgroups of bipolar subjects. In contrast, thalamic volume decreases are more consistently seen across unipolar subjects than is the increase in thalamic volume in bipolar subjects. To date we have not detected any neuropsychological correlate of thalamic volume change. As discussed below it may be useful to examine the relationship between dimensions of affective disorder and structural measure in addition to exploration of their diagnostic significance.

We hypothesized that course of illness, daily mood variability, and cognitive impairment are specific dimensions of mood disorders with unique neurobiological underpinnings. In a prospective study carried out in a subgroup of volunteers on whom MRI morphometric data were available, thalamic volume was one of the best predictors of mood variability across diagnostic categories of mood disorder patients. There was a relationship between structural measures (including the thalamus) and each of these dimensions (course of illness, daily mood variability, and cognitive impairment) which crossed diagnostic lines. Within diagnoses, thalamic volume was negatively correlated with measures of day-to-day mood variability and depressive symptoms in a sample of nonhospitalized patients. Thus, smaller thalamic volumes appear to be associated with mood abnormalities across diagnostic categories of unipolar and bipolar patients.

No. 24E
THE THALAMUS IN LANGUAGE AND NEUROCOGNITION

Bruce Crosson, Ph.D., *Clinical Psychology, University of Florida, Box 100165/Hlth Sciences Ctr, Gainesville FL 32610-0165*

SUMMARY:

Evidence implicating the thalamus of the language-dominant hemisphere in lexical-semantic functions and in verbal working memory will be explored. Semantic paraphasia in cases of thalamic aphasia is sometimes so severe that spoken discourse deteriorates into jargon. A recent examination in our laboratories of two cases with lesions in the anterior portion of the dominant thalamus suggests that the problem lies not in the semantic system per se, nor in the store of lexical (word) representation. Rather, the deficit lies at the interface between the semantic and lexical systems when patients have to select the correct lexical form to represent the intended concept. Further, evidence from a new functional neuroimaging study performed in collaboration with colleagues at the Medical College of Wisconsin indicates that the dominant thalamus is involved in verbal working memory, both when the semantic properties and when the phonological properties of words are emphasized. A model implicating selective engagement of cortical mechanisms by a system involving the frontal lobes, the inferior thalamic peduncle, the nucleus reticularis, and thalamic nuclei (Nadeau & Crosson, in press) can explain both of these findings. The ramification of this model for neurocognition in general and for schizophrenia will be discussed.

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2. Buchsbaum MS, Someya T, Teng CY, et al: Positron emission tomography and magnetic resonance imaging of the thalamus in never-medicated patients with schizophrenia. *Am J Psychiatry, 153*:191-199, 1996.
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4. Dupont RM, Jernigan TL, Heindel W, et al: Magnetic resonance imaging and mood disorders. Localization of white matter and other subcortical abnormalities. *Arch Gen Psychiatry* 52:747-755, 1995.
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SYMPOSIUM 25—PHENOMENOLOGY IN DIAGNOSIS AND PSYCHOTHERAPY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should have an understanding of what is phenomenology and how the phenomenological approach is used in psychiatric diagnosis and in understanding psychopathology, as well as in the technique of psychotherapy.

No. 25A
INTRODUCTION TO PHENOMENOLOGY

Richard D. Chessick, M.D., *Department of Psychiatry, Northwestern University, 9400 Drake Avenue, Evanston IL 60203-1106*

SUMMARY:

I will trace the confusing notion of phenomenology from Hegel through Husserl to its present-day uses in psychiatric diagnosis and treatment. It is interesting that the philosopher-psychologist Brentano, one of the first precursors of the use of phenomenology in psychology, had an important influence on both Husserl and Freud before they developed their famous work. I will concentrate here only on the importance of phenomenology to the psychiatrist in his or her efforts at diagnosis and treatment. From the point of view of the psychiatrist or psychotherapist, the phenomenological stance is used to react to what is simply there in a felt experience; the therapist does not disconnect, isolate, or interpret aspects of this experience. "Phenomenological reduction" or "bracketing" demands refrainment from judgment about morals, values, causes, background, and even the subject (the patient) and the so-called objective observer (the psychiatrist). One pays special attention to one's own state of consciousness in the presence of a patient - for example, to the "feel" of a schizophrenic, the ambience such an individual creates.

The point of this stance is that the psychiatrist must continue to observe and listen in what is called the phenomenological sense, staying with the patient's material and taking everything the patient says at face value rather than searching for hidden processes, whether psychological or biological. This approach attempts to resolve the well-known problem that in the standard psychiatric interview or encounter a distance is created between the patient and the psychiatrist, a gap that can be unproductively filled by abundant theoretical conceptions and ideas. Phenomenological reduction of the emotional distance between the patient and the therapist is the crucial procedure, leading to a true meeting, as the famous philosopher-psychiatrist Jaspers pointed out. This is something hard to scientifically define, but we have all experienced such true encounters from time to time, as is often illustrated in great works of drama or literature.

Phenomenology does not replace our ordinary diagnostic or therapeutic procedures; it is an additional technique to achieve understanding of the patient. The application of phenomenology to psychiatry raises the valid question of whether we as psychiatrists can be sure we are seeing and hearing our patients as they really are, rather than as projections of our theories or DSM-IV classifications about them. The aim of phenomenological study is to rediscover the living person and the existential reality for that person, a capacity that tends to get lost in "scientific" investigations of humans.

No. 25B
PERSONALITY AND DEPRESSION: PSYCHOTHERAPEUTIC CONSIDERATIONS

Hermann Lang, M.D., *Psychotherapy, University, Klinikstrasse 3, 97070 Wuerzburg, FRG*

SUMMARY:

Psychotherapy can intervene at two points with regard to the personality of the depressive patient. First, if pharmacological treatment results in an improvement, it is imperative to focus on the situation that triggered the pathological affect in order to start a rehabilitation process. To achieve such a rehabilitation requires a sound knowledge of the patient's personality, for it is the personality which forms the precondition that under the circumstances of the trigger situation psychopathological symptoms can arise. It now becomes the task of the therapy to remove the conditions of this pathogenic situation and to elaborate on ways to avoid such peril in the future. Secondly, one of the central aims should be to amplify the onesidedness within the emotional and cognitive structures of the depressive personality. The extent to which a change in the structure of this personality, the so called "typus melancholicus," can be achieved, is also discussed.

No. 25C
CONTRIBUTIONS TO THE PHENOMENOLOGY OF TIME AND SPACE IN THE BORDERLINE PATIENT

Heinz Weiss, M.D., *Psychotherapy, University, Klinikstrasse 3, 97070 Wuerzburg, FRG*

SUMMARY:

One of the difficulties the borderline patient is confronted with concerns the construction of his mental space. As more recent psychoanalytic work (D. Meltzer, H. Rey, J. Steiner) has demonstrated, the borderline patient lives at the border between external reality and his internal world. Since he has no true acknowledgment of separateness, he finds himself neither totally inside nor totally outside of his objects. Characteristic clinical features like the "agoraphobic-claustro-phobic dilemma" (H. Rey) result from this situation. He also tends to deny the reality of temporariness and death. He therefore finds himself enclosed in an omnipotent and omnipresent world ("romantic illusion," J Steiner), with restricted personal relationships, in which past, present, and future are not clearly differentiated. One consequence of this situation is that, opposed to the neurotic who suffers from repressed memories, the borderline patient lives in a much more concrete way inside his past. Refering to phenomenological and psychoanalytical approaches the consequences of this understanding are elaborated with special reference to problems of treatment technique and symbol formation.

No. 25D
PSYCHOTHERAPY OF DELUSION AND PRACTICAL ASPECTS OF PHENOMENOLOGY

Prof. Dr. Christoph Mundt, *Psychiatric University Hosp, Voss-Str 4, Heidelberg 69115, Germany*

SUMMARY:

Psychotherapy of delusion is usually considered to be far from promising, even more so since one of its classical criteria, according to Jaspers, is the patient's inability to correct delusional beliefs. Nevertheless, delusional patients require psychotherapy, especially if they do not respond to neuroleptic treatment.

Phenomenological hypotheses about the nature of delusion are indispensable for psychotherapeutic approaches. Phenomenology is defined for this instance by approaches which go beyond symptoms to the alteration of the underlying mental function and do so by elaborated methodology of primarily clinical means.

Taking such hypotheses into consideration sheds light on: Affective charge of the delusion, the degree of fixation in the personality, its compensatory function for impending mental disorganization, and its expressive—though concretistic—function for the patient's

most important yet unresolved life themes. In the acute phase this knowledge can help to disactualize the theme; in the post-acute phase this can help to reflect the destiny of blocked themes or to mourne about them. Clinical considerations on the basis of these aspects include how to help the patient to more adequate self-presentation, how to deal with the pre-predicative concretistic information delivered by the delusional belief, and how to use extradelusional mental well-functioning for developing more flexible cognitive styles, for example by training to change perspectives.

No. 25E
SIGNIFICANCE OF INTUITION FOR DIAGNOSIS AND CLASSIFICATION

Alfred Kraus, M.D., *Department of Psychiatry, University of Heidelberg, Vosstrasse 4, Heidelberg 69115, Germany*

SUMMARY:

The application of operational criteria for diagnosis by the diagnostic manuals has led to a repression of intuitive-etiological acts in the diagnostician. This lets us question what significance intuition had or still has not only for diagnosis in psychiatry but also for the foundation of psychopathological entities. Some possibilities of a phenomenological description of intuitive experiences and of making them fruitful for the diagnosis and classification of psychopathological entities are discussed, with examples of diagnoses.

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SYMPOSIUM 26—CLINICIAN'S GUIDE TO SURVIVING MANAGED CARE
APA Consultation Service Board

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to

1. Recognize the survival value of behavioral group practices and provider networks.
2. Understand how to create these new provider systems.
3. Provide the essential clinical services and manage the practice.

No. 26A
NETWORK DEVELOPMENT

Matthew E. Weinstein, *Managed Networks of America, 905 East Horsehoe Court, Virginia Beach VA 23451*

SUMMARY:

Organizing groups of providers into coalitions or "networks" requires careful consideration of criteria for selecting members and the commitments that they must make to insure success. In addition to ethical and professional standards, attention must be given to management dynamics, organizational skills, and philosophical alignment.

This presentation will describe how attempting to build an organizational infrastructure can be accomplished or frustrated by group dynamics. In addition, detailed examples of operational system requirements will be provided such as single point of access, utilization management, clinical outcomes, patient satisfaction, and management information systems.

Many providers have hurried to form legal entities, believing that the primary solution to network building is obtained through forming large groups. This presentation will define the critical success factors for development by focusing upon the criteria for selecting participants and selection of essential operating systems.

No. 26B
LEGAL ISSUES AND RELATED BUSINESS CONSIDERATIONS

Paul Litwak, J.D., *Attorney & Counselor at Law, 4104 Holly Road, #202, Virginia Beach VA 23451*

SUMMARY:

Consolidation of fragmented outpatient practices and hospital resources into cost-effective, clinically integrated regional health care services systems is an excellent strategy for survival in a changing health care market. Clinicians may pursue one or all of the tactics associated with this strategy, including establishment and marketing of a provider network, entry of risk-based managed care contracts (capitation or case rates), establishment of shared business management systems, establishment of single and multidisciplinary group practices, and economic integration and consolidation of practices and health services organizations. Each of these tactics presents complex legal and business problems.

This portion of the program will describe the critical legal issues that must be considered by clinicians who wish to get into position to survive managed care. Special attention will be paid to the business considerations associated with various types of transactions, and to the practical problems faced by clinicians who must make difficult choices about the future of their practice.

No. 26C
CAPITATION: PREPARING BIDS AND PROPOSALS

Gayle Zieman, Ph.D., *Mesa Mental Health, 6723 Academy, NE, Albuquerque NM 87109*

SUMMARY:

In order to be prepared for seeking and accepting capitation contracts to provide mental health services through full or partial at-risk arrangements, provider groups and networks must understand what business components are required and how to price these services.

This presentation will describe the anatomy of a capitation proposal and the management services that must be developed and staffed. An outline of a capitation proposal and a full capitation cost bid will be presented and given as handouts.

The goal of this presentation is to show that with the proper preparation partial and full at-risk contracts can be clinically and financially rewarding for mental health provider groups.

No. 26D
THE CLINICAL DELIVERY SYSTEM

Robert K. Schreter, M.D., *Sheppard Pratt Health System, 2360 West Joppa Road, #222, Lutherville MD 21093-4616*

SUMMARY:

In order to survive, clinicians are coalescing into single and multi-specialty mental health group practices. These groups must be capable of providing the full range of mental health and substance abuse care to large populations spread over wide areas under a variety of payment arrangements including capitation.

This presentation will describe the clinical services necessary to treat populations of patients and how to link them into an outpatient continuum of care. Special attention will be paid to the clinical management services necessary to support the practice and the business.

Some believe the solution to cost containment and managed care lies in playing with the dollars. This presentation will attempt to show the answer lies in developing innovative clinical services and programs along the continuum of care.

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3. Schreter RK, Sharfstein SS, Schreter CA, (eds): *Allies and Adversaries—The Impact of Managed Care on Mental Health Services.* APPI, 1995.
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SYMPOSIUM 27—SCHIZOPHRENIA AND OCD

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation the participant should be able to describe the relationship between schizophrenia and obsessive-compulsive disorder, and also be able to describe several approaches to study this complex and fascinating relationship. Clinical issues of diagnosis and treatment will be stressed.

No. 27A
OBSESSIONS AND COMPULSIONS AS A DISTINCT CLUSTER OF SYMPTOMS IN SCHIZOPHRENIA: NEUROPSYCHOLOGICAL STUDY

Ileana Berman, M.D., *Department of Psychiatry, Taunton State Hospital, PO Box 4007, Taunton MA 02780;* Demetra Pappas, B.S., Barbara Viegner, Ph.D., Amalia Merson, M.D., Miklos F. Losonczy, M.D., Alan I. Green, M.D.

SUMMARY:

Using neurocognitive testing, the present study attempts to assess whether obsessions and compulsions may be a distinct cluster of symptoms in schizophrenia. We formulated our hypothesis based on data from nonschizophrenic patients, expecting to find that schizophrenic patients with obsessive-compulsive (OC) symptoms would experience more difficulties in the same cognitive areas as nonschizophrenic patients with obsessive-compulsive disorder (OCD), specifically in the ability to change cognitive sets, visual-spatial skills, and delayed visual memory. Patients had separate psychiatric and cognitive evaluations: the psychiatric assessments were done concomitantly by two research psychiatrists who were blind to the scores on cognitive tests, while cognitive performance was assessed by psychologists who remained blind to the results of the psychiatric assessments. The OC and non-OC schizophrenic subjects did not differ significantly on PANSS scores. Moreover, there was no association between OC scores and positive and negative symptoms. However, compared to non-OC schizophrenic patients, those with OC symptoms performed worse on cognitive tests involving visual-spatial skills, delayed nonverbal memory, and cognitive shifting abilities. In addition, the severity of OC scores correlated with poor performance in some tests measuring those cognitive functions reported abnormal in nonschizophrenic OCD patients (i.e., scores on the Trails B, delayed visual memory, similarities, and WCST perseverative answers and errors). Moreover, a discriminant analysis in which the discriminant factors were the scores from the tests hypothesized to be associated with OC symptoms (i.e., scores on the Block Design, Trails B, verbal fluency FAS, delayed visual memory, similarities, and WCST perseverative answers and errors) we found that OC and non-OC groups showed a trend toward a significant difference (chi-square = 8.9; p = 0.08), with 81% of the cases correctly classified in either OC or non-OC groups. These results support our hypothesis that OC symptoms may constitute a distinct cluster that coexists with the typical psychotic symptoms in schizophrenia. These findings encourage continuation of research in this area.

No. 27B
SCHIZOPHRENIA WITH OCD: CLINICAL CONSIDERATIONS
Harwood Academic Publishers, Buffalo, NY 1997

Joseph Zohar, M.D., *Department of Psychiatry, Chain Sheba Medical Center, Tel-Hashomer, 52621, Israel;* Yehuda Sasson, M.D., Michal Lustig, Talma Hendler

SUMMARY:

As many as 15% of chronic schizophrenic patients also suffer from obsessive-compulsive disorder (OCD). This increased prevalence of OCD in schizophrenia compared with that in the general population (2%) has raised intriguing questions regarding the association between OCD and schizophrenia. Moreover, the presence of OCD in schizophrenia was found to predict a poor prognosis. Many schizophrenic patients can differentiate the ego-dystonic obsessive-compulsive symptoms that they perceived as originating from within themselves from the ego-syntonic delusions that they perceived as introduced to them from outside. We will present an open study (ABA design) in which the anti-obsessive medication clomipramine (CMI) was added to ongoing antipsychotic medications in a subgroup of schizophrenic patients with OCD. Eighteen patients completed this open study. Twelve showed marked decrease in OC symptoms; in nine, it was also associated with improvement in their psychosis (as expressed by decrease in their BPRS). In all patients for whom reinstitution of CMI treatment was possible, improvement in OC symptoms was observed once again. Diagnostic issues and theoretical implications of these findings will be discussed.

No. 27C
CLINICAL NEUROPSYCHIATRIC AND TREATMENT FINDINGS IN OBSESSIVE-COMPULSIVE SCHIZOPHRENIA PATIENTS

Michael Y. Hwang, M.D., *Department of Psychiatry, FDR VAMC, PO Box 100A, Montrose NY 10548;* Evelyn M. Howanitz, M.D., Edward R. Allan, M.D.

SUMMARY:

Background/Objective: While obsessive-compulsive (OC) phenomena in schizophrenia have long been recognized, its clinical and pathophysiological implications remain obscure. Prior to DSM-III-

R, diagnostic convention precluded simultaneously diagnosing schizophrenia and obsessive-compulsive disorder (OCD), and as a result OC schizophrenia was believed to occur only rarely. Recent epidemiological studies (e.g., ECA study) and clinical reports, however, indicate significantly higher comorbidity and worse prognosis in OC schizophrenics.

We investigated ten OC schizophrenics in comparison to ten non-OC schizophrenics to examine their characteristic clinical and neuropsychiatric profiles.

Methods: Twenty chronic schizophrenic inpatients in a large university-affiliated urban state hospital participated in a cross-sectional study. All subjects met DSM-III-R criteria for chronic schizophrenia and were between 20 to 50 years old. All patients underwent at least four weeks of symptom stabilization on individualized neuroleptic treatment. The OC schizophrenics also met a strict operationalized obsessive-compulsive symptom criteria for a minimum of six months. Demographic, psychopathological, neuropsychiatric, and functioning level assessments were performed in three to four divided sessions. Open label treatment study with adjunctive specific serotonin reuptake inhibitors (SSRI) was conducted with patients' consent.

Results: Preliminary data suggest poorer clinical course and lower functioning levels among OC patients. In addition, these patients demonstrated greater negative symptoms with more pervasive frontal lobe impairments. Treatment with the adjunctive SSRI in addition to ongoing neuroleptics brought about marked symptom reduction and functional improvement in most patients. Our observation also suggests differential symptom response to the SSRIs. While OC symptoms and WCST performance have shown improvements with SSRI, no significant improvements were noted in their positive and negative symptomatology.

Conclusion: Our findings suggest that OC schizophrenics may possess distinct clinical and neurobiological profiles and may require specific symptom assessment and treatment strategies for optimal outcome.

No. 27D
ARE SOME NEUROLEPTIC REFRACTORY SYMPTOMS REALLY OBSESSIONS?

Paul C. Bermanzohn, M.D., *Department of Psychiatry, Hillside Hospital, 87-80 Merrick Boulevard, Jamaica NY 11432;* Linda Porto, M.S.N., Samuel G. Siris, M.D.

SUMMARY:

It is generally recognized that OC patients (without schizophrenia) may become psychotic if they completely lose insight into the absurd or pathological nature of their preoccupations. In a person with schizophrenia, such an obsession could not be distinguished from a schizophrenic delusion.

A DSM-IV diagnostic study of 37 patients with chronic schizophrenia revealed that 19 (51.4%) had significant OC symptoms and 11 (29.7%) met full criteria for OCD. Seven of these 11 patients (63.6%) had been classified as neuroleptic-refractory.

In addition, eight (21.6%) exhibited an obsessive preoccupation with a delusional content; four of them had such "obsessive delusions" as their earliest symptoms.

It is suggested that some patients with OC schizophrenia may be classified as neuroleptic refractory and treated only with ever-increasing doses or changes of neuroleptics. This raises two intriguing questions: (1) What percentage of neuroleptic refractory schizophrenia patients actually have some form of OC-like symptomatology? and (2) Might some of this group respond better if their OC symptoms were treated using adjunctive anti-obsessional agents rather than only adjusting or changing neuroleptics? Phenomenology and treatment observations will be described in detail.

No. 27E
A PROFILE OF OBSESSIVE-COMPULSIVE SYMPTOMS IN SCHIZOPHRENIA

Linda Porto, M.S.N., *Department of Research, Hillside Hospital, PO Box 38, Glen Oaks NY 11004;* Paul C. Bermanzohn, M.D., Samuel G. Siris, M.D.

SUMMARY:

Objective: Obsessive-compulsive (OC) symptoms and the schizophrenias often present as intertwined phenomena whose relationship remains poorly understood. The purpose of this research is to provide a detailed phenomenological description of OC symptoms in schizophrenia.

Method: Fifty chronic schizophrenia patients from a comprehensive New York outpatient treatment program were interviewed to make lifetime diagnoses of schizophrenia or schizoaffective disorder and for obsessive-compulsive disorder (OCD) using the Structured Clinical Interview for DSM-IV and the Yale-Brown Obsessive-Compulsive Scale symptom checklist.

Results: Forty-six percent (n = 23) evidenced clinically significant OC symptoms and 26% (n = 13) met criteria for OCD. Three distinct groups emerged: (1) patients whose OCD was unrelated to their psychotic symptoms; (2) patients whose OCD was related to, but not restricted to psychotic symptoms; and (3) patients whose OCD existed on a continuum with their psychosis. The last group tended to incorporate their OC symptoms into delusional beliefs during the active phase of illness and shift to OCD during full or partial remissions.

Conclusions: These findings support previous clinical constructs that OCD and schizophrenia are not always dichotomous disorders, but may be interconnected. Illustrative cases will be presented.

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2. Hwang MY, Opler LA: Schizophrenia with obsessive-compulsive features: Assessment and treatment. *Psychiatric Annals* 24:9;468-472.
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4. Fenton WS, McGlashan TH: The prognostic significance of obsessive-compulsive symptoms in schizophrenia. *Am J Psychiatry* 143:437-441, 1986.

SYMPOSIUM 28—CONTROVERSIES IN MANAGED CARE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be aware of specific areas of controversy and uncertainty related to managed psychiatric care. Attendees will have a greater understanding of the strengths and weaknesses of managed care and a more realistic vision of managed care systems of the future.

No. 28A
IS PRIVATE PRACTICE COMPATIBLE WITH MANAGED CARE?

Jay M. Pomerantz, M.D., *123 Dwight Road, Longmeadow MA 01106-1748;* Benjamin Liptzin, M.D., Alfred H. Carter, M.D., Michael S. Perlman, M.D.

SUMMARY:

This presentation describes a new multidisciplinary, private practice model called a Professional Affiliation Group (PAG).

At the heart of what we do is the PAG. That entity is by definition a small group of three to eight, fully licensed, independently practicing, mental health professionals of different disciplines. It includes at least one psychiatrist who functions as the PAG leader. Each psychologist, psychiatric social worker, psychiatric nurse, and psychiatrist maintains an office, autonomy, and full responsibility for his/her own patients. The PAG meets regularly, approximately every two to three weeks, to discuss problem cases, coordinate treatment, and to discuss cost control.

Our multidisciplinary organization of 15 PAGs has been in operation in Western Massachusetts for five years. It offers provider-managed mental health and substance abuse treatment under a capitation arrangement to the 67,000 members of an IPA/HMO. This past year has seen this "virtual group practice" move to a more permanent organizational status as the mental health private practice component of a large physician hospital organization (PHO). This not only meant that we kept our original HMO contract, but we also have additional patients coming to us from other HMOs and PPOs.

No. 28B
IS THERE A FUTURE FOR UTILIZATION REVIEW?

William M. Glazer, M.D., *Mass General Hospital, Harvard Univ. School of Med., Beach Plum Lane, Menemsha MA 02552;* Geoffrey V. Gray, Ph.D.

SUMMARY:

Since the 1970s, three tactics have intensified as efforts to contain costs have failed: shifting the economic risk from the payer to the provider, the use of organized service delivery systems, and utilization review (UR). In this presentation, consideration will be placed on the current and future value of UR. The presenter will describe a blueprint and a model UR tool to delineate current and future directions for UR. To date, many UR applications are still in prototypical forms, not having been subjected to the rigors of psychometric validation. More importantly, most mental health UR applications do not accurately allocate treatment intensity levels correlated to the presentation of the patient's condition. UR in capitated systems will not be external to the care, but will be integrated into the process of care itself. Thus, UR will no longer be a meta-assessment, but rather an internalized process, fully owned by clinicians. At this point, UR will have transformed into a "decision support" function where it will provide a means for internal continuous quality improvement by linking guidelines to outcomes.

No. 28C
WILL ACADEMIC PSYCHIATRY SURVIVE MANAGED CARE?

Thomas Carli, M.D., *Department of Psychiatry, University of Michigan, 900 Wall Street, Ann Arbor MI 48105;* Michelle Riba, M.D.

SUMMARY:

Academic psychiatry departments are undergoing massive forces of changes in each of their core missions: research, education, and clinical service. The very survival of academic departments is in question as they struggle to balance these often competing changes. This paper will review the changes in research funding and the emergence of "managed scholarship," the pressures managed care is imposing on resident education, and the necessary redesign of clinical services. The recent reorganizations of the University of Michigan Medical Center and health system can serve as a prototype for these changes. How do large academic health centers reduce costs, network and merge, shift into alternatives to inpatient, redesign traditional funding streams, and transform from a culture of "soloists" and "fiefdoms" into a "coordinated symphony" of true multispecialty group practice? And if these academic departments meet the challenges of managed care, how can education and research fit in? Special note will be made of how an academic psychiatry department can develop its own separate managed care behavioral health organization and the unique issues of having an academic department as one's own preferred provider.

No. 28D
CONSOLIDATION IN HEALTH CARE: IS BIGGER BETTER?

Anthony F. Buono, Ph.D., *Management, Bentley College, 175 Forest Street, Waltham MA 02154*

SUMMARY:

Strategic alliances between health care organizations are rapidly becoming a critical dimension of the industry's strategy as well as many reform initiatives. The question that lingers is whether such consolidation will actually lead to better health care. As critics of our business system have emphasized, bigness, in and of itself, does not necessarily translate into effectiveness and efficiency.

Although interfirm combinations offer organizations the opportunity to expand their product and service options beyond existing capabilities and current product-market domains, there is an inherent fragility in these interfirm agreements which makes them quite complex to manage. A basic problem associated with strategic alliances in general and health care alliances in particular is that many, if not most, managers and administrators are unfamiliar or uncomfortable with the problems and difficulties of managing in these interorganizational arrangements. Indeed, as recent experience is beginning to indicate, the effort to develop truly integrated health care services is a daunting challenge.

The presentation will examine some of the fundamental organizational and human resource concerns associated with typical consolidation strategies (mergers, acquisitions, joint ventures), and the general ramifications associated with facilitating successful health care alliances.

No. 28E
WHO WILL MANAGE THE MANAGERS?

Stephen J. O'Connor, Ph.D., *Business Administration, University of Wisconsin, PO Box 742, Milwaukee WI 53201*

SUMMARY:

Over the past decade, attention has centered on improving relations between physicians and health care managers. More recently, these relations have deteriorated as the amount, complexity, and pace of change in our health care environment have threatened to unravel this fragile working relationship. Improving these relations is critical, not only for the survival of any one health care organization or profession, but for the overall performance of the United States health system. Undoubtedly, it is in the best interest of managers and physicians to reexamine and modify the nature of their relationships so that they can prepare themselves to take advantage of the opportunities, as well as avoid the hazards, a changing health system will bring. This presentation will examine this relationship and ultimately attempt to answer the question posed in the title: "Who will manage the managers?" In doing so, we will first consider how this tempestuous and conflict-ridden association has evolved and speculate where it may be heading in the future. Next, we will explore the many obvious and not so obvious differences that exist between physicians and managers that have a bearing on the relation-

ship. Finally, suggestions will be advanced for improving manager-physician relations.

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SYMPOSIUM 29—SCHIZOPHRENIA: NEW RESEARCH

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The purpose of this symposium is to present the current clinical aspects of schizophrenia, including cognitive dimensions and brain imagery. At the conclusion, participants will be able to comprehend the rationale of this modern nosological construct, its limits, and the directions of future research, especially for etiology and treatment.

No. 29A
CLINIC OF SCHIZOPHRENIC'S THOUGHT DISORDERS, REVISITED: A COGNITIVE COMPREHENSIVE APPROACH

Marie-Christine Hardy-Bayle, M.D., *Department of Psychiatry, CHV-Versailles, 1 Rue Richaud, Versailles 78000, France;* Veronique Olivier, Yves Sarfati, Jean-Francois Chevalier, Christine Passerieux

SUMMARY:

Many studies have shown the nonspecificity and the imprecision of the Bleulerian concept of "associative loosening" (Cooper 1972, Andreasen 1979). Attempts were made to replace it with more precise diagnostic criteria, notably Schneider's first rank symptoms (1959). Nevertheless, schizophrenic patients clearly show specific communication disorders and we believe that communication disorder could remain an important diagnostic criterion of schizophrenia if it was described more precisely. The difficulty in describing specific communication disorders in schizophrenic patients could be due to the fact that current descriptions such as the Scale for the Assessment of Thought, Language and Communication Disorders (TLC, Andreasen, 1979) do not refer to a pathogenic dysfunction model that explains clinical symptoms. Taking up the Bleulerian view of a clinical description based on a pathogenic model, we propose a rating scale for the assessment of communication disorders in schizophrenic patients. The scale consists of clinical items that could be the direct expression of the three major hypotheses of cognitive dysfunction, which have been postulated to explain communication dysfunction in these patients. We assessed the frequency of the 16 items in the scale in a total of 80 subjects (43 schizophrenics, 27 affective disorders, and 10 normal control subjects) and performed a principal component analysis of the ratings of the schizophrenic patients assessed during an acute phase. The results of this study showed that this item schedule was specific to schizophrenic patients and, in particular, could statistically significantly discriminate schizophrenic patients from affective disorder patients with psychotic symptoms.

No. 29B
CHARACTERIZATION OF 500 SCHIZOPHRENIA PATIENTS TREATED IN 1996

Jean-Marie Vanelle, M.D., *SHU PR 100, Hospital Ste Anne, 1 Rue Cabanis, Paris 75014, France;* Christian Spadone, Marie-France Poirier, M.D., Jean-Pierre Olie, M.D., Dominque Attar-Levy, M.D.

SUMMARY:

In a previous study we have already analyzed sociodemographic and clinical parameters from a regularly treated population in 1993 of 300 schizophrenic patients. Some well-know data (e.g., schizophrenic subtype distribution by age and poor status of hebephrenic form) and some new data (e.g., good social insertion for half of the schizophrenic patients, relatively poor outcome parameters for paranoid subgroup) were described. A new study concerning the population of schizophrenic patients (according to the ICD-10), among our regulary treated out-population of 3,500 out- and inpatients, has been reconducted in 1996. Many sociodemographic and clinical parameters are being studied and analyzed (statistical analysis is performed by chi-square tests and correspondance analysis) by age, sex, marital status, employment, housing situation, social support, categorization of schizophrenia, type of follow-up during the year (hospitalization, number of consultations, etc), and type of treatment.

These results will be compared to those obtained in 1993 for the whole schizophrenic population and ICD-10 subgroups.

No. 29C
MULTIDIMENSIONAL MARKERS OF VULNERABILITY IN SCHIZOPHRENIA SPECTRUM

J. Dalery, M.D., *Centre Hospitalier Specialise, 95 Boulevard Pinel 69677, Bron Cedex, France;* B. Karoumi, M. Sauod, G. de Lamerie, T. d'Amato

SUMMARY:

Healthy siblings of schizophrenic patients share with patients some neurocognitive patterns that may well be markers of genetic vulnerability (Cannon et al., 1994; Nuechterlein et al., 1994).

The main objective of this study was to determine whether schizophrenics and their nonschizophrenic siblings have a similar pattern of neuropsychological deficit when compared with normal controls.

Thirty-five probands with schizophrenia, 20 of their nonschizophrenic siblings, and 20 unrelated normal individuals underwent a comprehensive neuropsychological test battery. This battery included the Continuous Performance Test, the Span Apprehension Task, and the Wisconsin Card Sorting Test.

Our results support the hypothesis that impaired information processing may serve as an indicator of genetic vulnerability to the disorder.

No. 29D
CLUSTERING AND SWITCHING ON VERBAL FLUENCY: COMPARISON BETWEEN SCHIZOPHRENIC AND HEALTHY SUBJECTS

Phillipe H. Robert, M.D., *Department of Psychiatry, Memory Center, Hospital Pasteur AV Voie Romain, Nice 06002, France;* Guy Darcourt, M.D., Valerie Migneco, J. Darcourt, M.D., M. Benoit, M.D., I. Chaix, M.D.

SUMMARY:

Several controlled studies of schizophrenia have demonstrated impaired verbal fluency; however, little is known about the underlying cognitive processes. We propose that two components of fluency performance are clustering and switching. Clustering represents the ability to organize output in terms of semantic or phonemic subcategories. Switching represents the ability to shift efficiently to a new subcategory. An extensive behavioral and neuropsychological battery including formal and semantic fluency tasks was administered to 78 schizophrenic subjects and 62 healthy subjects. First results indicated that: (1) in comparison with the control group, schizophrenic performances were significantly impaired for words generation / clustering / switching in semantic fluency and only for words generation / switching in formal fluency, (2) in the control group, switching was more highly correlated ($R = 0.904$, $P < 0.001$) than clustering with words generated on formal fluency. In contrast, performance at the semantic fluency task was more correlated with clustering ($R = 0.697$, $P > 0.001$). In the schizophrenic group, observation of clinical dimension (according to SANS and SAPS items) indicated that disorganized and negative dimensions were correlated with switching (formal fluency) and clustering (semantic fluency). Furthermore, there was no correlation with productive dimension. The present study suggests that clustering and switching are two dissociable components highly related to the total of words generated. The next step of the study will be to demonstrate, using SPECT with cognitive stimulation, that the switching component is related to frontal lobe functioning and the clustering component to both frontal-temporal functioning.

No. 29E
HEIGHT AND SCHIZOPHRENIA: RELATIONSHIP TO PREMORBID FUNCTION

Peg C. Nopoulos, M.D., *Department of Psychiatry, University of Iowa, 200 Hawkins Drive, Iowa City IA 52356;* Nancy C. Andreasen, M.D.

SUMMARY:

To evaluate global deficit in development and its relationship to premorbid function, height was compared in a large group ($n = 226$) of male schizophrenics and a group of healthy male controls ($n = 142$) equivalent in parental education and socioeconomic status. The mean height of the patients (177.0 cm) was significantly shorter ($p < 0.005$) than the mean height of the controls (179.4 cm).

Within the patient group, those in the lower quartile of height compared to the upper quartile had significantly poorer premorbid function as measured by (1) social relationships ($t = 2.46$, $p < 0.007$); (2) school performance measured by grades ($t = 1.81$ $p < 0.036$) and need for special education ($t = 1.78$, $p < 0.002$); and (3) estimate of premorbid VIQ using the NART ($t = 2.2$, $p < 0.02$). In addition, when the whole patient sample was analyzed these measures of premorbid function as well as a measure of motor development (age at which child first walked) correlated significantly with height.

These findings provide additional support for the hypothesis that schizophrenia may occur as a consequence of neurodevelopmental factors. Furthermore, this is manifested as a *global* deficit in growth and function resulting in smaller stature, slower motor development, poorer social skills and deficit in cognitive abilities.

No. 29F
A NEW CLASSIFICATION OF ANTIPSYCHOTICS BASED ON 5-HT2/D2 RECEPTOR IMAGING

Shitij Kapur, M.D., *Department of Psychiatry, The Clarke Institute, 250 College Street, Toronto ON M5T 1R8, Canada;* Gary Remington, M.D., Sylvain Houle, M.D., Robert B. Zipursky, M.D.

SUMMARY:

In a series of PET studies of dopamine D_2 (^{11}C-raclopride) and 5-HT_2 (^{18}F-setoperone) receptor occupancy we have observed that (1) "typical" neuroleptics bind mainly to the dopamine D_2 receptor and there may be a therapeutic window between 60% to 80% of D_2 occupancy, which may provide optimal antipsychotic response with limited Parkinsonian side effects; (2) the two "atypical" antipsychotics, clozapine and risperidone, both exhibit high 5-HT_2 occupancy (hence termed serotonim-dopamine antipsychotics or SDA); (3) while the D_2 occupancy of risperidone is similar to that obtained with typical antipsychotics, that of clozapine is clearly lower; (4) the neuroleptics with combined 5-HT_2/D_2 antagonism may lose their "atypical" properties if used in doses where their D_2 occupancy is too high.

We suggest that the word "atypical" antipsychotic is becoming too nonspecific and a clinically relevant classification based on *in vivo* pharmacological properties is needed. A classification based on neuroimaging data is presented wherein the "typical" neuroleptics are classified as "high-D_2", risperidone as a "high-D_2 SDA," and clozapine is a "low-D_2 SDA." The attributes and limitations of this classification and its value in understanding and classifying the newer antipsychotics will be discussed.

No. 29G
FOLLIES, DISCORDANTS AND SCHIZOPHRENIA (CHASLIN, 1912)

Marc L. Bourgeois, M.D., *199 Rue De St Genes, 33000 Bordeaux 00110, France 33400;* Marc Geraud, M.D., Thierry Haustgen, M.D.

SUMMARY:

French clinicians have long been ambivalent with, if not hostile to the construct of schizophrenia. There are several reasons for this, especially the creation of several nosological models or descriptive syndromes which have remained in popular use in France. In 1911, G. Ballet proposed the model of "psychose hallucinatoire chronique" (PHC), and in 1912, Ph. Chaslin described "folies discordantes" (both are still present in the professional vocabulary of French psychiatrists). E. Bleuler (1926) said that, would the term have existed in 1911, he could have chosen "folies discordantes" rather than "schizophrenia" to replace "dementia precox."

Initially, "discordance" was a pure descriptive concept, synonymous with incoherence, incongruence, bizarreness, strangeness, but it became more of a psychopathological explanation and a mechanism, like "dissociation," "spaltung," etc. In its two acceptations, "discordance" is still in use among French clinicians.

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SYMPOSIUM 30—CURRENT AND FUTURE TRENDS IN FORENSIC PSYCHIATRY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should have a well developed understanding of trends in therapist-patient boundary issues, sex offender statutes and treatment considerations, the psychiatrist's role in the criminal justice system, and challenges to confidentiality and privilege.

No. 30A
SEX OFFENDERS: CRIMINALS OR PATIENTS

Fred S. Berlin, M.D., *Department of Psychiatry, Johns Hopkins, 104 East Biddle Street, Baltimore MD 21202-2755*

SUMMARY:

The criminal justice system treats the income tax evader, the purse snatcher, and the individual afflicted with pedophilia similarly. Each should be punished and taught a lesson so that he will change his ways.

A psychiatric disorder such as pedophilia cannot be punished or legislated away. If a man goes into prison sexually attracted to children, prison cannot erase such attractions. If a man goes into prison having had difficulty successfully resisting unacceptable sexual temptations, prison cannot confer upon him the capacity to do so. Pedophilia, and the other paraphilic disorders, are every bit as much a public and mental health problem as they are a criminal justice issue.

God and/or nature has instilled within each one of us a number of powerful biological drives. Absent eating, the hungry man will die. Absent sexual behavior, the human race would die. It is important to eat and it is important to have sex. As Sigmund Freud pointed out, when the sexual drive, a drive that like all others recurrently craves satiation, is "aimed" in the wrong direction (e.g. toward children) proper treatment may be necessary to assist the afflicted individual. It is that drive, so invisible and unobservable, that can in the absence of proper treatment overcome the resolve to resist it. Appropriate professional intervention in the case of the paraphilic disorders should be done with an appreciation of differential diagnosis, ideological factors, the rationale underlying proper treatment, and the breadth of treatment options.

No. 30B
CONFLICTS IN CONFIDENTIALITY AND PRIVILEGE

Robert L. Sadoff, M.D., *Department of Psychiatry, University of Pennsylvania, Benjamin Fox Pavilion, Ste 326, Jenkintown PA 19046-3706*

SUMMARY:

Treating psychiatrists have always maintained the need for confidentiality of their patients' presentations in the course of therapy. Patients have depended upon their psychiatrists keeping their secrets in order to insure a basic trust in the doctor-patient relationship.

A recent United States Supreme Court case upheld the need for confidentiality in psychotherapy. However, there are instances in which the verbal communications and the records kept by psychiatrists on their patients, may be introduced into court hearings.

The American Psychiatric Association, in its Code of Ethics, has stressed that confidentiality is not equivalent to secrecy. Patients may waive their right to confidentiality or their privilege in the doctor-patient relationship by raising their mental state in a civil or criminal case. Patients may also waive their confidentiality or privilege during emergencies and if the patient threatens to harm a particular third person.

This presentation will highlight the risks for the treating psychiatrist when confidentiality and privilege may be waived either voluntarily or involuntarily by their patients. Helpful guidelines will be given to the practicing psychiatrist about the managment of confidential information given in the course of treatment.

Various cases will be presented as part of the general discussion highlighting the important issues affecting confidentiality in the psychiatrist-patient relationship.

No. 30C
CULPABLE MENTAL STATES AND THE PSYCHIATRIST

Michael M. Welner, M.D., *Department of Psychiatry, New York University, 58 East 79th Street #4R, New York NY 10021-0229*

SUMMARY:

Many regard mental health input as overly sympathetic to the offender, a glaring loophole—as much an impediment to justice as minor technicalities that cause charges to be dropped. Death penalty legislation provides additional ethical challenge to the role of the psychiatrist. Even when psychiatrists are retained by the prosecution, this is done primarily to refute or minimize psychiatric testimony presented by the defense. If psychiatry, the study of human behavior, cannot contribute to the court's understanding of both aggravating and mitigating factors equally, it is not an objective science to the criminal court.

It is true that many convicted felons are seriously mentally ill even if criminally responsible. Is there psychiatric information that should be considered as *aggravating* the offense? What implications does this have for the role of psychiatry in the criminal court?

No. 30D
BOUNDARY ISSUES

Thomas G. Gutheil, M.D., *Department of Psychiatry, Massachusetts Mental Hlth Cntr, 74 Fenwood Road, Boston MA 02115*

SUMMARY:

This presentation will address current controversies, current perceptions, and current craziness around the issue of boundaries. Both theoretical and risk management dimensions will be addressed.

REFERENCES:

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SYMPOSIUM 31—CLINICAL ASPECTS OF BPD
Joint Session with the American Academy of Psychoanalysis

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be familiar with the course of borderline personality disorder, its pharmacological, and psychotherapeutic treatment and its differential diagnosis in adolescents.

No. 31A
THE COURSE OF BORDERLINE DISORDERS

Michael H. Stone, M.D., *Department of Psychiatry, NYS Psychiatric Institute, 225 Central Park West, #114, New York NY 10024-6027*

SUMMARY:

The long-term course of borderline disorders has been studied primarily under the heading of borderline personality disorder (BPD) as defined by DSM (as reflected in the late 80's reports by Plakun, McGlashan, Stone, Paris, and Kroll). Wallerstein at Menninger's and Stone at Psychiatric Institute looked at outcomes in patients diagnosed by the broader criteria of Kernberg. BPD is actually a subset of Kernberg's Borderline Personality Organization (BPO). In the short term (< 5 yrs.) BPD patients are still usually functioning poorly. After 10 years from index hospitalization or after age 30, approximately two-thirds begin to improve in both social and occupational spheres. Factors contributing to better-than-group-average performance include high IQ, self-discipline, attractiveness, artistic talent, and ability to abstain from substance abuse. Negative factors include antisociality, chronic hostility, vengefulness, transgenerational incest history, parental brutality, and schizotypal traits. Similar results emerge from 10- to 30-year follow-up of BPD patients seen in private practice. Suicide rate in BPD is in the range of 3% to 9%. Patients with BPO, not meeting BPD criteria, are usually dysthymic, and have the highest recovery and the lowest suicide rates.

No. 31B
PHARMACOTHERAPY OF THE BORDERLINE PATIENT

Larry J. Siever, M.D., *Department of Psychiatry, Bronx VA Medical School, 130 West Kingsbridge Rd (116A), Bronx NY 10468*

SUMMARY:

The development of new, more easily tolerated antidepressants and mood stabilizers coupled with advances in our understanding of the neurobiology of personality disorders, have enabled the development of more effective pharmacotherapies for the borderline personality disorder patient. While treatment response may be less consistent and easy to gauge for Axis I disorder such as major depression, effective pharmacologic treatments have been described for three target symptom domains of borderline personality disorder: (1) comorbid Axis I disorders, particularly major depressive disorder; (2) impulsive aggression, including anger dyscontrol; and (3) affective instability. In borderline patients, the more favorable side effect profile of the newer antidepressants such as the SSRIs or related compounds has resulted in greater tolerability than the tricyclic antidepressants as well as reduced risk of fatal overdose. Furthermore, several studies suggest that the impulsivity and anger dyscontrol of borderline patients may be more ameliorated by SSRIs than the depressive symptoms themselves. As reduced serotonergic activity has been associated with impulsive aggression, SSRIs remain a beneficial pharmacotherapy for these disorders and double-blind trials of these agents are underway and appear to confirm preliminary open trials. A pilot study in our laboratory suggests that serotonergic responsivity at baseline may predict responsiveness to the SSRI fluoxetine. While affective instability has not been extensively studied in empirical trials in borderline patients, available data suggest that carbamezepine, valproate, and lithium may be effective in the affective dyscontrol associated with borderline personality disorder. While more double-blind control studies are needed in this area, available data suggest that pharmacotherapy can be a useful addition to the therapeutic armamentarium of the mental health professional treating the borderline patient.

No. 31C
ADVANCES IN PSYCHOTHERAPY OF PATIENTS WITH BPD

Harold W. Koenigsberg, M.D., *Department of Psychiatry, Cornell Med Center/NY Hospital, 21 Bloomingdale Road, White Plains NY 10605*

SUMMARY:

Within the last several years, a number of advances in the psychotherapy of borderline patients have been reported. Refinements have been proposed in the psychodynamic psychotherapy of borderline patients to address recurring complications in treatment. The strategy, tactics, and techniques of a psychodynamic supportive psychotherapy directed toward borderline patients have been articulated, and a cognitive-behavioral treatment program has been shown to be efficacious. The strengths and limitations of each psychotherapeutic approach have become clearer, leading to a more sophisticated rationale for treatment selection. Psychotherapy may be facilitated by the addition of medication, when the two modalities are carefully integrated. Patients who may not be able to utilize a particular form of therapy at one point may be able to do so later, after gains have been achieved through other modalities, or time has brought the patient to a more accessible place in the life cycle. Thus, some patients may not be able to engage in exploratory therapies initially, but may do so after work in other modalities has improved impulse control and anxiety tolerance. In selecting a treatment it may be helpful to do so from the point of view of its place in an overall treatment-career trajectory.

No. 31D
IS TODAY'S BORDERLINE ADOLESCENT TOMORROW'S BIPOLAR ADULT?

Clarice J. Kestenbaum, M.D., *Department of Psychiatry, NYSPI, 15 West 81st Street #14B, New York NY 10024-6022*

SUMMARY:

There is a spectrum of affective disorders associated with positive family history (increased genetic loading.) Researchers have observed specific traits common to cyclothymic and borderline adolescents who subsequently develop bipolar disorder (irritability, explosive anger, impulsivity, dysphonia, restlessness, boastfulness, stimulus seeking, substance abuse.) Bipolarity in adolescence has been found to be comorbid with ADHD, conduct disorder, anxiety disorder, OCD, MDD, and BPD.

Siever and Davis have described phenomenologically corresponding Axis I and Axis II disorders. (The dimension impulsivity/aggression resulting in impulsive disorders as well as dramatic cluster as personality disorders such as BPD, they suggest, is mediated by seritoninergic systems, while affective instability leading to major

affective disorder and dramatic cluster disorders is mediated by the cholinergic system.)

In adolescents predisposed to bipolar disorder there is an interruption of normal development resulting in disturbed interpersonal relations, impaired sense of identity, inability to understand, and emotional strong affects. Maladaptive behaviors are often labeled "borderline" before manic-depressive illness is diagnosed. Treatment strategies using a dual track approach are suggested.

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SYMPOSIUM 32—LATE-LIFE DEPRESSION: A DISTINCT ENTITY?

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The clinician will learn about the theoretical and treatment implications of the data that demonstrate that late life-depression is significantly different than depression in younger patients.

No. 32A
TREATMENT RESPONSE TO ANTIDEPRESSANTS IN YOUNGER VERSUS OLDER PATIENTS

Per Kragh-Sorensen, M.D., *Department of Psychiatry, Odense University Hospital, JB Winslowvej 20, Odense DK 5000, Denmark*

SUMMARY:

The type and severity of depressive syndromes influence treatment approaches. Depressions of greater severity, with melancholia, delusions, or active suicidal ideation or plans require hospitalization. Characteristically this group of patients is not included in most clinical trials today. The controlled efficacy studies with newer antidepressants have been carried out on outpatients with mild to moderate, often nonmelancholic depression. From these trials it is concluded that both younger and elderly patients respond to various antidepressant medications during acute treatment, but the relative efficacy of the specific medications is unclear.

However, in four controlled clinical trials carried out over more than a decade, we found that the newer antidepressants paroxetine, citalopram, and moclobemide (reversible monoamine oxidase inhibitor), were less effective than the tricyclic antidepressants (TCAs), clomipramine and nortriptyline. The studies involve 461 hospitalized depressed patients (age 20-90 years). Three of the trials were carried out by the Danish University Antidepressant Group (DUAG). The fourth trial was an international multicenter study. According to DSM-III and DSM-III-R, the patients had a major depression and predominantly melancholic major depression.

In this particular group of inpatients we found no clinically significant difference in profile of symptomatology, when comparing younger and elderly patients. The treatment response rate was independent of age. In our opinion these results may have the consequence that TCAs will remain the drug of choice in cases of moderate to severe melancholic major depression. Prospective studies have yet to come.

No. 32B
PHENOMENOLOGY OF DEPRESSION IN YOUNGER VERSUS OLDER PATIENTS

Kurt B. Stage, M.D., *Department of Psychiatry, Odense University Hospital, JB Winslowsvej 20, Odense DK 5000, Denmark*

SUMMARY:

Depression is the most prevalent psychiatric disorder in the elderly. Several studies indicate that 10% to 15% of persons over 65 years suffer from significant depressive symptoms. Despite the high prevalence, most cases of depression in the elderly remain unrecognized and untreated. Why so many depressions in the elderly remain unrecognized and untreated is unknown. Reports concerning the psychopathology of elderly depressed patients are inconclusive. It is often stated that the depressive symptoms differ between elderly and younger depressed patients and that these symptomatic differences result in difficulty, and often failure, in diagnosing depression in the elderly.

To compare symptomatology and diagnostic profile between younger and elderly major depressed patients, data from four clinical trials—involving 461 hospitalized depressed patients—were analyzed stepwise by principal component analyses, latent structure analyses, and single item analyses. No clinically significant difference in profile of severity was found. The DSM-IV concept of major depression refers to symptoms independent of age. Age seems to have no influence on the diagnostic aspect of depression as measured on the Newcastle (1965) Scale. Our findings support an algorithm of melancholic depression as having distinct quality of depression as the most valid item: the presence of this item in the absence of severe psychosocial stressors, personality disorders, anxiety, and outward aggression.

No. 32C
DYSTHYMIC DISORDER IN THE ELDERLY

Davangere P. Devanand, M.D., *Department of Psychiatry, New York State Psychiatric, 722 West 168th Street, Box 72, New York NY 10032-2603;* Mitchell S. Nobler, M.D., Steven P. Roose, M.D., Harold A. Sackeim, Ph.D.

SUMMARY:

Of 224 consecutive elderly outpatients seen in a late life depression clinic, 40 (17.9%) met criteria for dysthymic disorder. The gender distribution was equal, and major stressors were common. The mean age of onset of dysthymia was 55.2 years, with an average illness duration of 12.5 years. Early-onset (< 21 years, 2.5%) and secondary dysthymia (2.5%) were rare. A history of major depression earlier during the course of dysthymic illness (17.5%), comorbid anxiety disorders (12.5%), and personality disorders (10%) were relatively uncommon. These data suggest that elderly dysthymics differ from young adult dysthymics, who are mostly female with an early onset and frequently have comorbid Axis I and Axis II disorders. Most elderly dysthymics do not appear to be young dysthymics who simply grew older.

In a second study, 23 elderly outpatients with dysthymic disorder participated in a 13-week, single-blind fluoxetine trial. Twelve of 20 dysthymic patients were responders (60%). Responders received open continuation treatment and subsequently discontinued fluoxetine (mean 32 weeks on medication). During the 24 weeks following discontinuation, 6 of the 12 patients relapsed. Clinical features, dose, and duration of fluoxetine treatment were not predictive of relapse.

These pilot data support the utility of SSRIs in the treatment of dysthymic disorder in the elderly. The 50% relapse rate following discontinuation suggests the need for clinical caution if discontinuation is being considered in elderly dysthymics following treatment response to SSRIs.

No. 32D
AGE AND ANTIDEPRESSANT MEDICATION

B. Timothy Walsh, M.D., *Clin. Psychopharmacology, NY State Psychiatric Institute, 722 West 168th Street, Unit 98, New York NY 10032-2603*

SUMMARY:

Introduction: It is commonly believed that although older individuals may be more vulnerable to side effects, the indications for antidepressant medication and the nature of their side effects are similar across the lifespan.

Methods: Literature review and preliminary data from an ongoing study of tricyclic antidepressants (TCAs).

Results: Despite the long-established efficacy of medication in the treatment of major depression in adults, only a single, recent study has suggested that antidepressants are useful for depressed children and adolescents. The side effects of TCAs also appear to differ in younger individuals: while in older subjects, TCAs are associated with orthostatic hypotension and weight gain, in younger subjects, TCAs may cause substantial increases in heart rate, a rise in lying blood pressure, and mild weight loss. While these differing effects may reflect differences in the diagnoses of the patient populations, there is reason to believe that age-related changes in the autonomic nervous system may underlie some of the age-related changes in the effects of medications.

Conclusions: Age appears to have a major impact on both the benefits and the side effects of psychotropic medications.

No. 32E
OUTCOMES OF GERIATRIC DEPRESSION

George S. Alexopoulos, M.D., *Department of Psychiatry, Cornell University Medical Col, 21 Bloomingdale Road, White Plains NY 10605*

SUMMARY:

Age-related clinical characteristics may influence the course of depression. We have observed that elderly depressives have a similar recovery rate as that of younger adults. However, late onset of first depressive episode was the strongest predictor of chronicity in the elderly, while weak social support best predicted chronicity in younger depressives. Depression with onset during senescence includes a large group of patients in whom medical and neurological disorders play an important role. Impaired medical health and dementing disorders have been found to trigger depression or worsen its course. Moreover, we have reported that neuroradiological are associated with poor response to antidepressants. We speculate that latent medical or neurological disorders contribute to the low recovery rate observed in late-onset depression. The lack of a relationship between social support and recovery in the elderly suggests that depression may become autonomous and less responsive to psychosocial factors with increasing age.

In geriatric populations, the likelihood of recurrence is increased in patients with a history of frequent episodes, anxiety after discontinuation of antidepressants, intercurrent medical illnesses, lifetime history of myocardial infarction, and high severity of depression. These findings underscore the role of medical, and particularly cardiovascular illnesses, on the long-term course of geriatric depression.

We have observed that 43% of elderly depressives with an initially reversible dementia had a 4.7 times higher chance to develop permanent dementia on follow-up than geriatric depressives who were cognitively unimpaired during the initial episode. Depressives with reversible dementia had late age of illness onset, psychomotor retardation, and delusions. We also reported an association between late-onset depression and neuropsychological, brain CT, and MRI abnormalities as well as development of dementing disorders on follow-up. Taken together these findings suggest that late-onset, severe, retarded, and delusional geriatric depression, associated with reversible dementia is a syndrome that often progresses to dementia. This clinical presentation differs from the benign "pseudodementia" described in middle-aged adults. Beyond their clinical significance, these observations suggest that the factors that determine the outcomes of geriatric depression are different than those of younger adults.

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SYMPOSIUM 33—NEW ANTICONVULSANTS IN MOOD DISORDERS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be familiar with the clinical utility of two newly released anticonvulsants, gabapentin and lamotrigine. These anticonvulsants will be reviewed from the standpoint of pharmacology and pharmacokinetics, clinical efficacy, and neurobiology.

No. 33A
PHARMACOLOGY AND PHARMACOKINETICS OF NEW ANTICONVULSANTS

Terence A. Ketter, M.D., *Dept Psych & Behav Sci, Stanford Univ. School of Med., Building 10, Room 3N-212, Stanford CA 94305-5543;* Mark A. Frye, M.D., Gabriela Cora-Locatelli, M.D., Timothy A. Kimbrell, M.D., Robert M. Post, M.D.

SUMMARY:

Three new anticonvulsants, felbamate (FBM), gabapentin (GBP), and lamotrigine (LTG), have been marketed in the United States, and several more are in development. These agents have varying mechanisms, metabolism, drug interactions, and adverse effects. Two important complementary mechanisms are enhancing GABAergic inhibition and suppressing glutamatergic excitation. FBM has antiglutamatergic, GABAergic, and sodium channel blocking properties. FBM is metabolized to inactive and glucuronide metabolites, and has hepatically mediated drug interactions. As FBM can cause aplastic

anemia and fatal hepatitis, its use is restricted to refractory epilepsy. GBP is a substrate and inhibitor of the large neutral amino acid carrier system, and blocks sodium channels. GBP is excreted unchanged in the urine and lacks hepatically mediated drug interactions. GBP may cause sedation, dizziness, and ataxia. Lamotrigine decreases glutamate release, and blocks sodium channels and 5HT3 receptors. LTG is metabolized to inactive glucuronides, and has hepatically mediated drug interactions. LTG may cause rash, headache, and sedation. Anticonvulsants in development include vigabatrin, tiagabine, and topiramate. Knowledge of the pharmacology and pharmacokinetics of new anticonvulsants is required for optimal therapeutics, should these agents be combined with psychotropics in epilepsy or treatment-resistant affective illness, or with other (nonpsychotropic) drugs in patients with medical comorbidity.

No. 33B
LAMOTRIGINE IN BIPOLAR DISORDER: PRELIMINARY DATA

Joseph R. Calabrese, M.D., *Department of Psychiatry, Case Western Research, 11400 Euclid Avenue, Ste 200, Cleveland OH 44106-3986;* Charles L. Bowden, M.D., Susan L. McElroy, M.D., John Cookson, M.D., John Anderson, M.D., Linda J. Rhodes, M.D., Mark J. Woyshville, M.D., Paul E. Keck, Jr., M.D., Sara Kundu, M.D., Carolyn Bolden-Watson, Ph.D., John A. Ascher, M.D., Gillian Paterson, Ph.D.

SUMMARY:

Although lithium possesses moderate to marked antimonic efficacy, its antidepressant properties are recognized as inadequate. Lamotrigine (LTG) is indicated as treatment for partial seizures and believed to possess mood stabilizing prophylaxis properties, particularly antidepressant effects. To evaluate this possibility, 67 patients with treatment refractory bipolar disorder underwent an open prospective six-month trial of either LTG add-on or monotherapy (mean exposure, 72 d). The 31-item Hamilton Depression Rating Scale (HAM-D), the SADS-C Mania Rating Scale (SADS-C MRS), the Global Assessment Scale (GAS), and the Clinical Global Impressions (CGI) Scale were completed every two-to-four weeks. Of the 39 patients who presented in the depressed phase, the mean baseline total HAM-D was 31.5 ± 9.2 and decreased to 18.0 ± 15.2 ($P < 0.0001$). Nine patients (23%) exhibited moderate improvement and 18 (46%) marked improvement; 28 remain on LTG. The baseline GAS was 49.4 and improved to 57.4 and the CGI-severity was 4.7 and decreased to 3.6. Mean CGI-improvement was 2.9. Of the 10 depressed patients who received monotherapy, none were moderate responders and five marked. Of the 25 patients who presented in hypomanic/manic/mixed, the baseline SADS-C MRS decreased from 21.1 ± 8.0 to 8.0 ± 9.9 ($P < 0.0001$). Four patients (16%) exhibited moderate improvement in the SADS-C and 15 (60%) marked improvement. Evidence from this ongoing trial suggests lamotrigine possesses a broad spectrum of efficacy in bipolar disorder including hypomania, mania, mixed states, and depression.

No. 33C
GABAPENTIN AND LAMOTRIGINE MONOTHERAPY IN MOOD DISORDER

Mark A. Frye, M.D., *BPB, NIMH, Building 10, Room 3N212, Bethesda MD 20892;* Terence A. Ketter, M.D., Timothy A. Kimbrell, M.D., Gabriela Cora-Locatelli, M.D., Robert T. Dunn, M.D., Robert M. Post, M.D.

SUMMARY:

There is a pressing need for new management options in mood disorders as many patients are commonly seen with illness refractory to conventional mood stabilization treatments, either alone and in various combinations. In this paper, we discuss the emerging evidence that lamotrigine and gabapentin, two drugs recently approved as adjunctive treatment for partial epilepsy, hold promise as adjunctive or alternative therapies for patients with mood disorder.

After a double-blind, two-week washout period, patients with refractory mood disorders received, in a randomized double-blind trial, either gabapentin monotherapy, lamotrigine monotherapy, or placebo for six weeks with two subsequent crossovers so that each individual would receive all three blinded agents. As disease polarity may influence response, both unipolar and bipolar mood disorder patients were studied.

The primary outcome measures were the Clinical Global Impression (CGI-BP), and Life Chart Methodology (LCM). The preliminary monotherapy response data to date (based on a CGI-BP rating of moderate or marked improvement) for lamotrigine was 53% and for gabapentin was 43%. Further response data by diagnostic subtype will be presented.

This preliminary evidence of clinical efficacy suggests that lamotrigine and gabapentin may ultimately become important additions to the mood disorder pharmacopoeia.

No. 33D
NEUROIMAGING OF RESPONSE TO NEW ANTICONVULSANTS

Timothy A. Kimbrell, M.D., *BPB, Nat'l Inst of Mental Health, Building 10, Room 3N-212, Bethesda MD 20892;* Terence A. Ketter, M.D., Mark A. Frye, M.D., Aimee L. Danielson, B.A., Brenda E. Benson, M.S., Robert M. Post, M.D.

SUMMARY:

Our group has previously reported fluorine-18 deoxyglucose (FDG) scan data demonstrating differential regional cerebral metabolic glucose utilization (rCMRglu) patterns in a heterogeneous mood disorder patient population who responded to carbamazepine and the calcium channel blocker, nimodipine. We have prospectively collected baseline placebo FDG scans prior to entry into a randomized, double-blinded, placebo-controlled study of the anticonvulsants lamotrigine and gabapentin in a refractory mood disorder population. Additionally, we are obtaining 5 oxygen-15 water scans during a passive introspection task at the end of each medication/placebo trial.

This combined approach allows for comparison of patient placebo rCMRglu and cerebral blood flow (CBF) versus a matched control group, and the assessment of significant CBF changes and their relationships to drug effects and clinical response within individual patients throughout the study period. Making use of individual scan data will be of benefit in better defining subgroups in a heterogenous patient population and better defining response prediction to these two promising agents.

Preliminary analysis of these data obtained by performing a voxel-by-voxel t-test demonstrated that responders to lamotrigine or gabapentin compared to controls have decreased rCMRglu ($p < .005$) in bilateral superior temporal regions, right insula, left dorsolateral prefrontal cortex, and the left inferior parietal region. Increases in rCMRglu ($p < .005$) were found in bilateral medial temporal regions (amygdala/hippocampus), brainstem, right caudate, bilateral thalamus, and bilateral occipital regions. Analysis of individual patient rCBF over the course of the study is currently underway.

This approach to neuroimaging should provide further insights into mood disorders, particularly regarding illness subtypes and therapeutic response markers.

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SYMPOSIUM 34—MANAGING ANXIETY DISORDERS: PHARMACOLOGIC ADVANCES

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to effectively treat panic disorder, obsessive-compulsive disorder and social phobia with newer pharmacologic agents. In addition, the participant should be able to recognize and manage side effects of newer antidepressant agents.

No. 34A
SOCIAL PHOBIA: CURRENT TREATMENT STRATEGIES

James W. Jefferson, M.D., *The Dean Foundation, 8000 Excelsior Drive, Madison WI 53717*

SUMMARY:

Social phobia is a prevalent, yet underrecognized and undertreated condition. The National Comorbidity Survey found a 12-month prevalence of 7.9% and a lifetime prevalence of 13.3% for this condition. Historically, alcohol has played a central role as a social lubricant and as self-medication for social phobia. More recently, other pharmacotherapies have been subjected to scientific scrutiny and have emerged as effective and safe treatments. Most, but not all, studies of beta blockers have found them to be useful for performance anxiety, but less so for generalized social phobia. Clonazepam has been beneficial as a short-term (double-blind study) and long-term (open study) treatment, but whether these results can be generalized to benzodiazepines as a class is unclear. While monoamine oxidase inhibitors are effective drugs for social anxiety, their difficulty of use (phenelzine, tranylcypromine) or unavailability (brofaromine, moclobemide) have made them less preferred. Benzodiazepines, particularly clonazepam, outshined placebo both as effective treatments. The SSRIs, however, are emerging as treatments of choice for generalized social phobia based on results of both open and double-blind studies. Cognitive behavior therapy is a well established intervention both alone and together with medication. More often than not, at least one other psychiatric disorder coexists with social phobia. Given the high prevalence of comorbid conditions, treatment combinations are often the preferred routes to success.

No. 34B
ADVANCES IN THE PHARMACOTHERAPY OF PANIC DISORDER

Peter P. Roy-Byrne, M.D., *Department of Psychiatry, Univ of WA/ Harborview Med Cntr, 325 Ninth Avenue, Box 359911, Seattle WA 98104*

SUMMARY:

The mainstays of pharmacologic treatment of panic disorder have been, in order of historic and chronologic development, tricyclic antidepressants and MAO inhibitors in the 1960's and 1970's, high potency benzodiazepines in the 1980's and, more recently, in the 1990's, selective serotonin reuptake inhibitors (SSRIs). Controlled studies now support the previously reported anecdotal efficacy of SSRIs, while anecdotal reports now suggest efficacy for both venlafaxine and nefazodone. Despite widespread public and clinician education, barely 50% of the most symptomatic patients received optimal pharmacotherapy in a recent study. Newer antidepressants have increased patient adherence due to their greater tolerability, and meta-analytic reviews suggest they may provide greater efficacy than older agents due to a broader spectrum of action. One study of longer term treatment with paroxetine suggests greater sustained tolerability defined by lower side effects than in the acute phase and reduced patient dropout compared with earlier tricyclic studies. Whether SSRIs will improve the long-term course of panic disorder, which has been characterized by clear residual symptomatology despite noticeable improvement, remains to be seen. The comparable, and in some studies greater efficacy of cognitive-behavioral treatment (CBT) compared to tricyclics and benzodiazepines must now be re-evaluated using these new and more powerful and tolerable agents. Consistent with this caveat, a recent study with fluvoxamine did suggest greater medication efficacy compared with CBT.

No. 34C
OCD: UPDATE ON PHARMACOLOGICAL MANAGEMENT

Teresa A. Pigott, M.D., *Department of Psychiatry, UTMB at Galveston, 4442 Graves Blg/301 Univ. Blvd, Glaveston TX 77555*

SUMMARY:

Epidemiological surveys indicate that the anxiety disorder, obsessive-compulsive disorder (OCD), is the fourth most common psychiatric illness in the U.S. Characterized by a chronic, but fluctuating course, OCD is frequently complicated by comorbid conditions such as mood and/or additional anxiety disorders. Separate multicenter, placebo-controlled trials of the serotonin reuptake inhibitors (SRIs) clomipramine, paroxetine, fluoxetine, sertraline, and fluvoxamine have established their efficacy in the treatment of OCD. Direct comparisons of SRIs suggest similar efficacy, but reduced tolerability, for clomipramine in comparison to fluoxetine, fluvoxamine, sertraline, and paroxetine in patients with OCD. Unfortunately, most patients achieve only partial symptom reduction (mean improvement, 25% to 40% from baseline) despite adequate SRI trials. Results from controlled trials of adjuvant lithium, buspirone, or thyroid hormone added to ongoing SRI therapy in OCD have been disappointing. However, a controlled study suggests that OCD patients with comorbid tic disorder preferentially respond to neuroleptic augmentation. These and associated studies will be presented in this symposium, as well as an overview of strategies for OCD patients who fail to respond to conventional pharmacotherapeutic interventions.

No. 34D
ADVERSE EFFECTS OF NEWER ANTIDEPRESSANTS

Krishna Das Gupta, M.D., *Citadel Psychiatric Clinic, 2001 Reed Road, Fort Wayne IN 46815*

SUMMARY:

During the last decade, antidepressant options have greatly expanded. Seven new antidepressants (i.e., bupropion, fluoxetine, nefazodone, mirtazapine, paroxetine, sertraline, and venlafaxine) with

milder side effects and lower therapeutic indices than MAOIs and TCAs have become available. Several newer antidepressants, particularly the SSRIs, have shown great promise in the treatment of anxiety disorders.

Side effect profiles differ not only across classes of antidepressants, but within the same class. Gastrointestinal upset, headache, and sexual dysfunction, caused by several new antidepressants, may result from serotonergic mechanisms. Many newer agents cause sedation and/or activation. Newer antidepressants also differ in their effects on cytochrome P450 isoenzymes. Fortunately, strategies that minimize most adverse effects and drug interactions are available. Awareness of such strategies enables clinicians to optimize compliance.

In summary, side effects of newer antidepressants are generally mild and can be effectively minimized with appropriate management. Individuals suffering from anxiety disorders may be more likely to seek and accept treatment now that these effective and well-tolerated medications are available.

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SYMPOSIUM 35 ELDERLY PERSONS WITH PSYCHOSIS IN THE COMMUNITY Joint Session with the American Association of Community Psychiatrists

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation the participants will be able to describe a model for measuring subjective well-being of SPMI elderly persons. They will be able to describe unmet service needs of a sample of SPMI elderly people and will be able to choose among psychopharmacological approaches helpful with this population. They will be aware of alternative ways of providing services in a variety of residential settings.

No. 35A
SUBJECTIVE WELL-BEING AMONG OLDER PATIENTS WITH SCHIZOPHRENIA

Carl I. Cohen, M.D., *Department of Psychiatry, SUNY Health Sciences Center, 450 Clarkson Avenue, Brooklyn NY 11203*

SUMMARY:

Despite a projected doubling of the aging schizophrenic population over the next 30 years, the mental health system is ill prepared to address their needs. A key question in gerontology is whether treatment and service interventions can improve subjective well-being (SWB) and quality of life. This paper examines a theoretical model of SWB using 117 older community-dwelling persons with schizophrenia (*m* age = 63) whose disorder began before age 45. We identified five significant predictors of SWB: male gender, absence of loneliness, older age, perceived reliability of social contacts, and fewer perceived life difficulties. The model was significant ($p < .001$) and correctly classified 79% of cases. The data supported the judgment theory of SWB, which theorizes that SWB is based on self-comparisons with one's age peers and past status. While a comparison with the general older population indicated that the sample was substantially worse off on several objective indicators of well-being—e.g., income, depression, physical limitations, network size—none of these variables were predictors of SWB. This does not mean that these objective conditions shouldn't be improved, and indeed, several of these variables are significant predictors of clinical depression in this population.

No. 35B
COMMUNITY SERVICE NEEDS OF SEVERE AND PERSISTENT MENTALLY ILL ELDERLY

Stephen J. Bartels, M.D., *Department of Psychiatry, NH-Dartmouth Res CT, 2 Whipple Place, Ste 202, Lebanon NH 03766-1360*

SUMMARY:

Objective: Little is known about the service needs of elderly with severe and persistent mental illness (SPMI), who will dramatically increase in number over the coming decades. This presentation summarizes a state-wide assessment of mental health service needs for older adults with SPMI.

Method: Descriptive and clinical ratings (BPRS, Mini Mental State Examination, functional ratings) and service data were collected on a random sample of 532 mentally ill elderly in New Hampshire.

Results: Seven percent of those served accounted for 70% of the services provided. Residential settings included 52% home or apartment, 19% residential care, and 29% in institutional long-term care. Assessments found that many in nursing homes had cognitive impairment or extensive personal or behavioral care needs, but approximately one third were less impaired and could be served in less intensive settings. However, adequate community-based services were lacking. The greatest unmet needs were in supported group home settings, psychiatric nursing, family support services, partial hospitalization, and substance abuse treatment. Overall, the greatest single service gap was in home-based services.

Conclusions: We found an over-reliance on institutional care for elderly with SPMI. However, traditional office-based services are inadequate to address the needs of this vulnerable population. Implications for health policy are discussed.

No. 35C
NEUROLEPTIC MAINTENANCE TREATMENT IN THE ELDERLY

M. Jackuelyn Harris, M.D., *Department of Psychiatry, Veterans Affairs Medical Cntr., 3350 La Jolla Village Drive, San Diego CA 92161;* Jane S. Paulsen, Ph.D., Jonathan P. Lacro, Pharm.D., Enid Rockwell, M.D., Dilip V. Jeste, M.D.

SUMMARY:

Introduction: Longitudinal studies of elderly patients have found that there may be a decrease in positive symptoms over time. This change in psychopathology, along with physiologic changes of aging (affecting pharmacokinetics and pharmacodynamics) complicate the evaluation of maintenance therapy in the elderly. We conducted a study to safely determine the lowest effective neuroleptic dosage in older psychotic patients and evaluate the clinical, neuropsychological, and psychosocial effects of neuroleptic dosage reduction.

Methods: 22 patients with schizophrenia and related psychotic disorders over the age of 45 who met DSM-IV criteria for "in remission" were compared to age and education matched patients who were currently off neuroleptics (n = 26) or maintained on neuro-

leptics (n = 28). The patients were assigned to either a 100% or a 50% taper group and had their dosage decreased by 25% each month if no worsening of symptoms occurred. All groups were followed for 11 months.

Results: 29% of patients in the taper group, 8% of neuroleptic free patients, and 0% of the maintenance group experienced some increase in psychopathology over the follow-up period. Patients treated with neuroleptics (taper group and maintenance group combined) were maintained on approximately 60% of their original neuroleptic dosage after stabilization without an increase in psychopathology.

Conclusion: Carefully selected older psychotic patients can be maintained on reduced dosages of neuroleptic medication without a significant increase in psychopathology. Neuropsychological and psychosocial findings will be discussed.

No. 35D
COMMUNITY-DWELLING ELDERS WITH PSYCHOSIS

Ray R. Raschko, M.S.W., *Elder Services, Spokane Mental Health, 5125 North Market, Spokane WA 99207*

SUMMARY:

Late-onset schizophrenia or the original term, paraphrenia, is used to describe individuals with a late onset of delusions and hallucinations characterized by a predominance of paranoid symptoms.

Elder Services is designed to locate, evaluate, and provide in-home treatment and services to high-risk community dwelling elders 60 years of age and older. A gatekeeper case-finding component was created to locate those isolated elders who do not have a support system to refer them. Gatekeepers include utility company employees, apartment managers, police and sheriff, postal workers, bank employees, cable television staff, and code enforcement staff among others. The majority of persons exhibiting symptoms of late-onset schizophrenia are referred by these sources.

An interdisciplinary team of clinical case manager, psychiatric nurse, and psychiatrist respond in-home and attempt to provide treatment and services. This particular group of elders present unique problems in engagement and service provision. The community response to them is often the initial focus of the team.

This presentation will cover all of the above including research data and service delivery issues.

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SYMPOSIUM 36—TERRORISM AND VIOLENCE: PERPETRATORS AND SURVIVORS
Joint Session with the International Society of Political Psychology, the APA Corresponding Task Force on National and International Terrorism and Violence, and the APA Council on International Affairs

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participants should be able to understand the psychological characteristics of perpetrators of political violence, including terrorists, torturers, and leaders of genocidal conflict; the psychological consequences of extreme political violence for the survivors; and the implications for intervention and treatment.

No. 36A
PSYCHIATRY AND ETHNIC CLEANSING IN YUGOSLAVIA

Kenneth B. Dekleva, M.D., *Department of Psychiatry, University of TX Southwestern, 5323 Harry Hines Boulevard, Dallas TX 75235;* Jerrold M. Post, M.D.

SUMMARY:

Radovan Karadzic, indicated in 1995 as an international war criminal on charges of genocide and crimes against humanity, is the most notorious psychiatrist turned politician in the former Yugoslavia. But other leading psychiatrists, both Serb and Croat, have also played important roles as activists and apologists for ethnic violence. While Karadzic's published poetry contains a vision of destructive, violent nationalist themes fused with personal myth of heroic leadership, the writings of other psychiatrists emphasize the psychodynamics of various ethnic groups in the former Yugoslavia, and contain rationalizations which have found their way into propaganda used to incite feelings of victimization leading to genocidal violence.

This talk will examine the careers of several of these physician-*cum*-politicians, and shed light upon the ethical dilemmas inherent in the shifting of role from physician to nationalist political activist. A unique aspect of the destructive political violence in the former Yugoslavia pertains to the disturbing role of psychiatric elites.

No. 36B
BOSNIAN SURVIVORS: MEMORIES AND WITNESSING AFTER DAYTON

Stevan M. Weine, M.D., *Department of Psychiatry, University of IL at Chicago, 1601 West Taylor Street, #423S, Chicago IL 60612*

SUMMARY:

The efforts at making peace in Bosnia requires the military and political structures set in Dayton, but must also involve psychologically informed approaches to the memories of ethnic cleansing that are left with survivors. The call for addressing survivors' memories in the peace work is made more urgent given that the communist government of the former Yugoslavia stifled survivors' memories from World War II in favor of a state-scripted narrative that served the state's interests in consolidating political power. Bosnian survivors of ethnic cleansing want the knowledge gained by virtue of their wonderful and horrific odyssey through history to contribute to an understanding that best protects the present and the future. Witnessing offers an interdisciplinary approach to working with survi-

vors' memories that can assist the self and encourage developing a civic dialogue and constructing a historical memory in support of peace, pluralism, and democracy. Central to this process is redefining merhamet, which was a self and group concept that was central to living in multi-ethnic Bosnia. What conditions has the Dayton partition created for dealing with the dilemmas of memory concerning genocide? What kinds of memory work must now be done in order to write a new kind of history that best furthers peace and recovery?

No. 36C
THE ROOTS OF MASS VIOLENCE

David A. Rothstein, M.D., *Department of Psychiatry, Swedish Coveant Hospital, 2851 West Bryn Mawr, Chicago IL 60659*

SUMMARY:

Hopes for a more tranquil world after the end of the cold war have been disillusioned, as we have seen an increase in terrorism and ethnic and racial violence. The exploitation by demagogues of the identification and generation of enemies has been an effective means of consolidating individual, group, ethnic, and national identity. That the loss of the superpower rivalry produced a search for new enemies, internal and external, is not surprising. These understandings of the roots of mass violence are increasingly being incorporated by behavioral scientists into interactive conflict resolution techniques in such areas as the Caucasus, the Middle East, and Bosnia. While the outlook is for continuing ethnic/nationalist conflict, the applications of newer understandings of the roots of mass violence offer promise for finding and applying processes other than violent conflict to long-standing ethnic rivalries.

No. 36D
PORTRAIT OF A RADICAL PALESTINIAN TERRORIST

Jerrold M. Post, M.D., *Political Psychology, George Washington University, 2013 G Street, NW, Ste 202A, Washington DC 20052*

SUMMARY:

This psychological portrait of a member of the Abu Nidal organization, considered the most violent of the radical Palestinian terrorist groups, is based on eight hours of interviewing, review of extensive court documents, and the subject's own testimony in association with the subject's federal trial for skyjacking. Raised in refugee camps, by age 9 he had been inspired to become a soldier for the revolution to seek justice for the Palestinian people and to regain the property of his family. He had been taught to view Israelis as enemy soldiers and saw his role as a heroic one. His action, which resulted in major loss of life, represented the fulfillment of his destiny. To the extent that his psychology is representative of many of his generation, this generational transmission of hatred argues for persistence of violence in this strife-torn region.

No. 36E
THE PSYCHOLOGY OF TORTURERS AND THEIR VICTIMS

Carroll A. Weinberg, M.D., *261 Indian Creek Road, Wynnewood PA 19096-3405*

SUMMARY:

The dyad of torturer and victim of torture is examined. The psychological mechanisms used by torturers, including physicians, which enable them to inflict psychological and physical damage upon their subjects, are reviewed. The "political necessity" for the greater good is a common rationale, and phenomena resembling the "doubling" first described by Lifton are frequent.

The so-called "torture syndrome" is reviewed and related to post-traumatic stress disorder. Particular issues in the psychiatric treatment of survivors of torture include the requirement for establishing a secure environment of trust, catharsis and regression, dealing with feelings of guilt, and the establishment of the new self and the continuation of dialogue with society.

No. 36F
THE PRISONER OF WAR EXPERIENCE AND ITS SEQUELAE

John O. Beahrs, M.D., *Department of Psychiatry, Oregon Health Sciences Univ, PO Box 1036, Portland OR 97207*

SUMMARY:

Prisoners of war (POWs) experience prolonged vulnerability and random terror, which lead to unique sequelae. Ex-POWs from Pacific theaters of combat during 1941-45 and 1950-53 endured the catastrophic stressors of combat and capture, followed by malnutrition, capricious brutalities, friendly bombings, and the risk of betrayal by peers who collaborated with their captors. After liberation and repatriation, most ex-POWs suffered from distressing levels of non-validation by significant others. Subsequent mortality rate was severe, normalizing only partially after age 40. The majority of current survivors suffer from cardiac and neurological complications of avitaminosis, and post-traumatic stress. They are highly ambivalent: fierce patriotism co-exists with mistrust, anger, and disillusionment; marriages are often strong, yet conflicted and distant. Compared to non-POW combat veterans, ex-POWs are likely to perceive themselves as passive recipients rather than perpetrators of hostile encounters, and suffer from more somatic and cognitive impairments. Correlates of aging—illness and wasting, death of family and friends, and waning competencies—reactivate the traumata of imprisonment and pose new therapeutic challenges. Ex-POW support groups provide a powerful boost to morale and help in coping with these stresses.

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SYMPOSIUM 37—PHYSICIAN-PATIENT RELATIONSHIP: WHAT'S ESSENTIAL?

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant will have an in-depth understanding of what is essential in the physician-patient relationship.

No. 37A
THE PATIENT-PHYSICIAN RELATIONSHIP: OVERVIEW AND HISTORY

Richard M. Glass, M.D., *Department of Psychiatry, University of Chicago, 1033 East 49th Street, Chicago IL 60615-1813*

SUMMARY:

There was a time, in all of medicine as well as in psychiatry, that the patient-physician relationship was the treatment. The scientific progress that has brought more effective treatments can also threaten the treatment relationship. This threat is limited provided that physicians recognize that a good history is still essential for diagnosis and that the best scientific, evidence-based treatment occurs in the context of a compassionate and empathic relationship. In other words, the patient-physician relationship remains the center of medicine. Increasingly consumerist patient attitudes can be uncomfortable for physicians, but can be approached by recognizing both the value and the limits of patient autonomy. The worst threats to the patient-physician relationship come from recent changes in the organization and economics of medical care that can compromise three factors essential to good relationships: time, continuity, and trust. Perhaps the greatest challenge facing physicians, individually and collectively, is the need to resist such compromises and to maintain medicine as an ethical profession grounded in a covenant of trust.

No. 37B
SOCIAL CONTEXT AND THE PHYSICIAN-PATIENT RELATIONSHIP

Melvin Sabshin, M.D., *Medical Director, American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005*

SUMMARY

National authoritarianism of any kind (political, social, religious, economic) can have a significant impact on the physician-patient relationship. The impact of such authoritarianism may fall upon the patient, the physician, or more commonly, on both.

We in the United States have lived within a democratic structure for almost all of our history. Some of the exceptions affecting the physician-patient relationship are worth noting: 1) During the period of slavery, medical care of the slaves followed different practices, and after slavery black citizens failed to receive equal treatment; 2) During national emergencies some citizens were deemed to be dangerous to the state and their medical treatment was different, Ezra Pound for example; and 3) Economic pressures have stratified physician-patient relationships, e.g., public hospital discrimination and aspects of managed care.

Despite the above examples, physician-patient relationships in the U.S. have been as good as any place in the world. Improvements are currently being made in patient rights. Challenges from managed care, however, threaten to limit physician options for providing high-quality care. While the physician-patient relationship is affected by outside forces, the physician has the responsibility to attempt to resist authoritarian intrusions and provide the best possible treatment in an ethical fashion.

No. 37C
PHYSICIANS, PATIENTS AND SOCIETY

Robert Michels, M.D., *Department of Psychiatry, Cornell Medical College, 525 East 68th Street, Box 170, New York NY 10021*

SUMMARY:

Physicians, patients, and their relationship can only exist in a larger social context. The essentials of that relationship depend upon that context; changes in the context affect the relationship and may lead to reconsideration of those essentials. At the same time values implicit in those essentials are important in evaluating various social contexts, identifying some that are preferable and rejecting others that conflict with those essential values.

No. 37D
PHYSICIAN AS ADVISOR

Peter D. Kramer, M.D., *236 Hope Street, Providence RI 02906-2212*

SUMMARY:

The physician as a trusted advisor is a growing concept of the physician-patient relationship. The impact of this on patients, on physicians, and on the profession will be examined.

No. 37E
WHAT THE PHYSICIAN MUST CONTRIBUTE TO THE PATIENT-PHYSICIAN RELATIONSHIP

Robert O. Pasnau, M.D., *Department of Psychiatry, UCLA/NPI, 760 Westwood Plaza, Los Angeles CA 90024*

SUMMARY:

This is clearly a complicated subject, much larger than the confines of a brief review, the subject of numerous books and articles spanning the history of medicine. In fact, the art of medicine and the role of the physician in the patient-physician relationship exceed the span of recorded history. Perhaps it is this timelessness in medical practice that provides the perspective allowing those of us near the end of our professional lives to see some of the dangers inherent in the changing environment of medical practice. The growth of scientific knowledge, the need for education and consent, and the financing of medical care have always provided challenges to the patient and the physician. The writings of Osler, Holmes, Balint, and Leigh and Reiser provide ample evidence of the wisdom of the previous ages. I believe that certain truths are self-evident. The medical model involves responsibility of physicians to be competent, to be compassionate, to be committed to the welfare of their patients, to be calm, cool, and comfortable in discussing, listening, and treating in the face of chaos and distress, and to create a moral and nonexploitative patient advocacy stance.

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SYMPOSIUM 38—VISUAL DIAGNOSIS OF MOTOR DISORDERS IN PSYCHIATRY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to visually recognize and differentiate catatonic stupor, primary neurological movement disorders, behavioral disorders in epilepsy and drug-induced movement disorders; manage behavioral manifestations; and understand the approach to complex motor disorders in psychiatric patients.

No. 38A
CATATONIA IN THE DIFFERENTIAL DIAGNOSIS OF STUPOR

Brendan T. Carroll, M.D., *Department of Psychiatry, VA Medical Center, 17273 State Route 104, #116A, Chillicothe OH 45601*

SUMMARY:

Catatonia, first described by Karl Ludwig Kahlbaum, included a wide range of motor abnormalities, including stupor. Plum and Posner identified catatonic stupor under the rubric of psychogenic unresponsiveness. The term "stupor" has a variety of connotations, but the definition "immobility, mutism, and relative preservation of consciousness" has been applied in a study of patients with catatonia. Psychiatric patients presenting with stupor alone showed few differences when compared with patients with catatonic signs such as negativism and waxy flexibility.

Patients presenting with stupor infrequently have catatonia (perhaps 1% to 4%). Nonetheless, such patients pose a diagnostic challenge to the neuropsychiatrist. The physician has several levels of investigation: (1) physical exam, (2) history obtained from other sources, (3) EEG, (4) amytal interview, (5) benzodiazepines, and (6) other laboratory studies. Great caution is necessary because the proper diagnosis and treatment of patients with catatonic stupor includes a wide window for differential diagnosis and a narrow window for therapeutic intervention.

The presenter will use data from studies on catatonic stupor, EEG data, the use of amobarbital and benzodiazepines, and videotape.

No. 38B
PSYCHIATRIC MANAGEMENT IN MOVEMENT DISORDERS

Edward C. Lauterbach, M.D., *Department of Psychiatry, Mercer University Sch of Med, 1550 College Street, Macon GA 31207*

SUMMARY:

Many patients in clinical psychiatric practice have underlying medical problems, including primary movement disorders. Some of these neurological disorders carry a proclivity to certain psychiatric disorders (e.g. bipolar disorder with Huntington's disease and primary dystonia), differential sensitivity to psychotropic drugs (e.g. Parkinson's disease), and peculiar motor features that confound psychiatric diagnosis (dystonia vs. conversion disorder). Further, certain psychotropics influence primary movement disorders. For this reason, it is important to recognize these motor disorders and understand their impact upon the practical management of psychiatric disorders. This presentation reviews current clinical diagnosis of these disorders including videotaped illustration of diagnostic features, clinical psychiatric epidemiology emphasizing the more important psychiatric disorders of increased risk, and clinical management with an emphasis on pharmacologic techniques. Neurological illnesses reviewed include Parkinson's disease, Huntington's disease, and primary dystonia. Clinical recognition of these disorders by videotaped examples is emphasized.

No. 38C
SEIZURES AND SEIZURE-LIKE MOVEMENT DISORDERS

Dietrich P. Blumer, M.D., *Department of Psychiatry, University of Tennessee, 135 North Pauline Street, Memphis TN 38105*

SUMMARY:

Videotaped examples of epileptic seizures will be presented demonstrating the features suggestive of primary generalized seizures and of seizures arising from the temporal lobe, frontal lobe, and other cerebral areas. Brevity and stereotypy tend to be characteristic for epileptic seizures.

Medical disorders including cerebrovascular, cardiac, respiratory, and various metabolic disturbances occasionally cause seizure-like events that may be confused with epileptic seizures. Pseudoepileptic ("psychogenic") seizures commonly present a difficult problem of differential diagnosis. Pseudoepileptic and epileptic seizures may be present in the same patient, and patients with pseudoseizures frequently show evidence of cerebral impairments.

Videotaped examples will demonstrate the more prolonged and variable movement patterns among patients with pseudoepileptic seizures. Pseudoseizures are akin to motility storm or immobilization spell resulting from acute life-threatening situations; they are somatoform reactions to severe past emotional traumata and to unresolved conflict situations presenting an existential threat to the individual. Chronic pain and depressive symptoms are frequently associated with pseudoseizures.

Inpatient EEG telemetry with video monitoring is usually required for the diagnosis of pseudoepileptic seizures and there are ample pitfalls in the process. Competent psychiatric evaluation and treatment is necessary for every patient with pseudoseizures.

No. 38D
RECOGNITION OF COMMON AND COMPLEX DRUG-INDUCED EXTRAPYRAMIDAL SYNDROMES

Thomas E. Hansen, M.D., *Department of Psychiatry, VA Medical Center, 3710 SW US Veterans Hosp Road, Portland OR 97201;* William F. Hoffman, M.D., Daniel E. Casey, M.D., George A. Keepers, M.D.

SUMMARY:

Appropriate management of drug-induced extrapyramidal syndromes (EPS), the largest group of motor disorders seen in psychiatric practice, depends on recognizing and distinguishing EPS symptoms. Problems may occur when symptoms occur at unexpected times, in unusual locations, or in coexistence with other syndromes as seen with tardive dystonia, facial tremors, and coexistence of tardive dyskinesia (TD) and parkinsonism.

Patients at our medical center have undergone videotaped EPS exams during active treatment for psychosis and while being withdrawn from antipsychotics. The prevalence of tardive dyskinesia and drug-induced parkinsonism has varied but each typically occurs in about 25% of patients. The rate of DIP coexistence in TD patients varied from 20% to 60% depending on treatment conditions. TD and DIP can vary reciprocally, but do not necessarily do so. Adjustments in antipsychotic and anticholinergic medication do not consistently affect symptoms in all patients, presumably representing individual patient variation and differing time course of response between syndromes. A review of videotapes from 119 patients found tardive dystonia in 11%, primarily affecting the upper extremity. Age, DIP, and TD were significantly correlated with severity of tardive dystonia.

This presentation will review data from the above noted studies, with videotaped illustrations of typical, atypical, and confusing examples of these conditions. During the case discussion format, differential diagnosis will be reviewed for several complex cases. Pathophysiology will be reviewed in the context of managing these syndromes.

No. 38E
VISUAL RECOGNITION OF DIFFICULT MOTOR DISORDERS

Edward C. Lauterbach, M.D., *Department of Psychiatry, Mercer University Sch of Med, 1550 College Street, Macon GA 31207;*

Thomas E. Hansen, M.D., Brendan T. Carroll, M.D., Dietrich P. Blumer, M.D.

SUMMARY:

A wide variety of motor disorders are observed in clinical psychiatric practice. These range from motor features of psychiatric illnesses (anxiety tremor, catatonia, psychomotor retardation) to the diagnostic features of primary neurological illnesses (Parkinson's and Huntington's disease, dystonia), from seizures and associated behaviors (aggression, compulsive behaviors, automatisms) to neurological complications of psychiatric treatment (drug-induced parkinsonism and dystonia, tardive dyskinesia, and akathisia). Occasionally, some neurological disorders mimic psychiatric disorders and vice versa. Visual observation and certain examination techniques are critical to diagnosis. Therefore, videotapes will be utilized in this presentation to illustrate the relevant diagnostic features. Examples of catatonia, neurological illness, epilepsy-related behaviors, and drug-induced motor disorders will be displayed. In particular, video presentations of a variety of interesting cases with complex motor disorders will be demonstrated. Discussion from the audience is invited and encouraged.

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SYMPOSIUM 39—PSYCHIATRY AND EUTHANASIA

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to recognize the psychological and psychiatric issues that are relevant in understanding and responding to the patient's wish to die and in the legal and ethical debate over euthanasia; understand the role of palliative care and other therapeutic approaches to easing human suffering, models of family-centered care, and the issues in the doctor-patient relationship.

No. 39A
LEGAL EUTHANASIA IN AUSTRALIA

Christopher Ryan, M.B., *Department of Psychiatry, Westmead Hospital, Westmead, Sydney 2145, Australia*

SUMMARY:

On July 1, 1996, the Northern Territory Rights of the Terminally Ill Act came into effect in Australia's Northern Territory, making voluntary euthanasia legal. The act allows physicians to prescribe and administer lethal substances to terminally ill patients who formally request assistance in ending their lives. This paper examines the provisions of the act, especially in relation to the role of the psychiatrist and describes the difficulties it has faced since promulgation. Its provisions and its difficulties are compared to the Oregon Death with Dignity Act. The act is examined in the context of the euthanasia debate. It is argued that the legislation is a good first attempt to create an act permitting voluntary euthanasia and warrants close study as a model for similar legislation elsewhere.

No. 39B
CLINICAL ISSUES IN ASSISTED SUICIDE

Brian J. Kelly, M.B., *Department of Psychiatry, University of Queensland, Princess Alexandra Hospital, Brisbane 4102, Australia*

SUMMARY:

A range of clinical issues that need to be incorporated in the ethical and legal considerations are reviewed. The request for euthanasia needs to be addressed in the context of the existing data concerning the patterns of psychiatric disorder and psychological symptoms in the medically ill, and the evidence regarding the psychiatric morbidity surrounding the wish to die and suicidal ideation in medically ill individuals. Factors concerning the diagnosis and management of psychiatric disorder in this setting will be addressed, in addition to the issues that affect the diagnosis and effective treatment of psychiatric disorder. A clinical framework can then be developed to appraise the wish to die, and develop appropriate therapeutic responses, since the findings from the limited existing literature in this field suggest a close association between the wish to die and the suicidal ideation, with a range of relevant psychosocial factors and psychiatric disorder that can be addressed in clinical management.

No. 39C
PALLIATIVE CARE: A RESPONSE TO HUMAN SUFFERING

David W. Kissane, M.D., *University of Melbourne, 104 Studley Par, New Victoria 3101, Australia*

SUMMARY:

Many requests for euthanasia are based upon fear of suffering, loss of dignity, and perception of burden to the family. Our society's capacity to tolerate suffering and compassionately care for its sick is critical to its ability to accept a natural dying process. The nature of suffering will be examined within the context of family, our principal system of care provision. Preparation of patients and their families about the process of dying eases existential distress and reassures about the management of pain and other symptoms. A family-centered model of care, based on empirical research into dimensions of family functioning (cohesiveness, expressiveness, and conflict resolution) that differentiate psychosocial outcome during palliative care and bereavement, will be presented as a preventive approach to facilitate adaptive coping. Through enhancing communication, clarifying roles, improving problem solving, and promoting family cohesion, the liaison psychiatrist in the palliative care team helps families to tolerate their anguish as members comfort one another and share grief. Alongside recognition and management of depression and delirium, the promotion of family competence empowers members to better contain suffering, say goodbye to their dying, and achieve a healthier psychosocial outcome for the bereaved.

No. 39D
EUTHANASIA: THE WISH TO DIE AND THE WISH TO KILL

Francis T. Varghese, M.B., *Department of Psychiatry, University of Queensland, Princess Alexandria Hospital, Bisbane 4102, Australia*

SUMMARY:

On July 1, 1996, Australia's Northern Territory became the first jurisdiction anywhere in the world to allow voluntary euthanasia. This legislation has caused considerable public debate about the role of doctors in the process. This presentation will examine the legal and ethical issues involved in doctor-assisted suicide. It will also examine some of the clinical issues that are ignored when the debate concentrates solely on issues of patients' rights and autonomy. The large amount of data relating to psychological and social factors in the wish to die in terminally ill patients will be examined to show that the issues involved are more complex than patients' rights and the notion of quality of life. The process of dying and the role of doctors and family in the care of the dying terminally ill patient will be examined from the viewpoint of the role of palliative care. Finally, psychodynamic issues in the patient's request for assisted suicide and the role of counter-transference forming a wish to kill in doctors involved in acceding to such a request will be examined.

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2. Kelly B, Varghese F: Assisted suicide and euthanasia: What about the clinical issues? *Aust NZ J Psych* 30:3-8, 1996.
3. Kissane DW, Bloch S, Dowe DL, et al: The Melbourne family grief study 1: Perceptions of family functioning in bereavement. *Am J Psychiatry*, 153:650-666, 1996.

SYMPOSIUM 40—QUALITY OF LIFE IN MULTICULTURAL SOCIETIES

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to understand the relationship of cultural influence on "quality of life," in order to strengthen our ability to effectively assess and improve functioning and recovery in multiethnic clinical populations.

No. 40A
CLINICAL-ANTHROPOLOGICAL ISSUES IN QUALITY OF LIFE

Robert A. Nemiroff, M.D., *Department of Psychiatry, UCSD, 2803 Inverness Drive, La Jolla CA 92037-2045*

SUMMARY:

In developing quality of life assessment there is an increasing need to pay more attention to the cultural dimensions of the domains of physical functioning, psychological state, somatic sensation, and social interaction of ethnic groups. This presentation will present new data and concepts about the effects of pathological hate and racism on the quality of life in multicultural societies. As societies become more diverse, there is the danger of increasing discrimination and bigotry. Identifying and understanding the clinical-anthropological features of pathological hatred is an important first step in resolving the problems of racism and discrimination.

Pathological hatred is defined as chronic aggression characterized by irrational belief systems that has the aim of destruction or humiliation of the person. Utilization of images from the Holocaust to contemporary hate groups will illustrate how the concepts of (1) irrational belief systems, (2) narcissism of small differences, (3) false victimization, (4) projected aspects of devalued selves; and (5) pseudospeciation help us understand pathological hate and will improve the psychological state aspect of quality of life assessments in multicultural societies.

No. 40B
QUALITY OF LIFE IN MINORITY PATIENTS WITH SEVERE MENTAL ILLNESSES

Anthony F. Lehman, M.D., *Department of Psychiatry, University of Maryland, 645 West Redwood Street, Baltimore MD 21201*

SUMMARY:

Quality of life (QOL) has become an outcome of considerable interest in health care research, including for persons with severe mental illnesses (SMI). As work proceeds in this area it is important to develop a better understanding of how quality of life varies among racial and ethnic subgroups in this patient population. This paper provides an overview of what is known about racial variations on QOL in the general population. It then presents data on QOL patterns for Caucasian and African-American persons with SMI in a large quality of life database. Although overall QOL differences are small, African-American respondents reported poorer objective QOL in the areas of financial security, employment, and social contacts. Conversely, they reported more contacts with their families and higher overall life satisfaction and satisfaction with interpersonal and family relations. The findings provide some insights into the experience of life satisfaction among persons with severe mental illnesses, in particular differences in access to resources and in expectations about life.

No. 40C
MULTIPLE PERSPECTIVES ON QUALITY OF LIFE

Ronald J. Diamond, M.D., *Department of Psychiatry, University of Wisconsin, 6001 Research Park Boulevard, Madison WI 53719*

SUMMARY:

There is increasing concern about the quality of life of persons with severe and persistent mental illness. Unfortunately there is little agreement about what is meant by quality of life or how to measure it. Clinicians, families, and the patient's themselves often have very different views of their quality of life. Quality of life can be conceptualized as a construct made up of a number of independent domains including the quality of housing, physical health, interpersonal relationships, money, occupational roles, and subjective sense of well being. Each of these domains can be assessed from the point of view of clinician, patient, or family, and the relative weighting of the importance of each of these domains to the overall quality of life can also vary from one observer to another. Data will be presented about the interaction between these different points of view, and how this varies in different ethnic groups in the United States as well as in other countries. The authors will point out how consideration of these various perspectives can help to guide clinical work.

No. 40D
QUALITY OF LIFE ASSESSMENT IN ASIAN-AMERICANS

Francis G. Lu, M.D., *Department of Psychiatry, University of CA at SF, 1001 Potrero Avenue, San Francisco CA 94131;* Mari Shimizu

SUMMARY:

The World Health Organization Quality of Life Group has defined quality of life as "individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standard, and concerns." This concept "highlights the view that quality of life is subjective,

includes both positive and negative facets of life and is multi-dimensional." The World Health Organization Quality of Life Assessment Instrument (WHOQOL) was presented at the 1996 World Congress of Psychiatry.

This presentation will review the concept of quality of life as it pertains to Asian Americans. First, a critique of the WHOQOL will be presented focusing on sociocultural variables such as religious/spiritual beliefs, social relationships, and levels of independence. Second, implications of recent United States quality of life research for Asian-American populations will be discussed. Such studies include the importance of focusing on the diagnosis and treatment of mental disorders in primary care patients to improve health-related quality of life. (Spitzer, 1995).

No. 40E
CULTURE-SENSITIVE ASSESSMENT OF QUALITY OF LIFE

Juan E. Mezzich, M.D., *175 East 96th Street Apt. 5L, New York NY 10128-6202;* Neal L. Cohen, M.D.

SUMMARY:

One of the critical requirements for valid assessment of quality of life is cultural sensitivity. In line with this, subject's self-perception is widely recognized as the key perspective for such assessment.

This paper will report on an attempt to achieve cultural sensitivity in the appraisal of quality of life, first, by identifying from the international literature ten critical dimensions of quality of life and, then, by encouraging the subject to rate each dimension according to his/her own culture-informed understanding of it. The ten dimensions are the following: (1) physical well-being, (2) psychological well-being, (3) self-care/independence, (4) occupational functioning, (5) interpersonal functioning, (6) social emotional support, (7) environmental community services, (8) personal fulfillment, (9) spiritual fulfillment, and (10) global quality of life. The concept of each dimension is flexibly worded in a prompt. Each rating is marked on a 10-point line displaying four simple anchor points.

Preliminary validation studies revealed that completion time tended to oscillate between 2 and 4 minutes, that 77% of subjects perceived its completion as either very or rather easy, that test-retest reliability was 0.90, and that the instrument significantly discriminated between two samples of subjects (mental health professionals and psychiatric patients) with presumably different levels of quality of life.

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SYMPOSIUM 41—EATING DISORDER TREATMENT RESPONSE TO MANAGED CARE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to understand new strategies for coping with limitations and lack of resources established by managed care.

No. 41A
TREATMENT OF EATING DISORDERS IN MANAGED CARE

Murray L. Zucker, M.D., *Psychiatric Services, Foundation Health, 1600 Los Gamos Drive, Ste 300, San Rafael CA 94903*

SUMMARY:

Due to multiple complex factors, managed care organizations (MCOs) are having an increasing influence on health care delivery, and as a result, behavioral health care is undergoing a transformation. The treatment of eating disorders in this environment raises many important issues and opportunities. This presentation will review the basic principles of behavioral managed care, explain the internal programs of the MCOs to achieve these goals, and discuss the opportunities for psychiatrists and academic departments of psychiatry especially as applies to the treatment of eating disorders.

Managed behavioral health care is based on the principles that quality, appropriate, medically necessary care can be delivered in a cost-effective manner using a credentialed provider network, which provides care in the least restrictive setting of a continuum of care and with a new emphasis on outcomes. Treatment is generally brief, symptom-focused with the goal of resuming function.

MCOs attempt to achieve the above through various internal programs: level of care (LOC) and medical necessity (MN) standards; a utilization management policy (UM); a quality management policy (QM) with use of peer reviewers, appeals process, complaints and grievance policy; and fraud and abuse investigations. In addition quality indicators are tracked, audits of practices and focused studies are performed, and outcomes and patient satisfaction studies are done.

Dealing with the treatment of eating disorders has been problematic for MCOs but there are opportunities for psychiatrists and university psychiatry departments, such as becoming a "center for excellence," comforting for care of large populations or "carving out eating disorders," developing a "continuum of care," and creating research possibilities.

No. 41B
COST-EFFECTIVE DAY TREATMENT FOR EATING DISORDERS

Allan S. Kaplan, M.D., *Department of Psychiatry, Toronto General Hospital, EN8-231, 200 Elizabeth Street, Toronto ON M5G 2C4, Canada;* Marion P. Olmsted, Ph.D., D. Blake Woodside, M.D.

SUMMARY:

The inpatient treatment of seriously ill patients with eating disorders is often characterized by lengthy expensive hospitalization, which third-party payers in the U.S. are increasingly unwilling to pay for. In Canada, all health care, including hospital based treatments for eating disorders, are provided free to patients and covered by government health insurance.

For clinical and economic reasons the Toronto Hospital developed in 1985 an intensive day hospital program (DHP) for seriously ill

patients who would have otherwise required inpatient care. The DHP operates weekdays, eight hours/day treating 60 to 70 patients/year through the cumulative effects of group psychotherapy, nutritional rehabilitation, and pharmacotherapy, and is highly effective in reducing bulimic symptoms and promoting weight gain.

To assess its cost effectiveness, a cost-analysis comparison between the DHP and inpatient program (IP) was conducted for the fiscal year ending March 31, 1996. The cost for 65 patients treated in the DHP was $525,000 Canadian compared to $1,100,000 for 25 patients in the IP. The cost per patient in the DHP represented 22% of the cost of inpatient care. The difference was largely attributable to the indirect "hotel" costs required for the maintenance of hospital beds in the IP.

The Toronto eating disorder experience confirms that clinically and cost-effective treatment can be provided without the need for expensive hospitalization. This approach should be of interest to U.S. health care providers.

No. 41C
COST-EFFECTIVE TREATMENT OF BULIMIA NERVOSA

W. Stewart Agras, M.D., *Department Of Psychiatry, Stanford University, 401 Quarry Road, Room 1326, Palo Alto CA 94304*

SUMMARY:

The objective of this presentation is to compare the effectiveness and cost-effectiveness of cognitive-behavioral therapy (CBT) and antidepressant medication (specifically desipramine) in the treatment of bulimia nervosa. A controlled study comparing CBT, desipramine given for 16 and 24 weeks, and the combination of medication and CBT will be described. From the viewpoint of effectiveness, cognitive-behavioral therapy was found significantly more effective than antidepressant medication, while the combined condition was marginally more effective than CBT alone. Moreover, medication given for 24 weeks was more effective than medication given for 16 weeks. However, a cost-effective analysis of this study at one-year follow-up reveals that despite being less effective than CBT, medication given for 24 weeks is the most cost-effective approach to treatment in terms of cost per recovered patient. Since there is initial evidence that a self-help manual combined with minimal therapist intervention is also an effective, and clearly a cost-effective approach to treatment, these findings will be combined into a suggested stepped care approach to the treatment of bulimia nervosa.

No. 41D
LEGAL DECISIONS IN THE TREATMENT OF ANOREXIA

Arnold E. Andersen, M.D., *Department of Psychiatry, University of Iowa, 200 Hawkins Drive, Iowa City IA 52242*

SUMMARY:

Because of extreme weight loss many patients with anorexia nervosa require extended medical and/or psychiatric hospitalizations. However, providers have become increasingly reluctant to support inpatient treatment for anorexia nervosa.

In Manheim vs Travelers Insurance Company (US District Court, Eastern District of NY, 9/15/95) an adolescent girl was admitted to a psychiatric hospital for five months of treatment for anorexia nervosa. The insurance company classified her disorder as psychiatric and paid only for the first 30 days. The court decided that treatment of anorexia nervosa, even in a psychiatric hospital, is logically covered by medical benefits until "the treatment becomes primarily psychiatric." This decision implies that the treatment of a malnourished, underweight anorexic with refeeding and weight restoration is primarily medical in nature and should be covered by medical benefits. This decision supports the contention of many experts in the field of eating disorders that malnourished, underweight anorexics are cognitively impaired and unable to utilize psychiatric treatment until they get to a healthy body weight. Weight gain and nutritional rehabilitation is primarily a medical treatment designed to reverse the effects of malnutrition.

This case, in part, relied on the logic of dual treatment by using the example of a person who makes a suicidal attempt by jumping out a window and breaks multiple bones. In this case, their medical benefits would provide support for a dual-treatment hospitalization. That is, payment would be made for hospitalization for broken bones while care was also provided at the same time for a mental disorder. In summary, this case helps to establish the shared medical-psychiatric basis for the reimbursement of treatment costs of anorexia nervosa.

No. 41E
DOCUMENTING RESPONSE TO TREATMENT AND OUTCOME

Walter H. Kaye, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh PA 15213-2593;* Radhika Rao, M.S.

SUMMARY:

Anorexia nervosa has been considered to be a chronic disorder with high morbidity and mortality, and no definite treatment. The high rate of relapse has made anorexia nervosa among the most expensive psychiatric disorders to treat. Two topics will be discussed in this session.

First, new advances in understanding and treating this illness suggest that aggressive early treatment is cost effective for many patients. That is, lifetime treatment cost would be less for patients who receive extended early treatments compared to prolonged but brief psychiatric and medical treatments of a chronic disorder. Extended early treatment should result in fewer psychiatric rehospitalizations and medical treatments as well as in improved long-term outcome. In support of this assertion, we have found in our double-blind placebo study that the administration of fluoxetine significantly reduces relapse. Moreover, in another study, we found that higher weight gain during hospitalization was associated with fewer rehospitalizations.

Second, substantiating such assertions has been difficult because of the complexity and cost of documenting response to treatment. Clinicians have become increasing concerned with documenting response to treatment because of pressure from managed care. Our center has developed new methods for tracking response to treatment and outcome in people with eating disorders. This methodology, which includes computer software for tracking progress in treatment as well as automated self-assessments, will be presented.

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SYMPOSIUM 42—PCP MODEL OF SCHIZOPHRENIA: FROM THEORY TO PRACTICE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation the participant should be familiar with the behavioral effects of phencyclidine (PCP) as they relate to the clinical symptoms of schizophrenia. The participant should be aware of the potential role of NMDA receptors in schizophrenia, and the potential treatment of schizophrenia with NMDA augmenting agents such as glycine.

No. 42A
DEVELOPMENT OF THE PCP/N-METHYL-D-ASPARTATE MODEL OF SCHIZOPHRENIA

Daniel C. Javitt, M.D., *Department of Psychiatry, Nathan Kline Institute, 140 Old Orangeburg Road, Orangeburg NY 10962*

SUMMARY:

Phencyclidine (PCP) was first developed in the late 1950s for use as a general anesthetic agent. However, in early clinical trials, PCP was found to induce prominent psychotic symptoms that closely resembled both positive and negative symptoms of schizophrenia. In subsequent controlled investigations PCP was also found to induce schizophrenia-like cognitive disturbances and thought disorder in normal volunteers, and potentially long-lasting exacerbation of symptoms in remitted schizophrenic subjects. In the 1960s and 70s, PCP became a major drug of abuse and accounted for the majority of drug-induced psychiatric hospitalizations. Up to 20% of patients exposed to PCP developed severe psychotic symptoms which, in many cases, were clinically indistinguishable from those of schizophrenia. A unique brain receptor for PCP was first discovered in 1979. Subsequent investigation demonstrated that binding of PCP to its receptor blocks neurotransmission mediated at *N*-methyl-D-aspartate (NMDA)-type excitatory amino acid receptors, indicating that endogenous NMDA receptor dysfunction may play a crucial role in the pathophysiology of schizophrenia. NMDA receptors are controlled by two neurotransmitters, glutamate and glycine, that must act in concert in order for receptor activation to occur. Although glutamate cannot be given because of drug-induced toxicity, glycine may be administered at doses sufficient to significantly increase brain glycine levels. In animals, glycine reverses the behavioral effects of PCP, indicating that it may constitute a clinically effective treatment for PCP psychosis-like symptoms in schizophrenia. This presentation will focus on the development of the PCP/NMDA model of schizophrenia, and the neurochemical effects of PCP and glycine on NMDA receptor-mediated neurotransmission.

No. 42B
PCP EFFECTS ON STARTLE GATING: A PREDICTIVE MODEL

Neal R. Swerdlow, M.D., *Department of Psychiatry, University of California, 9500 Gilman Drive, La Jolla CA 92093-0804;* Vaishali P. Bakshi, A.B., Mark A. Geyer, Ph.D.

SUMMARY:

In humans and rats, the startle reflex is inhibited when the startling stimulus is preceded 30 to 500 msec by a weak prepulse. Prepulse inhibition (PPI) has been used in an animal model with face, predictive, and construct validity for the sensorimotor gating deficits in schizophrenia patients, because PPI is reduced or eliminated in these patients, and in dopamine (DA)-stimulated rats. Furthermore, the ability of antipsychotics to restore PPI in apomorphine-treated rats strongly correlates with their clinical potency (R = 0.991). PPI is also reduced in rats by the psychotomimetic noncompetitive glutamate antagonist phencyclidine (PCP). Unlike the effects of DA agonists on PPI, those of PCP are not reversed by typical antipsychotics such as haloperidol or raclopride, but are antagonized by the putative atypical antipsychotics clozapine, olanzapine, remoxipride, and quetiapine fumarate. The PPI-disruptive effects of PCP are not reversed by the D1 antagonist SCH 23390, the DA-5HT antagonist risperidone, or the selective $5HT_2$ receptor antagonists ketanserin or ritanserin. Given these findings and the theoretical linkage between PCP effects, glutamate dysfunction, and negative symptoms of schizophrenia, the restoration of startle gating in PCP-treated rats may be a useful model for predicting atypical antipsychotic properties in novel compounds.

No. 42C
N-METHYL-D-ASPARTATE MODULATION OF PREPULSE INHIBITION

Erica J. Duncan, M.D., *Department of Psychiatry, New York VAMC, 423 East 23rd Street, New York NY 10010;* Stephen Madonick, M.D., Burton M. Angrist, M.D., Elsa Bartlett, Ed.D., Arthi Parwani, M.D., John P. Rotrosen, M.D.

SUMMARY:

Objective: Phencyclidine (PCP) and ketamine, noncompetitive inhibitors of glutamatergic neurotransmission at the N-methyl-D-aspartate (NMDA) receptor site, produce a clinical picture of positive and negative symptoms in normals that is strikingly similar to the positive and negative symptoms of schizophrenia. D-cycloserine (DCS) is a partial agonist at the NMDA-associated strychnine-insensitive glycine binding site. At low doses it noncompetitively enhances NMDA neurotransmission. In previous trials, negative symptoms and cognitive performance improved in schizophrenics treated with DCS. Schizophrenics are known to have abnormalities in prepulse inhibition of the acoustic startle reflex (PPI), a sensory gating paradigm. A similar deficit in PPI is seen in animals treated with dopamine agonist and NMDA antagonist agents. The purpose of this work is to investigate the modulation of sensory gating by an agonist (DCS) and antagonist (ketamine) at the NMDA receptor site.

Method: We will present data from a study of PPI in schizophrenics before and during double-blind, placebo-controlled treatment with DCS, and from a study of PPI in normals before and during double-blind, placebo-controlled ketamine infusion.

Results/Conclusions: Results of these studies will be discussed in terms of possible NMDA-mediated contribution to schizophrenic symptomatology.

No. 42D
BEHAVIORAL AND RCBF EFFECTS OF KETAMINE

Adrienne C. Lahti, M.D., *Department of Psychiatry, MPRC, Maple and Locust Streets/SGHC, Baltimore MD 21228;* Henry H. Holcomb, M.D., Martin A. Weiler, M.D., Margaret Zhao, M.S., Deborah Medoff, Ph.D., Carol A. Tamminga, M.D.

SUMMARY:

To evaluate glutamatergic transmission in the pathophysiology of schizophrenia, we have compared the action of the NMDA antagonist ketamine on behavior and regional cerebral blood flow (measured using $H_2{}^{15}O$ and PET) in schizophrenic and normal individuals. Behavioral changes with ketamine were evaluated using three subanesthetic doses of ketamine (0.1, 0.3, and 0.5 mg/kg) and placebo given to normal and schizophrenic volunteers in a double-blind injec-

tion study. Normal individuals show a dose-related increase in psychotic features with ketamine. Psychotic symptoms included illusions and perceptual distortions, unusual thought content, and suspiciousness. These were milder than symptoms in schizophrenic patients who experienced hallucinations, delusions, and thought disorganization. Ketamine effect on regional cerebral blood flow (rCBF) was studied in medicated patients and normal volunteers given acute ketamine (0.3 mg/kg). The effect of ketamine on rCBF changes was evaluated by contrasting the first three post-ketamine injection scans (6, 16, and 26 minutes after ketamine) with the three baseline scans. Both normals and schizophrenics showed an increase in anterior cingulate rCBF, but the activation was significantly greater ($P < 0.05$) in schizophrenic patients. Differences in the course of rCBF changes over 65 minutes in the two groups will be presented. These data suggest that already-psychotic persons are more sensitive to the effect of ketamine, and implicate a dysfunctional glutamatergic system in schizophrenia.

No. 42E
CHALLENGE STUDIES WITH GLYCINE AND D-CYCLOSERINE

Deepak Cyril D'Souza, M.D., *545 Neptune Ave Apt 14B, Brooklyn NY 11224-4052;* Roberto B. Gil, M.D., Edward Zuzarte, M.D., Donna Damon, B.A., Danielle Abi-Saab, M.A., John H. Krystal, M.D.

SUMMARY:

Background: Based on the NMDA deficit hypothesis of schizophrenia, facilitation of NMDA receptor function may have therapeutic potential. The NMDA receptor glycine site offers a safe method of enhancing NMDA receptor function. Clinical trials with glycine and the partial glycine site agonist D-cycloserine (DCS) have been modestly positive. At Yale we have attempted to advance the interpretation of results from clinical trials with a series of studies. In the first study we examined the dose-related central bioavailability (CSF levels), and pharmacological effects of iv glycine (100 and 200mg/kg) in healthy subjects. In the second study we examined the agonist dose range of DCS, by characterizing the dose-related pharmacological effects of DCS (0, 50, and 500mg) in medicated and unmedicated schizophrenic, and healthy subjects. In the third ongoing study we are determining the ability of iv glycine to block the psychotomimetic effects of ketamine in healthy subjects.

Results: IV glycine increased CSF glycine levels but did not produce any behavioral or cognitive effects. Neither dose of DCS had any behavioral effects, but 50 mg DCS impaired performance on a task of selective attention in unmedicated schizophrenics. Preliminary data from the third study and implications of the results will be discussed.

No. 42F
GLYCENERGIC AUGMENTATION OF N-METHYL-D-ASPARTATE RECEPTOR-MEDIATED NEUROTRANSMISSION IN THE TREATMENT OF SCHIZOPHRENIA

Uriel Heresco-Levy, M.D., *Department of Psychiatry, Herzog Hospital, POB 35300, Jerusalem 91351, Israel*

SUMMARY:

Growing evidence suggests that a deficiency in the neurotransmission mediated by the NMDA subtype of excitatory amino acid (EAA) receptors may contribute to the pathophysiology of schizophrenia. The only therapeutic approach applicable to date for counteracting this hypothesized reduction in EAA neurotransmission targets the strychnine-insensitive glycine (Gly) recognition site of the NMDA receptor complex. Addition of glycenergic compounds, such as Gly or D-Cycloserine (DCS), to ongoing antipsychotic drug regimens may improve schizophrenia symptoms. We are conducting two double-blind, placebo-controlled, six-week crossover adjuvant treatment trials in which treatment-resistant chronic schizophrenic patients are receiving 0.8 g/kg/day Gly and/or 25 mg × 2/day DCS. Preliminary results indicate that Gly treatment was well tolerated, resulted in increased serum Gly levels ($p < .005$), and induced a mean 36% reduction in negative symptoms ($p < .0001$) as measured by the Positive and Negative Syndrome Scale (PANSS). Secondary improvements were induced in depressive ($p < .02$) and cognitive ($p < .05$) symptoms. Patients with the lowest pretreatment Gly serum levels experienced the greatest reductions in negative symptoms. These findings (1) support the hypoglutamatergic hypothesis of schizophrenia; (2) indicate that low Gly levels may contribute to psychopathology, and (3) suggest a novel approach for the treatment of negative symptoms and neurocognitive deficits associated with schizophrenia. Final data will be presented and discussed.

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SYMPOSIUM 43—HIGH-RISK LONGITUDINAL STUDIES OF ALCOHOLISM

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be familiar with the most recent findings from the major, currently active, longitudinal studies of individuals at high risk for developing alcoholism before the addiction has been established.

No. 43A
THE NATURAL HISTORY OF FAMILIAL ALCOHOLISM IN MALES

George E. Vaillant, M.D., *Department of Psychiatry, Brigham & Womens Hospital, 75 Francis St, Boston MA 02138*

SUMMARY:

Studies supporting Cloninger's original Type 1/Type 2 hypothesis for classifying the genetic transmission of alcoholism have sometimes failed to control for important sources of potential bias. First, the environmental effects of parental alcoholism must be distinguished from the genetic effects of parental alcoholism. Second, antisocial personality disorder must be distinguished from alcohol dependence. Third, to control for developmental effects the alcoholics should be followed into late midlife. This report will address these potential sources of bias in a 50-year prospective study of the development of alcoholism in two community samples of 456

disadvantaged youth and 204 Harvard graduates. We found that the age of onset of alcoholism and the degree of antisocial symptomatology were correlated with disturbed family environment but were quite independent of the presence or absence of a heredity positive for alcoholism. In addition we found that the major risk factors predicting alcoholism—heredity positive for alcoholism, ethnicity, antisocial behavior, and hyperactivity—did not predict the long-term outcome of the men's alcoholism. We concluded that the risk factors predicting *when* a person develops alcoholism are different from those predicting *whether* a person develops alcoholism; and the risk factors predicting the development of alcoholism are very different from those predicting recovery.

No. 43B
PREDICTORS OF ALCOHOLISM IN DANISH HIGH-RISK MEN AT AGE 30

Joachim Knop, M.D., *Department of Psychiatry, Gentofte Univ. Hosp., DK-2900 Hellerup 00090, Denmark;* Donald W. Goodwin, M.D., Elizabeth C. Penick, Ph.D., William F. Gabrielli, Jr., M.D., Per Jensen, M.D., F. Schulsinger, M.D.

SUMMARY:

The Danish Longitudinal Study of Alcoholism recently completed a 30-year review of 241 men who have been studied from birth. Two-thirds are high-risk sons of alcoholics confirmed by a national psychiatric registry. Ten years ago at age 19, before any had developed a serious drinking or drug problem, the subjects were extensively examined in Copenhagen. Over their lifetime, the examinations have included: prenatal and perinatal observations; school reports and teacher ratings; EEG and ANS measures with and without stimulation; neuropsychological tests; extensive social and developmental histories; a medical/neurological evaluation; a review of psychopathology and psychiatric disorder; and, for a subsample, an alcohol challenge test during which electrophysiological, subjective, and behavioral observations were made. About two dozen premorbid measures distinguished the high-risk from the low-risk groups ten years ago. These measures were considered putative markers or predictors of alcoholism in men. Surprisingly, most of the markers failed to predict alcohol abuse or dependence at age 30. Yet, a retrospective analysis revealed numerous premorbid variables that did separate those subjects who would and would not later develop alcoholism by age 30. Both the premorbid and retrospective results will be discussed in context of the high-risk paradigm.

No. 43C
PREDICTING ALCOHOLISM 15 YEARS LATER

Marc A. Schuckit, M.D., *Department of Psychiatry, VA Medical Center, 3350 La Jolla Village Drive, San Diego CA 92161*

SUMMARY:

This presentation reviews the methodology and results from an ongoing study that began in 1978. Over the next 10 years a sample of 453 men (average age 20 years), who were all drinkers but not alcohol-dependent, and half of whom had an alcohol-dependent father were identified and tested. Forty percent of the sons of alcoholics but less than 10% of the controls demonstrated a low intensity of response to alcohol as measured by subjective feelings, motor performance changes, and biological measures. Between 1989 and 1994 all 453 subjects were located, with 450 (99.3%) agreeing to a full evaluation of their interval histories of alcohol and drug use and problems as well as psychiatric histories. The results revealed that a low level of response to alcohol at approximately age 20 was a potent predictor of alcohol dependence almost a decade later. However, neither the sons of alcoholics nor those with low levels of response to alcohol demonstrated high rates of major psychiatric disorders. The ongoing 15-year follow-up is evaluating six areas of life functioning and environmental characteristics that might interact with family history and the low response to alcohol in predicting alcohol dependence.

No. 43D
RISK TO OFFSPRING IN HIGH-DENSITY PEDIGREES

Shirley Y. Hill, Ph.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh PA 15213*

SUMMARY:

Breaking the cycle of intergenerational alcoholism might best be achieved by intervening in the lives of high-risk children before alcohol abuse becomes entrenched in their lifestyles. Multiple predictors may be needed to explain a major portion of variance in outcome, however. Among these are neurobiological indices of familial/genetic risk, which appear to hold promise for discriminating high-risk (children/adolescents of alcoholic parents or children/adolescents from multiple-affected relatives) from low-risk offspring.

Our ongoing follow-up study, begun in 1991, has reached the 5th wave of the data collection. It includes a sample of 8- to 18-year-old children from multigenerational alcoholic pedigrees. These high-density pedigrees had been identified through a *pair* of alcoholic brothers (child's father and uncle).

Analyses completed after an average of 2.5 waves revealed important high-risk/low-risk differences: offspring from high-risk families begin drinking earlier (13.2 years old vs 14.7 years old), drank more per occasion, and were more frequently intoxicated than those from low-risk families. A survival analysis showed this significantly earlier onset was associated with a number of predictors: higher scores on extraversion, greater postural sway, and lower amplitude of the P300 component of the event-related potential.

No. 43E
A HIGH-RISK STUDY OF ALCOHOL ABUSE

Sheldon Weintraub, Ph. D., *Department of Psychiatry, SUNY at Stony Brook, Stony Brook NY 11794*

SUMMARY:

A prospective, longitudinal study of children vulnerable to alcohol abuse affords a unique opportunity to identify marker variables and early signs of substance abuse, as well as potential environmental precipitants. In this paper, findings from the Stony Brook High Risk Project relevant to substance abuse will be presented. Specifically, behavioral characteristics of school-aged children vulnerable to alcohol abuse will be presented, as well as follow-up data on substance abuse and diagnosable psychopathology collected ten years later during early adulthood. The sample consists of 474 offspring, including 138 at risk for alcohol abuse and psychiatric disorder (comorbid), 227 at risk for psychiatric disorder alone (PD), and 109 children whose parents are diagnosis-free. The childhood phase consisted of assessments of the children aged 7 to 16; the young adulthood phase consisted of follow-up interviews and assessments of those offspring over the age of 18. Analyses revealed greater adjustment problems and family disorganization in the risk groups, but the comorbid and PD risk groups were generally not discriminable. At follow-up in young adulthood, DSM-III disorders were more common in the risk groups, and substance abuse and antisocial personality were more frequent in the comorbid risk group.

No. 43F
INDICATIONS OF RISK-ONSET FROM EARLY CHILDHOOD

Robert A. Zucker, Ph.D., *Department of Psychiatry, University of Michigan, 400 E Eisenhower Pkwy, Ste 2, Ann Arbor MI 48108;* Hiram E. Fitzgerald, Ph.D., C. Raymond Bingham, Ph.D.

SUMMARY:

Findings are summarized from the early waves of a prospective family study, (N = 312 families) following initially 3- to 5-year-old sons of alcoholic fathers, both of their biological parents, and a yoked set of nonalcoholic community control families. Where present, a daughter in each family is also being followed. Families are assessed at three-year intervals, at least until offspring reach adulthood, and a broad network of biological, psychiatric, psychological, and social variables has been collected on all family members with the goal of being able to establish potential etiologic connections between early markers of risk and a later alcoholic or other drug involved outcome. Results through age 11 indicate (a) that familial risk, as assessed by density of family history, level of alcoholic symptomatology, comorbid psychopathology, cognitive impairment, and indices of social dysfunctioning are higher in high-risk families; (b) risk is most heavily aggregated in families where the father's alcoholism is comorbid with antisocial symptomatology; (c) assortative mating for both alcoholism and comorbid symptomatology is highest here; (d) child risk, as assessed by measures of externalizing behavior problems, cognitive development, and difficult temperament, is detectable at ages 3 to 5, and is most heavily concentrated in these families; (e) stability of child risk across time occurs in these families, but risk is fluid in other alcoholic and control families.

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SYMPOSIUM 44—NICOTINE, SMOKING AND SCHIZOPHRENIA

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to recognize that (1) nicotine use may implicate a specific neurobiological abnormality in schizophrenia, (2) pharmacologic treatment of schizophrenia can modulate smoking behavior, (3) nicotine may modulate symptoms of illness and side effects of treatment, (4) smoking cessation treatments can be developed to address the unique issues in this population.

No. 44A
SCHIZOPHRENIA AND NICOTINIC CHOLINERGIC RECEPTORS

Robert Freedman, M.D., *Department of Psychiatry, University of Colorado, 4200 East 9th Avenue/CB C-268, Denver CO 80111;* Sherry Leonard, Ph.D., Leonard E. Adler, M.D., Merilyne C. Waldo, Ph.D., Ann Quincy, M.D.

SUMMARY:

Schizophrenic patients have the highest use of nicotine of any mentally ill group. Interpretation of this observation includes the possibility that this high rate of nicotine use is an attempt at self-medication of an underlying neuronal abnormality. Human and animal neurophysiological experiments suggest that a recently discovered neuronal cholinergic receptor, the α7-nicotine receptor, is involved in some of the sensory processing disturbances that occur in schizophrenia. The α7-nicotinic receptors are critical for inhibitory neuronal function in the hippocampus and other regions of the brain concerned with the regulation of response to sensory stimuli. Schizophrenic patients often appear to respond to sensory stimuli that normal subjects ignore, which suggests that they have a defect in this regulation of sensory response. Genetic studies of the inheritance of this sensory processing disturbance provide evidence for linkage at a chromosome 15 site close to the gene for the α7-nicotinic receptor. The data are thus consistent with the possibility that schizophrenic patients have an inherited defect in a neurophysiological mechanism, which is related to a specific cholinergic receptor that can also be activated by nicotine. This defect may be the physiological manifestation of an inherited diathesis for schizophrenia.

No. 44B
EFFECTS OF ANTIPSYCHOTIC DRUGS ON SMOKING

Joseph P. McEvoy, M.D., *Adult Admission Unit, John Umstead Hospital, 1003 12th Street, Butner NC 27509-1695;* Edward Levin, Ph.D., Jed Rose, Ph.D.

SUMMARY:

Approximately 80% of patients with schizophrenia smoke. Patients with schizophrenia smoke more after starting haloperidol treatment, relative to their baseline rate of smoking when free of antipsychotic medications.

In a double-blind study comparing treatment with low, moderate, and high doses of haloperidol, we demonstrated haloperidol dose-related impairments in the cognitive performance of patients with schizophrenia. Nicotine administered by transdermal patch produced a dose-related reversal of the haloperidol-induced impairments.

Treatment-refractory patients with schizophrenia decrease their smoking when switched to clozapine at therapeutically effective serum levels. Patients treated at subtherapeutic clozapine serum levels show no change on smoking measures.

No. 44C
NICOTINE WITHDRAWAL AND REPLACEMENT IN SCHIZOPHRENIA

Gregory W. Dalack, M.D., *Department of Psychiatry, Ann Arbor VAMC, 2215 Fuller Road (116C), Ann Arbor MI 48105;* Lisa Becks, B.A., Elizabeth Hill, Ph.D., Ovide Pomerleau, Ph.D., James H. Meador-Woodruff, M.D.

SUMMARY:

The prevalence of smoking among individuals with schizophrenia is much higher than expected, while smoking cessation rates are lower than expected. One possible explanation for these observations

is that smoking, and specifically nicotine, modulates core symptoms of schizophrenia and side effects of treatment. Reciprocally, acute withdrawal from nicotine might be expected to exacerbate psychiatric symptoms. In this presentation we will discuss two experiments in which the use of nicotine (via cigarettes or transdermal patch) was controlled in order to study the effects on psychiatric symptoms and carbon monoxide measurements. Both studies involved heavy smokers with schizophrenia.

Experiment 1: In a randomized, double-blind, placebo-controlled, crossover design, subjects were evaluated during three days of smoking abstinence while wearing placebo or active (22mg/day) nicotine transdermal patch. Daily nicotine blood levels, vital signs, and psychiatric ratings were obtained. Heart rate changes accurately reflected treated vs. untreated withdrawal. Smoking abstinence was confirmed by carbon monoxide (CO) measurements. Preliminary analysis suggests that smokers with schizophrenia experienced an increase in medication side effects during untreated withdrawal, which may cause difficulty maintaining early abstinence.

Experiment 2: We examined the short-term effectiveness of transdermal nicotine replacement on decreasing cigarette smoking behavior. In a randomized, placebo-controlled, crossover design, subjects were admitted overnight on two separate occasions, and allowed to smoke as they pleased while wearing placebo or active (22mg/day) nicotine transdermal patch. Over a 36-hour period, smokers with schizophrenia wearing the active patch decreased their smoking such that CO levels decreased by up to 50%, without acute change in psychiatric symptoms.

These data suggest that nicotine may play a role in modulating treatment of schizophrenia, and that use of nicotine transdermal patch may be an intervention to decrease smoking (and associated health risks) for patients who are unable to succeed in an acute cessation model.

No. 44D
MOTIVATIONAL ENHANCEMENT THERAPY AND NICOTINE REPLACEMENT IMPROVE SMOKING CESSATION OUTCOMES

Douglas M. Ziedonis, M.D., *Department of Psychiatry, Yale University, 34 Park Street, New Haven CT 06508;* Patricia Harris, Stephen A. Wyatt, D.O., Kimberlee Trudeau, Tony P. George, M.D., Diane Johnson, Ph.D.

SUMMARY:

The APA's Nicotine Dependence Treatment Guidelines provide excellent general suggestions; however there are limited data on treating individuals with schizophrenia. This presentation shares treatment experience based on an 18-month smoking cessation program within the Connecticut Mental Health Center and focuses on teaching the use of motivational enhancement therapy techniques for this population. About 75 patients were treated in a 10-week smoking cessation study that compared once versus twice weekly psychosocial treatment. All patients were offered free nicotine replacement. Baseline and ongoing carbon monoxide testing occurred. The once weekly therapy group received either supportive, behavioral, and psychoeducational group therapy or motivational enhancement individual therapy (MET). MET uses an empathic approach to build the patients' motivation to change and strengthen their commitment to change. The therapist actively uses follow-up letters and phone calls. The individuals in the twice-weekly therapy group received both MET and group therapy. Twice-weekly treatment had longer treatment retention and more smoking reduction than weekly treatment. Both groups had similar six months total abstinence follow-up rates (about 15%). MET and nicotine replacement improves smoking cessation efficacy for psychiatric patients. Other treatment strategies will be discussed. Supported by NIDA P50-DA04060 (TK) and K20-DA0193 (DZ).

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SYMPOSIUM 45—SYSTEMS CHANGE INCLUDES PSYCHIATRIC REHABILITATION
Joint Session with the World Psychiatric Association's Section on Psychosocial Rehabilitation

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should (1) know the large-scale deinstitutionalization and reduced length of stay occurring in Korea and Japan with concomitant development of community treatment, (2) understand the growth of the family movement in China to reduce stigma, (3) appreciate Quebec's adaptation of French sectorization, (4) learn how Mexico's standards include rights and rehabilitation.

No. 45A
CANADA: PROVINCIAL PLANS

Gaston P. Harnois, M.D., *Manhattan Psychiatric Ctr, Ward's Island, New York NY 10035;* Michel Messier, M.D.

SUMMARY:

The province of Quebec has developed a provincial plan that seeks to provide for the public sector with the WHO Collaborating Center at Douglas Hospital, Montreal. The emphasis is on making changes to adapt the French model of sectorization for use in Quebec. The model emphasizes treatment team continuity of responsibility and is similar to the assertive community treatment now being disseminated throughout the United States, but the treatment teams generally have more authority and cover catchment areas of about 70,000. From the start the plan has emphasized including psychiatric rehabilitation among the community-based services to be offered. Rehabilitation has been received with some enthusiasm.

No. 45B
CHINA: RELAPSE REDUCED

Chen Yang Fang, M.D., *Manhattan Psychiatric Ctr, Ward's Island, New York NY 10035;* Martin Gittelman, Ph.D.

SUMMARY:

Since the early 1980s the Chinese Ministry of Public Health has worked actively with the World Health Organization and its nongovernmental organizations (NGOs), including the World Association for Psychosocial Rehabilitation, to provide treatment and rehabilitation for China's estimated 10 million persons with serious mental illness.

With relatively few trained psychiatrists (10,000) and a limited number of mental hospitals, China has increasingly used novel, low-cost methods to maximize the numbers of disabled persons who could be assisted. Since 1988 the thrust has been toward the education of the family and the community, working with village or neighborhood doctors (previously called barefoot doctors). These doctors work under the supervision of physicians and usually reside close to the patients and families they serve.

Several large-scale randomized and controlled scientific studies show, on more than 4,000 persons suffering from mental illness and their families, that it is possible to obtain an extremely low rate of relapse and hospitalization for persons with mental illness utilizing medication and community-based psychosocial treatment. Reported rates of relapse have been lower than those reported for many developed countries. Since 1992 the China Disabled Persons Association has been carrying these programs out in 32 countries and municipalities for a population of 70 million.

No. 45C
JAPAN: DEVELOPING COMMUNITY TREATMENT

Naotaka Shinfuku, M.D., *Manhattan Psychiatric Ctr, Ward's Island, New York NY 10035*

SUMMARY:

It has been well-known that psychiatric treatment in Japan has depended excessively on hospitalization. The average length of stay in 1988 was 496 days, (41 times that in the United States) using 1,048 hospitals. In 1990 there were 439,963 beds, one of the highest number of beds per capita in the world. Treatment has traditionally emphasized rest, relaxation, and withdrawal from the world. This has not always been compassionate, in that there has been a strong stigma attached to mental illness. In recent years there has been a strong interest in developing community-based programs, some of which will be described in this paper. Psychiatric rehabilitation has been included from the start of community planning, and is well received. Comparisons will be drawn with other countries in the Pacific region from the author's experience as WHO regional mental health advisor.

No. 45D
KOREA: MOVING TO COMMUNITY-BASED TREATMENT

Boo Yon Rhie, M.D., *Manhattan Psychiatric Ctr, Ward's Island, New York NY 10035;* S. Peter Kim, M.D.

SUMMARY:

Public health policies regarding individuals with mental illness in the Republic of Korea were marked by misunderstandings until the early 1980s. For the past 30 years there has been sporadic interest in the passage of a mental health act, but it has not yet passed. Despite lack of legislation about human rights and statutory definitions, inpatient hospitalization has increased rapidly. With little post-hospital care, relapse was frequent and often occurred very soon after discharge. In 1995 there were 18,640 specialized beds for psychiatric patients with an additional 1,700 in asylums in a total of 462 hospitals. The number of psychiatrists and other mental health professionals has been increasing rapidly.

Recent consultations have recommended passage of the mental health act, establishment of a National Institute of Mental Health, sectorized community treatment and rehabilitation programs, training programs at home and abroad, legislation for the handicapped, human rights, etc. The recommendations are being implemented rapidly, including an annual conference of psychiatric rehabilitation. Rehabilitation and continuity of care have received the highest priority for implementation.

No. 45E
MEXICO: ACCREDITATION ON STANDARDS FOR HOSPITALS

Rosalba Bueno-Osawa, *Manhattan Psychiatric Ctr, Ward's Island, New York NY 10035*

SUMMARY:

As some attenders at the APA meeting must be aware, there has been considerable confusion about the quality of mental health care in Mexico. This paper describes the development and adoption of national standards for psychiatric hospitals in Mexico. In addition to what one might expect from any standard setting exercise, there was great support for including requirements for rehabilitation and research as part of each hospital's mission. The standards have been signed into law by the president and now are being implemented.

No. 45F
UNITED STATES: TEACHING RESIDENTS REHABILITATION

Zebulon C. Taintor, M.D., *Department of Psychiatry, NY University Medical Center, 550 First Avenue, NB 20N11, New York NY 10016;* Robert Cancro, M.D., Carol A. Bernstein, M.D., Brian J. Ladds, M.D., Bruce M. Levine, M.D.

SUMMARY:

After a year of planning we started our first section of 12 residents one day a week for six months. Our goals are:

(1) knowledge: content of standard texts and recent issues of the *Journal of Psychiatric Rehabilitation;* different models of rehabilitation as evidenced by visiting diverse community facilities (clubhouse, therapeutic community, vocational rehabilitation, etc.); efficacy data for the various modalities involved.

(2) skills: rehabilitation readiness assessment; lead group of up to eight patients for 75 minutes in hospital or clinic; prescribe rehabilitation modalities with the same expertise they have for medications.

(3) attitudes: at least sympathize with, if not adapt, basic tenets of rehabilitation philosophy.

The day consists of team meetings, leading a group, supervision, a didactic hour, and community visits. Guest presenters in the didactic hour include people who have recovered from schizophrenia, family members, vocational rehabilitation workers, intensive case managers, and presentations on welfare, disability, housing, and work. Residents were unhappy with texts that emphasized philosophy over practicality, opposition of rehabilitation to treatment, the sparseness of efficacy data, and the overzealousness of people they met and whose work they read. Issues about maintaining the role of the patient's physician were handled by including the rehabilitation group in the comprehensive treatment plan.

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SYMPOSIUM 46—JOINT UNIVERSITY AND STATE FORENSIC TRAINING AND RESEARCH

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to (1) recognize steps in developing a joint training program; (2) recognize issues in diagnosing adolescent homicide; (3) recognize noncompliance, mental illness, and criminality.

No. 46A
QUALITIES OF ADOLESCENTS SEEN FOR FORENSIC EVALUATIONS

Michael P. Duran, M.D., *Department of Psychiatry, Forensic Center, PO Box 2060, Ann Arbor MI 48106;* Diane E. Heisel, M.D., Craig A. Lemmen, M.D., Stephen C. Cook, M.D.

SUMMARY:

This study will investigate the characteristics of child and adolescent criminal defendants referred to the Center for Forensic Psychiatry over the five-year period from 1989 through 1994. A database was compiled of over 175 adolescents referred for criminal forensic evaluations during this time period. The data will include basic demographic information, reasons for referral, criminal history, type of crimes committed, substance abuse history, psychiatric history, and outcomes of the evaluations. Some hypotheses will be made concerning typologies of criminal adolescent offenders. Examples of types of results obtained include a 30% to 50% increase in the number of referrals made in 1993 and 1994 compared with previous years and the ratio of person crimes to property crimes, which is around 4:1.

No. 46B
RESIDENCY TRAINING IN FORENSICS: REVISITED

Kathryn J. Ednie, M.D., *Department of Psychiatry, Forensic Center, PO Box 2060, Ann Arbor MI 48106;* Michelle Riba, M.D.

SUMMARY:

With the impetus of a contract between the department of community health's forensic bureau and the University of Michigan to provide education, the training of psychiatric residents in state facilities has been expanded. Last year we reported on the initial development of the forensic rotation for psychiatric residents. The program continues to expand, with further didactic and experiential components. We will describe the continued development of the curriculum.

No. 46C
RELATIONSHIP TO VICTIM IN ADOLESCENT PARRICIDE

Catherine F. Lewis, M.D., *Law and Psychiatry, Yale University, 34 Park Street/PO Box 1842, New Haven CT 06508;* C.J. Voigt, M.D., Elissa P. Benedek, M.D.

SUMMARY:

Objective: To examine a population of adolescents charged with the murder of a family member and to assess the impact of relationship to victim (mother, father, step-father, step-mother) on crime characteristics.

Methods: Data were gathered via chart review for adolescents (under age 18) referred for the murder of a family member to the Center for Forensic Psychiatry (Ann Arbor, MI) from 1977 to 1996. Data gathered included demographic data, method of murder, relationship to victim, substance use at the time of the crime, accomplice, confession, preceding argument, abuse of perpetrator by victim, psychiatric symptoms, and commission of a second crime at the time of the murder.

Results: There were statistically significant differences between adolescents killing mothers versus fathers and parents versus stepparents.

Conclusion: Specific differences among groups will be discussed. Implications of these differences will also be explored.

No. 46D
TATTOOS IN FORENSIC PSYCHIATRIC INPATIENTS

William Cardasis, M.D., *Department of Psychiatry, Center for Forensic Psychiatry, PO Box 2060, Ann Arbor MI 48106*

SUMMARY:

Objective: The literature on tattoos in psychiatric patients and prisoners suggests that persons with tattoos have a higher incidence of antisocial (APD) and borderline (BPD) personality disorders than the general population. The author examined the relationship of tattoos to personality disorders in a maximum security forensic psychiatric setting.

Method: Inpatients of the forensic hospital who consented to participate in the study were administered a semi-structured interview to determine the presence of tattoos. APD and BPD were determined by a DSM-IV checklist of diagnostic criteria and by DSM-IV admission diagnosis. Various parameters of each tattoo as well as demographic data of the patients were recorded.

Results: Tattooed subjects were significantly more likely to have diagnoses of APD, substance abuse, and a history of sexual abuse, suicide attempts, and juvenile delinquency.

Conclusion: The presence of tattoos in forensic psychiatric inpatients may help alert the clinician to important diagnostic and transference issues related to impulsive and self-harmful behavior and unstable affective states that may develop in treatment.

No. 46E
CRIME AND MENTAL ILLNESS: CONTRIBUTING FACTORS

Ernesto F. Figueroa, M.D., *T & R, Forensic Center, PO Box 2060, Ann Arbor MI 48106;* Jonathan H. Rootenberg, M.D., Kenneth R. Silk, M.D.

SUMMARY:

It has been documented that poor compliance with medications and substance abuse contribute to symptom relapse in individuals with major mental illnessess. To our knowledge little research has been done into how these two factors contribute to criminal behavior in this group of patients.

This is a preliminary study exploring the effect of medication noncompliance and substance abuse in mentally ill subjects who became involved with the criminal justice system. Our sample consisted of patients who had been referred to the Ann Arbor Center for Forensic Psychiatry to be evaluated for criminal responsibility.

Medication compliance was assessed by history and record review and substance abuse was assessed with the CAGE questionnaire and history of alcohol or drug abuse at the time of the offense. We compared patients who had been found responsible with those patients that were recommended Not Guilty by Reason of Insanity (NGRI) to test the hypothesis that those patients that were recommended NGRI were more likely to have been off medications and/or abusing substances prior to their offense. Information from 50 patients, 25 in each group, will be presented. This study may provide empirical support to the notion that an important avenue toward preventing criminal behavior in mentally ill individuals would be by monitoring medication compliance and carefully addressing substance abuse behavior.

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SYMPOSIUM 47—DEPRESSION IN WOMEN ACROSS THE REPRODUCTIVE CYCLE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able: 1) To recognize and diagnose mood disorders in premenstruum, pregnancy, the postpartum period, and menopause. 2) To identify high-risk populations and develop an approach to management. 3) To sensitize clinicians to the use of new and effective pharmacological interventions in this group of patients.

No. 47A
COMPREHENSIVE TREATMENT APPROACH TO PREMENSTRUAL DYSPHORIC DISORDER

Diana Carter, M.B., *Department of Psychiatry, St. Paul's Hospital, 1081 Burrard Street, Vancouver BC V5Z 1Y6, Canada;* Donna Forsyth, R.D.N., Annie Kuan, B.A.

SUMMARY:

Premenstrual dysphoric disorder affects 3% to 5% of women of reproductive age. Recent research has shown that selective serotonin reuptake inhibitors (SSRIs) are often an effective treatment.

Other approaches include dietary changes, exercise and stress and anger management.

In this paper a systematic, multidisciplinary approach to the treatment of women with PMDD referred to the PMS Clinic, Women's Health Centre, Vancouver, Canada, is discussed. This program involves an educational group session, dietary and lifestyle counseling and referral to a physician for assessment and medical treatment if necessary. Using daily self-rating scales, visual analogue scales and ratings of satisfaction with the program we discuss the effectiveness of each step of the program, and the implications for cost effective treatment.

No. 47B
ANTIDEPRESSANTS IN PREGNANCY AND LACTATION

Zachary N. Stowe, M.D., *Department of Psychiatry, Emory University, 1639 Pierce Drive, Atlanta GA 30322;* Alexis M. Llewellyn, B.A., Michael J. Owens, Ph.D., James C. Ritchie, Ph.D., Clint Kilts, Ph.D., Charles B. Nemeroff, M.D.

SUMMARY:

Numerous epidemiological studies have suggested that women are at greater risk for developing both affective and anxiety disorders. There is evidence that the childbearing years represent a time of increased vulnerability, underscoring the need to develop scientifically derived guidelines for treatment of these disorders during pregnancy and lactation. The majority of data on the use of psychotropic medications during pregnancy and lactation comes from post-marketing surveillance, case reports, or inadvertent conceptions during clinical study. The physiological and chemical characteristics of medications that determine the degree of placental passage and excretion into breast milk include: 1) degree of ionization; 2) protein binding; 3) half life of elimination; and 4) molecular weight. In our current study, we collected 22 mother-umbilical cord serum pairs at delivery from women taking antidepressants. Sertraline (0.43 $\pm$ 0.14) and fluoxetine (0.93 = 0.61) demonstrated incomplete placental passage (ratio < 1.0), and similar results were demonstrated for their metabolites. In a series of breast feeding women who took either sertraline, fluoxetine, paroxetine, or venlafaxine, breast milk samples were collected to determine the gradient and time course of excretion into breast milk. Serum was obtained from 12 nursing infants exposed to sertraline and follow-up data were collected for the first two years of life. The purpose of this presentation is to present the preliminary data, discuss application of such findings and future study to the development of clinical treatment guidelines.

No. 47C
PREVENTION OF RECURRENT POSTPARTUM DISORDERS

Katherine L. Wisner, M.D., *Department of Psychiatry, Case Western Reserve Univ., 11400 Euclid Avenue, Suite 200, Cleveland OH 44106*

SUMMARY:

Objective: Postpartum depression occurs in 10% to 15% of women, while postpartum psychosis occurs in 2 to 3 per thousand births. These mothers are worried about recurrence after later births. This paper will discuss strategies for prevention of recurrent episodes.

Method: Information was derived from a literature review.

Results: In limited case series, progesterone and estrogen have been reported to prevent postpartum disorders. Another approach has been to use psychotropic agents prophylactically. Data from open trials by Stewart et al (1991) and Austin (1992) showed that administration of lithium in the immediate postpartum period prevented recurrent affective psychoses. Stewart et al treated 21 women with lithium and averted recurrent episodes in 19 patients. In Austin's series of 17 women, only 2 of 9 women who received lithium prophylaxis suffered postpartum mania; 6 of 8 unmedicated women suffered manic episodes. To prevent recurrent postpartum major depression, Wisner and Wheeler (1994) offered 23 women immediate post-birth antidepressant treatment or monitoring alone. A signifi-

cantly greater proportion of the monitored (5/8) compared to medicated (1/15) women suffered recurrence.

Conclusions: Data from open trials are highly encouraging, and psychotropic prevention should be considered for women at risk. Definitive data from randomized clinical trials (an NIMH-funded trial is being performed currently by the author) are urgently needed.

No. 47D
PARTNER SUPPORT IN POSTPARTUM ILLNESS

Shaila Misri, M.D., *Department of Psychiatry, St. Paul's Hospital, 1081 Burrard Street, Vancouver BC V5Z 1Y6, Canada;* Dana A. Sinclair, Ph.D.

SUMMARY:

This paper will describe a prospective study currently being conducted at St. Paul's Hospital, University of British Columbia, on Partner Support in Maternal Recovery from Postpartum Illness.

The purpose of the study is to assess whether partner education and support impacts on the process of recovery in these depressed women treated with SSRIs. Women either married or co-habiting with a DSM-IV diagnosis of postpartum depression (onset of illness within 12 postpartum months) are recruited from the reproductive psychiatry program. Patients are randomly assigned to two groups.

Group I - Control Only. Seen for 6 clinical visits. At baseline a number of instruments are filled out by the patient including the Edinburgh Depression Scale. Partners also fill out relevant subjectively rated scales, while the clinician assessment is based on the Mini International Neuropsychological Interview (MINI). At 6 and 8 weeks, post-treatment evaluation is measured.

Group II - Subjects and their partners are seen jointly for three of the six visits. Both subjects and partners are evaluated in the control group. The partners receive additional psychoeducational information. Post-treatment evaluation is done at 6 weeks, and follow-up assessment is conducted at 8 weeks.

Currently 18 subjects are enrolled in the study. The aim is to recruit 50 subjects. This study will demonstrate the effectiveness of partner intervention in pharmacologically treated mothers in puerperium.

No. 47E
PREVALENCE OF DEPRESSION IN MENOPAUSE

Leslie W. Tam, M.D., *5233 Canterbury Drive, San Diego CA 92116-2007;* Barbara L. Parry, M.D.

SUMMARY:

Menopause has been the focus of attention in recent research but with an emphasis on coronary heart disease, gynecologic and metabolic diseases. Mood disorders in menopause and the effects of hormone replacement therapies on mood have been less thoroughly studied. The literature on whether or not there is an association between menopause and depression is controversial. The studies that claim no association are often fraught with methodologic errors or exclude certain groups of women, such as those with surgical menopause or those with prior history of depression. The studies that find an association between depression and menopause seem to pinpoint the peri-menopausal period, but often use nonclinical assessment tools and are vague with regard to whether they are reporting major depression or depressed mood. We studied menopausal patients seen at a women's health center and collected a Beck Depression Inventory as well as psychiatric and medical history. We plan to invite all patients with a Beck score greater than 10 to have a complete work up, including a Structured Clinical Interview for DSM-IV Diagnoses. We will analyze and present preliminary data.

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SYMPOSIUM 48— PSYCHOPHARMACOLOGY ON THE INTERNET

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, participants should:

1) appreciate the potential of the Internet to enhance research, education, and practice in the field of psychopharmacology, and

2) have specific resources that they can make use of themselves.

No. 48A
APA ELECTRONIC JOURNAL

Donald F. Klein, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, Unit 22, New York NY 10032-2603*

SUMMARY:

The American Psychiatry Association and the American Psychological Association have jointly agreed to publish an electronic journal on treatment evaluation. Dr. Klein will review the promise of such a journal and the current policies for authors and reviewers. In particular, moving the journal from the purely episodic and didactic mode of the ordinary academic journal to a more interactive, dialogue facilitating, mode will be discussed.

No. 48B
EDUCATIONAL USES OF THE INTERNET: THE PSYCHOPHARMACOLOGY MAILING LIST

Ivan K. Goldberg, M.D., *1346 Lexington Avenue, New York NY 10128-1507*

SUMMARY:

The psychopharmacology mailing list is a virtual community of approximately 1,000 mental health professionals, mostly psychiatrists, from 34 countries. At the hub of a mailing list is a mail reflector, a computer that when it receives a message in the form of an e-mail from a subscriber, bounces copies by e-mail to all who subscribe to that list. Mailing lists can be open or closed. Closed ones, such as the psychopharmacology list, screen prospective members and only allow those who qualify to subscribe. Subscriptions are free of charge, and are only available to mental health professionals.

The largest number of members of the psychopharmacology list come from the United States, with the second largest number coming

from Canada. If one adds to these members those from the United Kingdom, Australia, and New Zealand, one has accounted for about 90% of subscribers.

On an average day the psychopharmacology list distributes from 30 to 40 messages to the subscribers. The subjects of these messages range from technical questions involving dosages and drug interactions to ethical issues. Messages regarding the treatment of individuals with mood disorders outnumber messages on any other topic.

No. 48C
PSYCHOPHARMACOLOGY TIPS ON THE WORLD-WIDE WEB

Robert C. Hsiung, M.D., *Department of Psychiatry, University of Chicago, 5737 South University Avenue, Chicago IL 60637*

SUMMARY:

An innovative use of the World-Wide Web, a collaborative, continually-evolving collection of psychopharmacology information, is demonstrated.

The Psychopharmacology Tips web site consists of practical psychopharmacologic strategies submitted by members of an ongoing psychopharmacology electronic mail discussion group and selected, edited, indexed, and adapted for the Web by the presenter. Psychopharmacology Tips is demonstrated "live," illustrating both its ease of use and its utility.

Feedback from users and summary usage statistics are shared. It is accessed about 10,000 times per month.

The significance of such a resource is discussed. It constitutes a highly practical and up-to-date knowledge base that supplements one's own clinical experience and the research literature. It serves consultation, continuing medical education, and even patient education functions.

No. 48D
RECRUITMENT OF PATIENTS FOR RESEARCH ON THE INTERNET: A PILOT STUDY

Steven E. Hyler, M.D., *Unit 112, WHCS, NY Psychiatric Institute, Unit #112 WHCS, 722 West 168th St., New York, NY 10032*

SUMMARY:

It is estimated that over 30 million people worldwide have accessed the Internet: the number increases by tens of thousands every week. Researchers who are interested in patient recruitment for their studies thus have access to a potentially limitless supply of subjects. A knowledge of the workings and culture of the Internet allows investigators to target specific populations, e.g., patients with specific disorders, that they are interested in recruiting. The sheer size of the Internet maximizes the possibility that researchers who are interested in recruiting patients with rare disorders will be able to reach a number of suitable subjects.

The purpose of this presentation is to outline a methodology to make use of the Internet for patient recruitment and research. Issues of feasibility, confidentiality, and efficacy will be discussed. In its simplest form, researchers can simply post notices to various targeted newsgroups describing the project and providing a telephone number to call. More ambitious projects might involve developing and posting custom forms to collect data on-line, to efficiently process large numbers of geographically distant subjects. Examples of both simple and ambitious attempts at recruitment and research will be presented.

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SYMPOSIUM 49—PSYCHIATRY'S CHANGING RELATIONSHIP WITH PRIMARY CARE: ECONOMICALLY VIABLE MODELS FOR PATIENT CARE AND TRAINING

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able

1) To estimate costs of mental disorders in primary care settings.

2) To understand models used for patient care and training: collaborative care, primary/psychiatry joint training programs, and telemedicine.

3) To understand how capitation and case rate methodologies are used to deliver mental health care to primary care networks in academic medical centers.

No. 49A
WHAT PRIMARY CARE FACULTY AND RESIDENTS NEED TO KNOW ABOUT THE COSTS OF UNDIAGNOSED MENTAL DISORDERS

R. Bruce Lydiard, M.D., *Department of Psychiatry, Medical University of SC, 171 Ashley Avenue, Charleston SC 29425*

SUMMARY:

In primary care settings, unrecognized psychiatric disorders contribute to patient morbidity and significantly increase the utilization of medical services. It is reported that behavioral and mood-related problems, including subsyndromal anxiety and depression, are associated with more than 25% of medical visits. Consultation psychiatrists have intervened by educating primary care physicians about the incidence and prevalence of psychiatric disorders, somatic presentations of psychiatric disorders, new screening instruments, and the need for aggressive treatment of mental disorders. There is increasing evidence that patients with depressive and anxiety disorders constitute an important subpopulation of health care seekers, and many of these are "high health-care utilizers." This presentation will present examples from the literature on the prevalence of depressive and anxiety disorders in patient samples seeking treatment from medical specialists (for example, cardiology, gastroenterology) and primary care physicians. Specific information regarding the economic burden of unrecognized anxiety and depressive disorders—as well as some information on those with both—will be reviewed. Specific interventions will be further highlighted in subsequent presentations in this symposium.

No. 49B
NEW MODELS FOR TRAINING PSYCHIATRIC FACULTY AND RESIDENTS TO TEACH PRIMARY CARE PHYSICIANS

Wayne J. Katon, M.D., *Department of Psychiatry, University of Washington, 1959 West Pacific Street, NE, Seattle WA 98195*

SUMMARY:

Psychiatrists have unique skills to offer in integrating psychological services into primary care clinics. However, the environment of primary care requires training in specific skills that are necessary to succeed with primary care patients and physicians. This presentation will focus on training programs that provide unique content skills such as increasing knowledge about somatization, comorbid medical and psychiatric illness, implementing guidelines on treatment of major depression, and treatment resistant anxiety and depression. Training in process skills such as rapid interview techniques, education and destigmatization regarding mental illness, running Balint groups, concise and lucid communication with primary care physicians, and working in mental health teams will also be described.

No. 49C
A SURVEY OF PSYCHIATRY/PRIMARY CARE JOINT TRAINING PROGRAMS

Mark E. Servis, M.D., *Department of Psychiatry, UC Davis Medical Center, 4430 V Street, Sacramento CA 95817;* Paul D. Cox, M.D., James Nuovo, M.D.

SUMMARY:

Educational collaborations between primary care and psychiatry have generated an increase in the number of combined training programs in family medicine/psychiatry, internal medicine/psychiatry, and pediatrics/psychiatry. A review of joint training programs from 1991 to 1995 reveals five new programs in family medicine/psychiatry, 23 new programs in internal medicine/psychiatry, and six new programs in pediatrics/psychiatry. Nearly 20% of all psychiatry training programs now offer combined primary care/psychiatry training. A structured telephone survey of 20 training directors of established primary care/psychiatry joint training programs was conducted. Programs were selected to provide size, geographic, and primary care specialty representation. The survey revealed common concerns around the complexity of combined training and uncertainty about the practice patterns of graduates. Problems identified by training directors included lack of an integrated and coordinated curriculum, limited peer support during training, impact of switching services during residency, and difficulty in establishing professional identity. Despite these challenges training directors expressed support for combined training programs due to the increasing number and the high caliber of applicants to these programs, the development of "bridging" persons between primary care and psychiatry, and the extension effect of building additional collaborations with primary care.

No. 49D
RURAL PSYCHIATRIC COLLABORATIVE CARE VIA TELEMEDICINE

Thelma Armstrong, *Mental Health, Eastern Montana, 2800 10th Avenue North, Billings MT 59101*

SUMMARY:

Telemedicine was initiated in 1959, but was not universally accepted because of high start-up costs. New technology, which is significantly cheaper and more convenient, has led to a resurgence of interest by the mental health field. The Eastern Montana Telemedicine Network was established in 1993 to provide high quality health care to patients in rural eastern Montana and to reduce expenses of travel incurred by physicians and patients. The EMTN has nearly ten sites with full motion interactive videoconferencing network and was funded by several grants. The July 1996 edition of *Telemedicine Today* ranked the EMTN program first in the number of psychiatry consultations provided over the past year. Between October 1995 and July 1996, 495 telemedicine consultations were provided, of which 436 were mental health consultations. The rural provider was present 43% of the time, which facilitated education of the provider. Savings to patients were estimated at over $62,000, based on travel time, lost wages, and food and lodging. Seventy-four percent of providers reportedly used teleconsultation as their only alternative to referring patients out of the community. Patient and provider satisfaction were high, averaging 7 on a scale of 1 (lowest) to 8 (highest).

No. 49E
IMPORTANT ADMINISTRATIVE/ECONOMIC ISSUES IN THE DELIVERY OF MENTAL HEALTH SERVICES TO PRIMARY CARE NETWORKS BY ACADEMIC DEPARTMENTS OF PSYCHIATRY

Donald M. Hilty, M.D., *1409 Pine Lane, Davis CA 95616;* Robert E. Hales, M.D., Antony Smith, Ph.D.

SUMMARY:

Increasingly, mental health services are being provided to patients by mental health groups who receive a fixed per member per month (PMPM) payment for all services provided. The PMPM payment varies according to the patients served, type of insurance (Medicare, Medicaid, or private), the degree of penetration (competition) of managed care in the area, and the intensity of utilization review. Nationwide, comprehensive PMPM rates have varied from $2 to $4. In California, rates have ranged from $2 to $3 PMPM. In addition, some mental health groups are using case rate methodologies, whereby practitioners and health care institutions receive a fixed amount of money to provide professional or institutional services for a specified period of time. In the UC Davis health system (UCDHS), a behavioral health center (BHC) was created to manage the capitated mental health care patients. The center receives $2.16 PMPM and a $.34 two-year start up subsidy to provide those services. Care is provided by faculty, psychiatry residents, psychology trainees, and social workers from various departments at the medical center. This paper will describe the systems developed by the UCDHS BHC to coordinate and evaluate the effectiveness of care and to provide consultation to the 13 university primary care network sites located in central California. Case rates are being provided to faculty and trainees and discounted fee-for-service rates are being provided to community based mental health providers. A six-month analysis was conducted comparing the two groups in terms of number of patient visits, number of hospitalizations, patient and provider satisfaction, and patient ratings on selected scales.

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SYMPOSIUM 50—DIAGNOSING AND TREATING DEPRESSION IN PATIENTS WITH PHYSICAL ILLNESSES

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM

At the conclusion of this presentation, the participant should (1) be knowledgeable about the prevalence data and depressive states and syndromal depression in immune-based disease (AIDS and cancer); (2) recognize state-of-the-art treatments and novel therapies for depression in medically ill patients; (3) be able to diagnose mood disorders and subsyndromal depression in medically ill patients; (4) be aware of neuropsychopharmacological research opportunities that exist.

No. 50A
MOOD DISORDERS IN HIV INFECTION

Dwight L. Evans, M.D., *Department of Psychiatry, University of Florida, 1600 Archer Road, Gainesville FL 32610;* John M. Petitto, M.D., Diana O. Perkins, M.D., J. Lesserman, M.D., Robert A. Stern, Ph.D., B. Zheng, M.D.

SUMMARY:

There is increasing evidence that a substantial proportion of patients with HIV infection have significant depressive symptoms including major depression. In addition, there is considerable popular enthusiasm for the notion that stress and depression are associated with alterations in cellular immunity as well as decreased survival in immune based diseases such as cancer and AIDS. This presentation will review the available literature on stress and depression-associated alterations in immunity. Furthermore, available studies of mood disorder and HIV infection will be presented, and data from an ongoing prospective evaluation of stress and depression in HIV infection will be discussed. Diagnostic data from structured psychiatric interviews and immunological measures will also be presented. Data will be discussed that documents the significance and prevalence of major depression in the early stage of HIV infection. Relatedly, the effects of stress and depression on immunity as well as HIV disease progression will be presented. Current analysis of this longitudinal study indicates that stressful life events are associated with significant reductions in key parameters of cellular immunity including natural killer cells and cytotoxic T lymphocytes. Furthermore, stress and depression are associated with an increased likelihood of early HIV disease progression.

No. 50B
PREVALENCE OF MAJOR DEPRESSION IN HIV-INFECTED INDIVIDUALS

J. Hampton Atkinson, Jr., M.D., *Department of Psychiatry, University of CA at San Diego, 9500 Gilman Drive, La Jolla CA 92093*

SUMMARY:

The purpose of this study was to determine the lifetime and other psychiatric disorders in HIV-infected persons, and "at risk" controls. In a two-year cohort analytic study, 279 HIV-infected men and 90 HIV negative risk group controls were examined semiannually for major psychiatric disorders using the Structured Clinical Interview for DSM-III-R (SCID).

Lifetime prevalence of major depression was elevated in both HIV-infected men (33%) and HIV negative "at risk" controls (30%). Current rates were also increased, and ranged from 4% (physically asymptomatic persons) to 10% (in physically symptomatic individuals). Two-year rates of "incident" major depression (excluding those with an episode at baseline) were likewise elevated (25% for HIV infected and 23% for controls), and was higher in men with symptomatic (Stage B & C) disease compared to asymptomatic (Stage A) illness (40% vs 19%).

Lifetime major depression is elevated in HIV-infected persons, but must be viewed both against the high background rates of the population "at risk," and high current rates in light of comparable rates in other chronic medical conditions.

No. 50C
PHARMACOLOGIC TREATMENT OF DEPRESSION IN HIV

Judith G. Rabkin, Ph.D., *Department of Psychiatry, Columbia University, 722 West 168th Street/Box 35, New York NY 10032*

SUMMARY:

Findings from five studies conducted to treat depression in HIV + patients, using conventional antidepressants (imipramine, sertraline, fluoxetine) and innovative treatments (dextroamphetamine, testosterone) will be reviewed. Trials were two weeks (dextroamphetamine) to eight weeks (fluoxetine, sertraline, and testosterone). Assessments of mood, quality of life, immune measures (T cell subsets, beta 2 microglobulin, natural killer cell count, and pilot study of viral load) were made before and after treatment.

Baseline HIV illness severity among study participants varied significantly. Most men in the sertraline study were asymptomatic; all men in the dextroamphetamine trial and half in the testosterone trial had CD4 cell counts under 50. Across studies, clinical responses were in the range found in medically healthy patients. The aggregate placebo response (across two placebo-controlled trials) was 33%, while response to active medication ranged from 70% (sertraline, open trial) to 93% (dextroamphetamine, open trial). Depression in HIV + patients, even in late stage HIV/AIDS, is as treatable as depression in medically healthy patients. Treatment of depression may not prolong life, but can improve quality of remaining life both directly and through increased adherence to complex and often arduous medical regimens.

No. 50D
CANCER AND DEPRESSION

David Spiegel, M.D., *Department of Psychiatry, Stanford Medical School, 401 Quarry Road, Room 2325, Stanford CA 94305-5544*

SUMMARY:

Significant anxiety and depression are common (and treatable) problems among the medically ill. Depression is three times as common (11%) among medical inpatients, and twice as common (6 % among medical outpatients), than in the general population (3%). Half of cancer patients have a psychiatric disorder, the most common of which are adjustment disorders with depression. Anxiety about cancer leads to delay in diagnosis which reduces prospects of long-term cancer survival by 10% to 20%. Depression is often underdiagnosed in the medically ill. Psychotherapy provides valuable emotional and social support, teaches symptom management skills (pain and anxiety) and active coping, facilitates emotional expression, reduces fears of dying and death, reordering life priorities, and improves relationships with family, friends, and physicians.

Women were recruited for a non-randomized protocol with baseline, three-, and six-month assessments. The dependent variable was total mood disturbance scores on the Profile of Mood States. Significant decreases in total mood disturbance over time (repeated measures ANOVA $F(1, 175 = 3.37, p < .02$ were demonstrated. Mean POMS scores declined from 24.8 (SD 31.7) at baseline to 15.9

(SD 33.6) at six months. Three randomized prospective trials of psychotherapeutic interventions among cancer patients have shown a surprising positive effect on survival time. These findings suggest a more active role for psychiatric treatment in the management of the medically ill.

REFERENCES:

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3. Rabkin JG: Prevalence of psychiatric disorders in HIV illness. *Int Rev of Psychiatry,* 8, 1996, in press.
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SYMPOSIUM 51—SOCIAL PHOBIA: NATURE NURTURED?

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be familiar with developmental, familial, and genetic variables in the etiology of social phobia.

No. 51A
SOCIOCULTURAL ASPECTS OF SOCIAL PHOBIA

Franklin R. Schneier, M.D., *Dept. of Therapeutics, NY State Psychiatric Institute, 722 West 168th Street, Unit 13, New York NY 10032*

SUMMARY:

By name and definition, social phobia is a disorder of *social* behavior, yet little is known about social and cultural influences on the etiology, course, and treatment of this disorder. One consistent finding which suggests the impact of social factors is the higher rate of treatment seeking among men with social phobia, as compared to women. This may be due to sex differences in role expectations for such activities as public speaking or assertive behavior. Also, although social phobia was once believed to be a disorder of the highly educated, epidemiologic surveys have shown it to be over-represented among persons of low socioeconomic status. Cross-cultural comparisons suggest that culture may influence the definition of social phobic psychopathology as well as its expression. For example, taijin kyofusho, a syndrome previously believed to be culture-bound in Japan, has been shown to overlap in some ways with social phobia symptoms. A more speculative issue is to what extent the growing awareness of social phobia (as well as other "disorders of social comparison," such as rejection-sensitive depression, body dysmorphic disorder, anorexia and bulimia nervosa) may be a consequence of broader individualistic and competitive trends in Western society.

No. 51B
CHILDHOOD ANTECEDENTS OF ADULT SOCIAL PHOBIA

Mark H. Pollack, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC-815, Boston MA 02114;* Michael W. Otto, Ph.D., Kristin Maki, B.A., Robert A. Gould, Ph.D., John J. Worthington III, M.D., Jerrold F. Rosenbaum, M.D.

SUMMARY:

In this presentation we will review findings from a study examining the rates and correlates of a childhood history of anxiety disorders in adults with a primary diagnosis of social phobia. Subjects were 100 outpatients with a primary diagnosis of social phobia who were participating in treatment trials examining the efficacy of medication or cognitive-behavior therapy for social phobia. Rates of childhood anxiety disorders were also evaluated relative to a panic disordered comparison group.

Onset of social phobia occurred before age 18 in 80% of the sample. Over half of the sample (54%) met criteria for one or more childhood anxiety disorders other than social phobia. A history of childhood anxiety was associated with an earlier age of onset of social phobia, greater severity of fear and avoidance of social situations, greater fears of negative evaluation, and greater anxiety and depression comorbidity.

Anxious children have been hypothesized to be at risk for a range of anxiety conditions at various developmental stages including the emergence of social phobia in adolescence and panic disorder later on in life. Findings from our study suggest that a history of childhood anxiety disorders is common among patients with social phobia and is associated with greater severity of adult illness as well as increased rates of depressive and anxiety comorbidity.

No. 51C
EXPERIENTIAL FACTORS IN THE DEVELOPMENT OF SOCIAL PHOBIA

Deborah C. Beidel, Ph.D., *Department of Psychiatry, Medical University of SC, 615 Wesley Drive, Suite 200, Charleston SC 29407*

SUMMARY:

Social phobia is a complex condition and its development is only poorly understood. Recently, more attention has been given to the role of experiential and environmental factors that may contribute to the onset of the disorder. This presentation will use the most recently available empirical data from the clinical, developmental, and social psychology literatures to review the importance of these factors for the development of social phobia, specifically, the contribution of environmental factors such as parental psychopathology, insecure parental attachment, peer neglect, under-developed social cognition, and social skill will be examined. For example, anxious, insecurely attached children are more likely to withdraw from peers in the social milieu. In turn, this peer isolation prevents opportunities for the acquisition of social cognition and social skill and those with limited skill are more likely to feel anxious and fearful in subsequent social encounters. A model proposing how all of these factors might combine with a biological predisposition to contribute to the development of social phobia will be presented.

No. 51D
SOCIAL PHOBIA RUNS (AND HIDES) IN FAMILIES

Murray B. Stein, M.D., *Department of Psychiatry, Univ. of California, San Diego, 9500 Gilman Drive, #0985, La Jolla CA 92093-0985;* Mariette J. Chartier, R.N., Andrea L. Hazen, Ph.D., Maria V. Kozak, M.A., Manuel E. Tancer, M.D., John R. Walker, Ph.D.

SUMMARY:

Social phobia has recently been observed to run in families. In our direct-interview family study of first-degree relatives of generalized social phobics (GSP) and first-degree relatives of nonsocially phobic controls, we found an approximate seven-fold increased rate of GSP among the former. In contrast, no increase in performance-only social phobia was detected. We also found that avoidant personality disorder (APD) was markedly increased among the GSP relatives

compared to the control relatives. When examined from a dimensional, rather than from a categorial perspective, similar findings emerged: significantly higher rates of self-reported social anxiety and fear of negative evaluation among first-degree relatives of GSP probands compared to first-degree relatives of controls.

These observations support the hypothesis that social phobia—but perhaps exclusively the generalized form—is a familial disorder. The increasing familial risk among more narrowly defined prototypes; i.e., GSP versus nongeneralized SP, strongly supports a major genetic contribution.

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2. Pollack MP, Otto MW, Sabatino S, et al: Relationship of childhood anxiety to adult panic disorder: Correlates and influence on course. *Am J Psychiatry*, 153, 376-81, 1996.
3. Beidel DC, Morris TM: Social phobia. In March JS (ed.), *Anxiety Disorders in Children and Adolescents*. New York: Guilford, 1995.
4. Stein MD: How shy is too shy? *Lancet* 347: 1131-1132, 1996.

SYMPOSIUM 52—COMBINED DRUG STRATEGIES IN CLINICAL PRACTICE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to understand the principles of rational copharmacy and use drug combinations with confidence in their practice.

No. 52A
IN DEFENSE OF COPHARMACY

Devdutt V. Nayak, M.D., *New York Methodist, 506 Sixth Street, Brooklyn NY 11215*

SUMMARY:

Traditional practice of psychiatry has always advocated the use of single-drug therapy, the rationale being that polypharmacy leads to a higher incidence of adverse effects and poorer patient compliance. In general, use of multiple similar drugs is to be avoided. However, "copharmacy," the simultaneous use of several different classes of drugs may be very helpful. Well tolerated monotherapy is effective only in 50% to 60% of patients with OCD, depression, and bipolar disorders. Adding other drugs can be beneficial from the pharmacokinetics as well as pharmacodymanic interactions. Combined treatments are growing with the introduction of newer "specific agents" and discovery of new uses for old agents, e.g., anticonvulsants, B blockers and Ca channel blockers. It is not uncommon for patients to have two or more diverse psychiatric disorders simultaneously or in succession, and comorbidity with drug and alcohol abuse is on the rise. With passage of time and recurrences some disorders will become chronic and refractory to single drug and only combination pharmacotherapy will bring some relief, lessen the mortality risk, and improve the quality of life for our patients.

No. 52B
CLINICAL STRATEGIES IN INTRACTABLE DEPRESSION

Jan A. Fawcett, M.D., *Department of Psychiatry, Rush-Presbyterian Medical Cntr, 1725 West Harrison, Suite 955, Chicago IL 60612*

SUMMARY:

This presentation will focus on the use of stimulant potentiation of various antidepressant medications including monoamine oxidase inhibitors in patients suffering from treatment resistant (partial response only with prior treatment) and treatment refractory depression (no improvement with prior treatments). Data will be presented reviewing clinical results and adverse effects encountered with the use of stimulant potentiation of MAOI medication as well as conventional antidepressants. Specific clinical issues involved will be addressed by the presentation of illustrative cases. Important considerations to be addressed in the selection of patients, obtaining of informed consent, and procedures and precautions to be taken in the administration of stimulant potentiation will be discussed.

No. 52C
RATIONAL COPHARMACY FOR BIPOLAR DISORDER

Philip G. Janicak, M.D., *Department of Research, Psychiatric Institute, 1601 West Taylor Street, Chicago IL 60612;* Rajiv P. Sharma, M.D., Eileen O'Connor, R.N., Edward Altman, Psy.D., Sheila Dowd, M.S., John M. Davis, M.D.

SUMMARY:

Optimal treatment of bipolar disorder often requires complicated multiple drug therapies during at least some phases of the illness. Unfortunately, there are few data from well-controlled studies to guide rational copharmacy for this disorder. In this context, we outline treatment approaches for various phases and subtypes of bipolar disorder based on the best available data. We discuss the role of low-dose conventional neuroleptics, as well as the use of novel antipsychotics (e.g., clozapine, risperidone) in combination with mood-stabilizing agents; benzodiazepines, particularly for acute manic exacerbations, to minimize antipsychotic use or as substitutes; the role of thyroid supplementation; and finally, ECT for either phase of the illness, especially when used in combination or sequentially with medication. We next consider anticonvulsant mood stabilizers, whether combined with other psychotropics or with each other, emphasizing their role for specific subtypes (e.g., rapid cyclers, mixed rates, organic mood disorders). The management of the depressive phase is also addressed, particularly regarding the potential for switching into mania or precipitation of a more virulent course. Finally, all these drug combinations will be considered for their acute and maintenance value, their clinically relevant pharmacokinetics, and their potential for serious interactions.

No. 52D
COPHARMACY IN TREATMENT-RESISTANT ANXIETY STATES

Michael R. Liebowitz, M.D., *Department of Psychiatry, NY State Psychiatric Institute, 722 West 168th Street/MB #120, New York NY 10032-2603*

SUMMARY:

Anxiety disorders like other psychiatric conditions are sometimes resistant to monotherapy. Depression and substance abuse are especially likely to complicate anxiety disorders, leading to treatment failure and chronicity. For example, monotherapy is ineffective in up to 40% of comorbid panic disorder and up to 60% of OCD. The circumstances where copharmacy is appropriate for anxiety disorders will be reviewed, and promising strategies for several disorders discussed. These include: for panic disorder, antidepressant plus benzodiazepine, multiple antidepressant plus beta blocker, or antidepressant plus benzodiazepine plus beta blocker strategies; for OCD, combined serotonin reuptake inhibitor (SRI) and selective serotonin

reuptake inhibitor (SSRI) (sometimes with an anticonvulsant), SRI or SSRI plus fenfluramine, or SRI or SSRI plus neuroleptic regimens. The kinds of evidence available for efficacy of these regimens will also be discussed. A limitation of the copharmacy literature is that, with a few notable exceptions, the positive evidence comes from clinical experience or uncontrolled trials. Recently, several copharmacy regimens that showed promise in open clinical trials in anxiety disorder patients did not prove effective in placebo-controlled trials.

No. 52E
TREATMENT OF DRUG-REFRACTORY SCHIZOPHRENIA

Sidney Fein, M.D., *Department of Psychiatry, New York Methodist, 506 Sixth Street, Brooklyn NY 11215*

SUMMARY:

Schizophrenia, a devastating and heterogeneous disease that consists of various subgroups, is often resistant to monotherapy. Approximately 10% to 30% of patients with schizophrenia show a poor response to neuroleptics alone. Even with treatment, 50% of schizophrenics lead severely debilitated lives. This paper reviews the literature on adjunctive treatments to augment neuroleptic effects. Successful adjunctive medications have been lithium, antidepressants, benzodiazepines, carbamazepine, reserpine, and electroconvulsive therapy (ECT). Also ECT in combination with clozapine has been successful. Some patients have responded to propranolol, clonidine, valproic acid, and L-dopa. Also, the combined use of risperidone with haloperidol and thioridazine will be reviewed. Thus, if a schizophrenic patient remains treatment resistant to an adequate trial of neuroleptics, a change to an atypical antipsychotic such as risperidone or clozapine, or augmentation treatment should follow.

No. 52F
POLYPHARMACY IN THE ELDERLY

Enid Rockwell, M.D., *Department of Psychiatry, Veterans Affairs Medical Cntr., 3350 La Jolla Village Drive, San Diego CA 92161;* Jonathan P. Lacro, Pharm.D., M. Jackuelyn Harris, M.D., Kathleen Warren, R.N., Alice Schalz, R.N., Dilip V. Jeste, M.D.

SUMMARY:

The field of geriatric psychopharmacology is characterized by several important differences from the practice of psychopharmacology in younger adults. The psychiatrist treating elderly patients must be cognizant of the additive adverse effects of psychotropic and nonpsychotropic agents, especially the side effects associated with muscarinic, adrenergic, and histaminic receptor antagonists. A good grasp of the pharmacokinetic and pharmacodynamic changes associated with aging is also essential.

This presentation will include a brief overview of the pharmacology of aging and examples of therapeutic vs. harmful polypharmacy (polymedicine). Dangerous drug interactions more common to the dementia patient will be addressed. Data from the "polypharmacy clinic" at the VA Medical Center, San Diego, will also be presented. We will also discuss appropriate use of multiple medications in elderly patients.

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1. Nelson JC: Combined treatment strategies in psychiatry *J Clin Psychiatry* 1993;54(9, Suppl):42-49.
2. Fawcett J, Kravitz HM, Zajecka HM, Schaff MR: CNS stimulant potentiation of monoamine oxidase inhibitors in treatment refractory depression. *Journal of Clinical Psychiatry* 11(2):127-132, 1991.
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SYMPOSIUM 53—PREDICTORS OF TREATMENT RESPONSE IN MOOD AND OCD-RELATED DISORDERS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, participants should be able to recognize specific temperaments, clinical symptoms, biological measures, and imaging measures that are predictors of response to specific medication/behavioral treatments.

No. 53A
TEMPERAMENT AND DRUG RESPONSE IN DEPRESSION

Hagop S. Akiskal, M.D., *Department of Psychiatry, Univ. of California, San Diego, 9500 Gilman Drive, La Jolla CA 92093-0603*

SUMMARY:

Standard psychopharmacologic methodology typically mandates comparing response rates of major depressive patients to new compounds versus placebo versus a reference antidepressant. Clinicians, however, are interested in knowing whether different types of antidepressants could be useful in specified subtypes of depression. Such efforts have generally failed to convince the research establishment; there seems to be meager data, if any, to argue for selectivity of certain antidepressants for "agitated," "melancholic," "dysthymic," "atypical," "retarded," or even "bipolar" depressives. Building on a retrospective analysis of clinical databases, the present paper presents the heuristic hypothesis that commonly observed clinical phenomenologic subtypes of depression—double-depressive, anxious, bipolar II, pseudo-unipolar, hostile, and psychotic—arise from diverse temperamental bases and respond differentially to TCAs, MAOIs, SSRIs, buproprion, lithium, anticonvulsants, and neuroleptics.

No. 53B
CLINICAL PREDICTORS OF RESPONSE TO TREATMENTS IN MOOD DISORDERS

Stuart A. Montgomery, M.D., *Department of Psychiatry, St. Marys Hospital, 20 South Wharf Road, London W2 1pD, United Kingdom*

SUMMARY:

The core symptoms of depression have been shown to correlate with different severities of depression and to be sensitive to treatment with effective agents. These symptoms were defined by sensitivity studies in the development of rating scales such as the MADRS but there are other important issues. The duration of illness is probably important. Brief depressions do not apparently respond to antidepres-

sants, whereas those with a more prolonged duration of about a month or longer do. In major depression the severity cut-offs, which predict response, have been investigated by several groups and a survey of results suggests that scores of about 15 or higher predict response. In dysthymia or chronic depression these are lower, which suggests that chronicity itself is an important factor in predicting a reliable drug placebo difference.

No. 53C
BIOLOGICAL PREDICTORS OF RESPONSE

Donatella Marazziti, M.D., *Department of Psychiatry, University of Pisa, Via Roma 67, Pisa 56100, Italy;* Giovanni B. Cassano, M.D.

SUMMARY:

Different markers have been proposed in biological psychiatry in the last decades, but none has proven to have a predictive value for the drug of choice. The current availability of peripheral serotonergic markers, such as the platelet transporter, as labeled by 3H-imipramine (^{3}H-IMI) or ^{3}H-paroxetine (^{3}H-Par), prompted us to evaluate whether they might be used as possible biological predictors in patients affected by major depression or obsessive-compulsive disorders. Platelet ^{3}H-IMI and/or ^{3}H-Par bindings were measured before and after treatments with different selective serotonin reuptake inhibitors (SSRIs).

The results showed that at baseline the number of both ^{3}H-IMI and ^{3}H-Par binding sites correlated with obsessive-compulsive symptom severity, as assessed by the Y-BOCS total score. After treatments with fluoxetine, fluvoxamine, and setraline, the number of binding sites increased toward normal values, with significant correlation with symptom improvement in depressed patients.

These findings suggest that platelet serotonin transporter complex is linked to the possible positive response to SSRIs of patients with major depression.

No. 53D
PREDICTORS OF RESPONSE IN OCD AND AUTISM

Eric Hollander, M.D., *Department of Psychiatry, Mt. Sinai Medical Center, 1 Gustave Levy Place, New York NY 10029;* Cheryl M. Wong, M.D., Concetta DeCaria, Ph.D., Bonnie A. Aronowitz, Ph.D., Serge A. Mosovich, M.D., Monte S. Buchsbaum, M.D.

SUMMARY:

Both obsessive-compulsive disorder (OCD) and autism are chronic disorders, which considerably impact on quality of life and costs of illness measures. In OCD, only 60% of individuals manifest a substantial response to potent serotonin reuptake inhibitors, and there may be a significant lag time of up to three months prior to treatment response. Therefore, early prediction of response to SSRIs would be very clinically meaningful.

For OCD patients, prolactin response to the partial 5HT agonist m-CPP, in males, and behavioral response to m-CPP in females, were strongly predictive of SSRI response. Thus, males with a more robust prolactin response (greater neuroendocrine sensitivity) and females with a greater behavioral/obsessional response (greater behavioral sensitivity) to this 5HT probe had a more robust response to SSRIs. Also, males with greater neurological soft signs, suggestive of diffuse neuropsychiatric impairment, had a poorer treatment response to SSRIs.

In autism, increased left anterior cingulate metabolic activity on FDG-PET correlated with greater obsessional severity and better social skills, and was predictive of a favorable response to fluoxetine treatment. Thus, specific measures of 5HT sensitivity, neuropsychiatric impairment, and anterior cingulate metabolism action may contribute to clinical decision-making in OCD and autism.

No. 53E
CLINICAL AND IMAGING PREDICTORS OF RESPONSE TO COGNITIVE-BEHAVIORAL THERAPY OF OCD

Jeffrey Schwartz, M.D., *Department of Psychiatry, UCLA NPI, 760 Westwood Plaza, Rm 67-468, Los Angeles CA 90024;* Arthur L. Brody, M.D., Sanjaya Saxena, M.D., Lewis R. Baxter, Jr., M.D.

SUMMARY:

Prior work by our group has demonstrated systematic changes in glucose metabolic rates in brain circuitry connecting the limbic cortex, striatum, and thalamus after successful drug-free cognitive-behavioral therapy in a group of 18 patients with OCD.

Further analysis of these data demonstrates a significant correlation ($r = .52$, $p = .025$) between pre-treatment left orbito-frontal cortex/hemisphere metabolic rate and change in the Yale-Brown OC Scale (Y-BOCS). Thus, higher pre-treatment orbital cortex metabolism correlates with larger percent improvement in clinical severity.

These data will be discussed within the context of a theory of cognitive-behavioral therapy response, which relates one's clarity of insight concerning the nature of mental states (e.g. "observing ego function") to one's capacity to alter his/her brain chemistry.

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4. Hollander E, Stein DJ, DeCaria CM, et al: A pilot study of predictors of treatment outcome in obsessive-compulsive disorder. *Biol Psychiatry* 33:747-749, 1993.
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SYMPOSIUM 54—LIGHT CAN TREAT NONSEASONAL DEPRESSION

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The participant will be able to help patients with ordinary nonseasonal depressions with bright light, using treatment methods which will be described. Special approaches will be presented for bipolar patients, patients with sleep phase disorders, and patients needing antidepressants and sleep deprivation.

No. 54A
BRIGHT LIGHT IN RAPID-CYCLING BIPOLAR DISORDER

Ellen Leibenluft, M.D., *Psychobiology, NIMH, Bldg 10, Rm 4S239, 10 Center Drive, MSC 1390, Bethesda MD 20892;* Erick H. Turner, M.D., Susana Feldman-Naim, M.D., Jeffrey Matthews, M.D., Thomas A. Wehr, M.D., Norman E. Rosenthal, M.D.

SUMMARY:

Patients with rapid cycling bipolar disorder (RCBD) are treatment resistant and experience dramatic changes in their sleep-wake cycle

as their moods switch between hypomania and depression. Given these facts, we have been interested in exploring the possible role of circadian dysregulation in the pathophysiology of RCBD, and in testing the efficacy of interventions such as bright light in patients with the disorder. This presentation will describe ongoing research in this area. To provide conceptual background for the work, we will present data comparing circadian regulation and the sleep-wake cycle in patients with RCBD vs. normals, and in hypomania vs. depression. In addition, we will present preliminary data about the use of morning and midday light in patients with RCBD. Finally, we will discuss methodological issues that arise when designing controlled trials in patients with RCBD and, where available, present data from an ongoing trial of bright light vs. negative ion generator therapy in this population.

No. 54B
COMBINATION OF SLEEP DEPRIVATION AND LIGHT THERAPY

Alexander Neumeister, M.D., *Clinical Psychiatry, NIMH, Building 10, Rm 4S-239, 9000 Rockville Pike, Bethesda MD 20892;* Ralph Goessler, M.D., Michael Lucht, M.D., Siegfried Kasper, M.D.

SUMMARY:

It is well known that a single night of total sleep deprivation (SD) or partial SD of the second half of the night exerts a rapid and dramatic, albeit usually short-lasting, improvement of mood. There are studies in the literature that indicate that light therapy may exert a synergistic effect on the SD response. The present study investigates whether light therapy, beginning in the morning after partial SD, is able to prevent the relapse after the recovery night, using a controlled, balanced, placebo-controlled parallel design. Medicated SD responders as well as nonresponders were randomly assigned to receive either bright light (BL/3000 lux) or dim light (DL/100 lux) therapy during the six days following partial SD. In the responder group BL prevented significantly (p 0.01) the relapse after the recovery night and prolonged significantly (p 0.05) the antidepressant effects of partial SD up to seven days. In contrast, patients in the DL condition relapsed after the recovery night and showed no further improvement after one week of DL therapy. PSD nonresponders did not benefit from light treatment. Light therapy has shown efficacy in preventing relapse after SD and also yields a possible new strategy for potentiation of responses to antidepressants.

No. 54C
LIGHT MASK TREATMENT OF CIRCADIAN PHASE DISORDERS

Roger J. Cole, Ph.D., *Synchrony, 12759 Via Felino, Del Mar CA 92014;* Lisa M. Cole, M.S., Daniel F. Kripke, M.D., Katsuhisa Ando, M.D., Jeffrey A. Elliott, Ph.D., Katharine M. Rex, B.A.

SUMMARY:

Circadian rhythm disturbance is prominent in sleep phase disorders and depression. Light regulates rhythms, and can produce powerful therapeutic benefits for both of these disorders. However, conventional light therapy can be inconvenient, and is difficult to administer at biologically optimal times, when patients are usually asleep. We have developed a special mask, which provides timer-controlled illumination through closed eyelids during sleep. We tested it on delayed sleep phase syndrome (DSPS) patients. Patients received either bright (3,000 lux, n = 9) or dim (0.1 lux, n = 9) illumination during the last four hours in bed for five mornings. The time of peak urinary excretion of the melatonin metabolite 6-sulphatoxymelatonin (6SMT) advanced by 2.1 ± 3.9 hours in the bright group and delayed by 1.0 ± 2.6 hours in the dim group (p = .034). Although these DSPS patients, on average, were not depressed, there was a trend (p < .10) toward reduced depression in the bright group after treatment. One bright subject experienced an apparent dramatic response to light, including a shift of nearly 12 hours in his peak 6SMT excretion, easy morning awakenings, and rapid remission of serious depressive symptoms. Light mask treatment through closed eyelids during sleep can shift circadian rhythms and might positively affect mood.

No. 54D
SPEED AND EFFICACY OF BRIGHT LIGHT TREATMENTS

Daniel F. Kripke, M.D., *Department of Psychiatry, University of CA at San Diego, 9500 Gilman Drive, Dept 0667, La Jolla CA 92093-0667*

SUMMARY:

Mood-uplifting benefits of bright sunshine have been recognized since antiquity, but modern bright light treatment has not been sufficiently implemented. Bright light effects on patients with nonseasonal depressions appear comparable in magnitude to the treatment benefits of antidepressant drugs but considerably more rapid in action. Controlled contrasts between bright light and psychopharmacologic treatments are lacking, but perhaps comparisons are unnecessary, since there is usually no reason to choose between these as alternatives. Bright light and antidepressants work especially well in combination. A syndrome of mild advanced sleep phase (nodding off watching television in the evening plus early-morning awakening) and mild depression seems surprisingly common among people over 60. Elderly patients may experience gratifying relief of symptoms simply by using a bright lamp by their TV chairs.

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SYMPOSIUM 55—APA PRACTICE RESEARCH NETWORK FINDINGS FROM ROUTINE CLINICAL PRACTICE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to understand the research aims of the *APA's Practice Research Network* and understand major trends related to psychiatry and psychiatric clinical practice patterns; and be aware of recent clinical and services findings from PRN studies, including findings related to child and adolescent psychopharmacology.

Practice Research Area Liaisons: Miguel A. Leibovich, M.D., *Department of Psychiatry, Harvard Medical School, 74 Fenwood Road, Boston MA 02115-6113;* James E. Nininger, M.D., *17 E. 76th Street, New York, NY 10021-1720;* Jorge A. Pereira-Ogan, M.D., *Trolley Square, Suite 22-B, Wilmington, DE 19806-3342;* Bernard

B. Foster, M.D., *3001 Highland Avenue, Cincinnati, OH 45219-2315;* Martin J. Kommor, M.D., *138 Whispering Woods Road, Charleston, WV 25304-2739;* Michael J. Gitlin, M.D., *Department of Psychiatry, UCLA, 300 UCLA Medical Plaza, Los Angeles, CA 90095;* James E. Campbell, M.D., *2908 W. Camelback Road, Phoenix, AZ 85017-3301;* Albert C. Gaw, M.D., *Department of Psychiatry, Bedford VA Hospital, 200 Springs Road, Bedford, MA 01730.*

No. 55A
NATIONAL SURVEY OF PSYCHIATRIC PRACTICE

Deborah A. Zarin, M.D., *Office of Research, American Psychiatric Association, 1400 K Street, NW, Washington DC 20005*

SUMMARY:

In 1996, the APA Office of Research, supported by a grant from the John D. and Catherine T. MacArthur Foundation, implemented the first annual *National Survey of Psychiatric Practice* to study critical clinical, financial, and other issues of importance in the field of psychiatry. The principal objective of this study, which gathered data on a large, randomly selected sample of APA members, was to collect nationally representative data on psychiatrists' professional activities, work settings, and patient caseloads to create a scientific baseline for current and future research in the rapidly changing field of psychiatry. Of the 1,500 APA members who were randomly selected for study participation, 70.6% responded to the survey. Key findings and trends related to psychiatrists' professional activities, practice settings, patient caseloads and referrals will be presented along with data on psychiatrists' participation in managed care plans and the financing and economics of psychiatric practice. The Office of Research plans to conduct this large national survey on an annual basis to track important changes and trends in psychiatric practice over time.

No. 55B
PRACTICE RESEARCH NETWORK STUDY OF PSYCHIATRIC PATIENTS AND TREATMENTS

Harold Alan Pincus, M.D., *Office of Research, American Psychiatric Association, 1400 K Street, NW, Washington DC 20005;* Joyce C. West, M.P.P.

SUMMARY:

Data from the PRN's core data, which are collected on an annual basis to systematically characterize network members, their practices, patient caseloads, and clinical treatment patterns, will be presented. This includes detailed patient-level clinical and treatment data, which have been collected on a randomly selected sample of psychiatric patients. These data provide a valuable database to study trends in psychiatry and psychiatric clinical practice patterns. Because the core data provide detailed, linkable data on psychiatrists, patients, and treatments, the relationship of various psychiatrist, patient, and financing/services delivery factors to clinical treatment patterns can be assessed.

Data will be presented on the sociodemographic and diagnostic characteristics of a large sample of psychiatric patients, including mental and general medical comorbidities, personality disorders, and level of functioning. Detailed data will be presented on the types and combinations of treatments provided to psychiatric patients, including psychiatric treatment settings, specific treatments, psychopharmacologic agents, and combinations of treatments provided to patients, including patients with specific types of disorders. Variations in the types of psychiatric patients and treatments utilized across different types of health plans and managed care organizations will also be presented.

No. 55C
PEDIATRIC PSYCHOPHARMACOLOGY AND ADHD STUDY

Deborah A. Zarin, M.D., *Office of Research, American Psychiatric Association, 1400 K Street, NW, Washington DC 20005;* Terri Taniellian, M.A.

SUMMARY:

Concerns have been raised among parents and prescribing professionals about the use of psychotropic medications in children and adolescents. Even though new scientific information on child and adolescent psychopharmacology has emerged, the knowledge base is still relatively thin across most childhood mental disorders. The PRN is currently developing a study that will seek to augment this knowledge base.

Despite the expanding research base in child psychopharmacology, the growing awareness of attention deficit hyperactivity disorder (ADHD) and the concern about increasing prevalence rates have highlighted the need for better information regarding the diagnosis and treatment of ADHD. This study will provide useful information concerning which types of patients benefit from which types of treatment and inform the profession regarding the types and efficacy of treatments currently being provided in the community.

Specific Aims: (1) Determine if there are differences in the patterns of prescribing for children and adolescents among child psychiatrists and psychiatrists for the treatment of ADHD and what factors might account for those differences; (2) Compare the patients and treatments found in use in the community to patients and treatments being studies in other clinical trials, thus assessing the generalizability of these studies; (3) Compare the treatments in use in the community to available clinical practice guidelines, textbooks, and other reference materials; (4) Collect data in preparation for a longitudinal outcomes study; (5) Compare ADHD patients treated by psychiatrists to ADHD patients treated by pediatricians and family practitioners; and (6) Gather preliminary data on the prevalence, pattern, and treatment of adult ADHD in psychiatric practices.

Study methods and preliminary findings will be described.

No. 55D
MDD PRACTICE GUIDELINE IMPLEMENTATION EVALUATION

Deborah A. Zarin, M.D., *Office of Research, American Psychiatric Association, 1400 K Street, NW, Washington DC 20005;* John S. McIntyre, M.D.

SUMMARY:

Although the APA's evidence-based MDD practice guideline offers considerable promise in improving the quality and outcomes of care, research has demonstrated that specific implementation efforts are needed to assure guidelines are effectively put into practice. The NYS Psychiatric Association, the APA, and RAND are conducting a study to evaluate the effectiveness of two practice guideline implementation strategies. This study will inform guideline dissemination efforts in psychiatry in order to bring about improvements in patient treatment and outcomes.

Study Design:

Sampling Psychiatrists. 408 randomly selected psychiatrists in NYS will participate in this study.

Sampling Patients. Each psychiatrist will report on 10 patients with MDD: 5 patients pre- and post-intervention. A small sample of patients may be contacted to validate information collected by the physician.

Intervention: Three types of interventions are planned:

1) A patient guide based on the MDD guideline.

2) A concise clinician guide based on the MDD guideline.

3) A series of opinion leader meetings.
Psychiatrists will be assigned to one of three groups: control group, low intensity intervention, or high intensity intervention.
Study methods and preliminary findings will be presented.

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3. Richters JE, Arnold LE, Jensen PS, et al: NIMH collaborative multisite multimodal treatment study of children with ADHD: I. Background and rationale. *J Am Acad Child Adolesc Psychiatry* 34:987-1000, 1995
4. Mittman BS, Siu A: Changing provider behavior: Applying research on outcomes and effectiveness in health care In: Shortell S, & Reinhardt U (eds): *Improving Health Policy and Management: Nine Critical Research Issues for the 1990's.* Ann Arbor: Health Administration Press, 1992

SYMPOSIUM 56—CRIMINALITY AND PSYCHOPATHOLOGY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should better understand and conceptualize the relationship between, and degree of overlap of, psychopathology and criminal behavior (ranging from white collar crime to criminal violence).

No. 56A
RECIDIVISTIC CRIME AS A CLINICAL DISORDER

Adrian Raine, Ph.D., *Department of Psychology, University Southern California, SGM Building, Los Angeles CA 90089-1061*

SUMMARY:

This paper explores the view that recidivistic crime may constitute a clinical disorder, and discusses criticisms of this approach. Crime may be construed as a mental disorder because it appears to fit a number of definitions of disorder. Nine previous definitions of mental disorder are outlined. It is argued that crime meets these criteria about as well (or badly) as many other clinical disorders. It is further argued that if a clear nomological network of social, cognitive, biological, and genetic relationships can be established around criminality, and if crime meets several definitions of disorder, then these two approaches, taken together, would constitute evidence that crime is a disorder. Thirteen criticisms of this view are then outlined, together with responses to these criticisms. It is argued that while criminal behavior is often viewed as volitional in nature, free will is better conceptualized as a dimension than as a dichotomy, and that there are strong social and biological pressures beyond the individual's control which shape that person's antisocial behavior. It is concluded that a future generation will draw the conclusion that recidivistic crime is indeed a clinical disorder.

No. 56B
BIOLOGY OF AGGRESSION: RELEVANCE TO CRIME

Emil F. Coccaro, M.D., *Department of Psychiatry, MCP Hahnemann, 3200 Henry Avenue, Philadelphia PA 19129-1137*

SUMMARY:

Evidence for a biological component to human aggression has been growing over the past 15 years. Data supporting a biological hypothesis of human aggression have included evidence of heritability from twin studies, evidence of altered serotonin function from cerebrospinal fluid, pharmaco-challenge, and platelet studies, as well as evidence of altered function within a variety of other neurotransmitter systems. In addition to these biological data, recent clinical trials suggest that aggression may be diminished by specific agents such as fluoxetine. This presentation will have two aims: first, an overview of the data relevant to a biological hypothesis for human aggression; second, an overview of case study of an individual with clinically significant impulsive aggressive behavior who committed homicide. Both clinical and biological (CSF 5-HIAA/HVA, fenfluramine challenge, glucose tolerance test) data will be reviewed. The correlation of biological and clinical characteristics with criminal behavior will be discussed.

No. 56C
RISK FACTORS FOR COMMUNITY VIOLENCE AMONG ACUTE PSYCHIATRIC INPATIENTS: THE MACARTHUR RISK ASSESSMENT PROJECT

Henry J. Steadman, Ph.D., *Policy Research Asc, 262 Delaware Avenue, Delmar NY 12054*

SUMMARY:

A longitudinal study of 1,136 acute psychiatric inpatients in three cities (Kansas City, Pittsburgh, and Worcester, MA) was designed to address the issue of risk factors for community violence. The study employed for the first time a triangulated measure of community violence composed of self-reports, collateral reports, and official records (arrests and rehospitalizations). Subjects were interviewed within one week of their target hospitalization and then five times, at 10-week intervals, during their first year after release.

Initial results suggest that the most efficient statistical models are radically different for men and women. In both groups, anger control has special importance. Impulsiveness, substance abuse, and social support networks have important, but widely different relationships between men and women. The implications of these results for future research and for risk management practices and policies will be addressed.

No. 56D
WHITE COLLAR CRIME: INDIVIDUAL OR SOCIAL ILL?

Andrew E. Skodol II, M.D., *Department of Psychiatry, NYS Psychiatric Institute, 722 West 168th Street, New York NY 10032;* John M. Oldham, M.D.

SUMMARY:

White collar crime is rampant in America. White collar crimes are "economic offenses committed through the use of some combination of fraud, deception, or collusion." The scope of white collar crime ranges from securities fraud and bank embezzlement to income tax evasion and unnecessary auto repairs. All involve a breach of trust in a relationship where a person has entrusted in another to act in his or her behalf. Although the term "white collar crime" was coined in 1940, surprisingly little attention has been paid to the systematic study of the personality characteristics or of the psychopathology per se of white collar criminals. Perpetrators of white collar crimes have been variously described as superior, greedy, ambitious, power-hungry, obsessed with success, charming, arrogant, clever, seeking mastery over challenges, exploitative, dishonest, irresponsible, undependable, disregarding of rules and social norms, insecure,

and excessively dependent on the admiration of others. The applicability of DSM-IV personality disorder concepts (i.e., narcissistic, antisocial), alternative nosologies of personality psychopathology (e.g., psychopathy, sociopathy), and both Cloninger's seven-factor and Costa and McCrae's five-factor models of personality to this clinical profile will be discussed. Individual factors can be contrasted to situational and broader social factors that may contribute to white collar crime.

No. 56E
PSYCHOPATHOLOGY, CRIME AND LAW

Paul S. Appelbaum, M.D., *Department of Psychiatry, University of Massachusetts, 55 Lake Avenue North, Worcester MA 01655*

SUMMARY:

The criminal law has always been somewhat uncertain about how to deal with claims that criminal behavior is motivated by psychopathology. Free will—that is, the belief that persons choose freely to participate in or abstain from criminal activity—is a foundational tenet of criminal law. Exceptions have evolved slowly over many hundreds of years, and always with a good deal of ambivalence. This is manifest clearly in the perpetual debate over the insanity defense and related issues. More recent attempts to expand exculpatory conditions have evoked the derisive claim that defendants are looking for an "abuse excuse." As new data become available suggesting links between psychopathology and criminal behavior, the law will be compelled once again to confront the question of when a disordered mind should be considered an exculpatory condition. It is likely to tread cautiously in expanding the grounds for exculpation, looking carefully at the extent to which the disorders described can be said to limit freedom of choice. This presentation will review the implications of empirical data linking psychopathology and criminal behavior for the criminal law, and the role that psychiatrists will be called upon to play as these issues become more prominent in criminal proceedings.

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2. Coccaro EF, Siever LJ: The neuropsychopharmacology of personality disorder. In: Bloom F, Kupfer D (eds.): *Psychopharmacology: The Fourth Generation of Progress*, pp. 1567-1579. Raven Press, New York, 1995.
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4. Stotland E: White collar criminals. *J Soc Issues* 33:179-196, 1977.
5. Morris N: *Madness and the Criminal Law.* Chicago, University of Chicago Press, 1982.

SYMPOSIUM 57—THE NEW HEROIN EPIDEMIC

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should understand the changes in heroin use over the past five years, and recognize the characteristics of a new population of heroin addicts. In addition, the participant will know the newest treatment modalities and public policy dilemmas.

No. 57A
HEROIN EPIDEMICS IN HISTORICAL CONTEXT

David F. Musto, M.D., *Child Study Center, Yale University, 333 Cedar Street, New Haven CT 06520-7900*

SUMMARY:

Heroin was commercially introduced to the world in 1898 by the Bayer Company as a superior cough suppressant. Gradually, heroin began to replace morphine as the opioid of choice among those taking an opioid for nonmedical reasons. Heroin had the advantage that it could be sniffed, smoked, and injected with more impact than the same amount of morphine. By 1915, heroin had surpassed morphine among those admitted for addiction to New York's Bellevue Hospital. By 1919 its popularity among teen-aged males in New York City had caused the city's health commissioner to call heroin addiction "an American disease."

Heroin use appears to have fallen in the 1930s and 40s, but there were signs of renewal in the early 1950s that led to draconian severity in federal drug laws, including the death penalty at the option of the jury. The modern heroin epidemic reached a peak about 1970, although recently heroin has risen again in popularity.

No. 57B
HEROIN IN THE 1990S: EPIDEMIC OR NOT?

Laurence M. Westreich, M.D., *Department of Psychiatry, New York University, 40 Park Avenue, #1K, New York NY 10016*

SUMMARY:

Heroin use in the United States has begun to shift from a low incidence endemic pattern to widely diffused and rapidly spreading epidemic proportions over the last five years. The Office of National Drug Control Policy (ONDCP), in a recent publication, stated that "The number of varieties and sources of heroin available, combined with an increased domestic demand, make the heroin market the fastest growing drug market reported on. . . ." Physicians must lead efforts to define the problem, treat addicted persons, and design public health policy that will sensibly confront this recrudescence of an old enemy in a new generation of users. The goal of this paper is to provide an understanding of these recent changes in heroin use, so that clinicians can more effectively diagnose and treat heroin addicts caught up in this upsurge. The article presents epidemiologic data from emergency departments and surveys of the general population that describe the new cohort of younger heroin users.

No. 57C
TREATMENT OF HEROIN DEPENDENCE

Herbert D. Kleber, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, Unit 66, New York NY 10032*

SUMMARY:

In comparison to cocaine dependence, good pharmacologic treatments are available for heroin dependence as well as effective nonpharmacologic approaches. Each, however, has advantages and drawbacks.

Much effort has been expended to improve detoxification. Methadone reduction is most common. Other techniques include clonidine, clonidine/naltrexone, buprenorphine, and acupuncture. Each has advantages over methadone with its problem of rebound symptoms associated with relapse. Methadone maintenance is the most common maintenance with positive outcomes in terms of crime, health, illicit heroin use, and employment. However, it is difficult to withdraw from alcohol and cocaine abuse is high. Buprenorphine maintenance, while still experimental, should soon be available, and may provide easier withdrawal and less cocaine use. Maintenance on naltrexone,

an antagonist, has the advantage of no withdrawal and less alcohol or cocaine use, but higher dropout rates and poorer initial acceptance. The residential therapeutic community has good outcome results, especially with the difficult group of criminal addicts, but poor initial acceptance and high dropout.

Although individual approaches are flawed, the range of treatment options could provide successful outcome for a majority of heroin addicts. Programs need to be willing to move patients to different modalities when they do not do well.

No. 57D
THERAPEUTIC COMMUNITIES AND THE NEW HEROIN USER

Mitchell S. Rosenthal, M.D., *President, Phoenix House Foundation, 164 West 74th Street, New York NY 10023-2301;* David A. Deitch, Ph.D.

SUMMARY:

This presentation will examine therapeutic community treatment for heroin abusers and its evolution in each of the nation's three peak periods of heroin use—the mid-Fifties through the Sixties, the mid-Seventies, and the mid-Nineties. It will consider the nature of heroin users entering treatment at these times, examining similarities and differences in user profiles, including psychosocial characteristics and patterns of drug use. In addition to the therapeutic community regimen, it will survey other treatment options, assessing treatment goals and outcomes for a full range of interventions. It will show how the nature of heroin users at each peak period has influenced development of therapeutic community treatment and how the therapeutic community has come to be regarded as the treatment of choice for heavy, high-risk drug users of the hard core.

No. 57E
CLINICAL ASPECTS OF THE NEW HEROIN EPIDEMIC

Robert B. Millman, M.D., *Public Health, New York Hospital, 411 East 69th Street, New York NY 10021-5603*

SUMMARY:

In the past two to four years there has been a remarkable increase in heroin use, particularly among the middle class and affluent sectors of society and in the media and entertainment industries. In part this is due to much increased supply, enhanced purity, and lower prices. In addition, heroin use has become romantic and exciting to many young people. We are likely to see increased impact of this drug use for many years to come. Prevention and treatment programs must change significantly to be responsive to this situation.

No. 57F
POLICY MAKING UNDER UNCERTAINTY: THE CASE OF HEROIN

Mark A.R. Kleiman, Ph.D., *Policy Studies, University of CA at LA, 3250 Public Policy Building, Los Angeles CA 90095*

SUMMARY:

The popularity of abusable psychoactives follows a somewhat predictable cyclic pattern: introduction, rapid spread, narrowing and deepening of the market, decline, quiescence, reintroduction. Ideally, policies should be matched to phases of the epidemic cycle, with enforcement and primary prevention focused on periods of rising prevalence and secondary prevention and treatment efforts concentrated after peaks in initiation.

Application of this theory is complicated by institutional resistance to shifts in resources among activities and among target drugs, and by data collection and analysis systems ill-adapted to the required capacity to be able to "call" an epidemic in timely fashion while distinguishing real threats from flashes in the pan.

While data collection and analysis could be improved, the problem will remain one of choice under uncertainty. That puts a premium on interventions worth undertaking when the probability of a new epidemic is much less than unity.

The current debate (and silence) about the nature and extent of the increase in heroin use, and what if anything to do about it, illustrate this class of problems.

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SYMPOSIUM 58—PROJECT MATCH: MATCHING AND MAIN EFFECTS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant will be familiar with patient/treatment matching research strategies and with main effect and matching results of a major multisite clinical trial matching different psychosocial treatments to alcoholic patients.

No. 58A
PROJECT MATCHING ALCOHOLISM TREATMENT TO CLIENT HETEROGENEITY (MATCH): RATIONALE, RESEARCH DESIGN, HYPOTHESES AND ANALYSES

Thomas F. Babor, Ph.D., *Department of Psychiatry, University of Connecticut, 263 Farmington Avenue, Farmington CT 06030-1410*

SUMMARY:

The following three manual guided ambulatory treatment modalities were evaluated, and delivered as individual therapy over a 12-week period to 1,726 clients: Twelve Step Facilitation Therapy (TSF), grounded in the conception of alcoholism as a spiritual and medical disease; cognitive behavioral therapy (CBT), based on the principles of social learning theory; and motivational enhancement therapy (MET), based on principles of motivational psychology and a process of change perspective. Fifteen *a priori* matching hypotheses were tested, based on matching variables selected because of their theoretical interest or empirical support. The specific matching hypotheses and treatments will be described in this presentation, along with an overview of the trial and its rationale. This presentation will also describe the research protocol, including urn random assignment, follow-up procedures, confirmation of drinking status, follow-up rates; and how tests for patient-treatment matching effects were conducted.

No. 58B
PSYCHOTHERAPY PROCESS AND THERAPIST EFFECTS

Kathleen Carroll, Ph.D., *Department of Psychiatry, Yale University, 34 Park Street, New Haven CT 06519*

SUMMARY:

Comparative psychotherapy efficacy research requires implementation of well-defined, differential treatments as well as control over threats to internal validity, such as diffusion or confounding of treatments, variations in treatment delivery, and differential attrition. A critical requirement in such studies is the demonstration of (1) treatment integrity, that is, that the treatments were delivered adequately and as intended, and (2) treatment discriminability, that is, that whether treatments compared were substantively different from one another in terms of defining characteristics of the treatments and that treatments did not differ substantially on variables hypothesized to be consistent across therapies.

This presentation will address the integrity and discriminability of the Project MATCH treatments; that is, whether Project MATCH treatments were implemented as intended and whether common threats to internal validity were controlled such that alternative explanations of the findings could be ruled out. The following research questions will be addressed: (1) Did the therapist implement study treatments as described in the respective manuals? Were the treatments discriminable? (2) Did participants receive an adequate dose of their study treatments? Were intended contrasts in treatment dose between the brief intervention (motivational enhancement therapy) versus cognitive behavioral therapy (CBT) and Twelve Step Facilitation (TSF) obtained? (3) Were the MATCH treatments confounded by exposure to other forms of treatment? Were extra-treatment exposures consistent with treatment assignment? (4) Did the treatments differ with respect to nonspecific aspects of treatment that might be related to outcome such as the therapeutic alliance and therapist skill?

No. 58C
PROJECT MATCHING ALCOHOLISM TREATMENT TO CLIENT HETEROGENEITY (MATCH): ONE-YEAR OUTCOMES

Ronald M. Kadden, Ph.D., *Department of Psychiatry, University of CT Med School, 263 Farmington Avenue, Farmington CT 06030-2103*

SUMMARY:

The post-treatment results will be described in terms of the main effects of the three treatment interventions over the 12-month outcome period, and in terms of matching effects over the same interval. The primary drinking outcome variables were percent days abstinent and drinks per drinking day. Treatment main effects indicate a substantial reduction in drinking during the 12-week treatment period and during the one year following treatment. Blood tests as well as interviews with clients' family and friends confirm clients' reports of their drinking. Additional secondary outcome measures, such as time to relapse, psychological symptoms, alcohol-related consequences, and employment functioning will also be described, as well as a composite measure of outcome. The variability of results across the 10 treatment sites and across therapists, and the effects of various covariates, will also be addressed. Finally, post-treatment results will be described in terms of ten *a priori* matching hypotheses that were tested over the course of the 12-month outcome period, along with a discussion of their possible clinical and scientific implications.

No. 58D
MATCHING TREATMENTS TO PSYCHIATRIC SEVERITY

Bruce J. Rounsaville, M.D., *Department of Psychiatry, Yale University, 34 Park Street, New Haven CT 06519*

SUMMARY:

Project MATCH found significant client-treatment interactions supporting matching hypotheses related to severity of pretreatment psychiatric symptoms. This presentation will explore process variables in the hypothetical causal chain that may have produced these matching effects. Patients in the outpatient study with lower pretreatment psychopathology had better drinking outcomes when treated with a 12-step facilitation (TS) approach than when treated with a cognitive-behavior (CB) approach. For example, during the sixth month after treatment, clients assigned to Twelve Step Facilitation were abstinent on 87% of days, compared to 73% for those assigned to cognitive-behavioral therapy. This effect persisted through most of the year following treatment, but by the end of the follow-up period, there were no significant differences (83% for Twelve Step Facilitation compared to 80% for cognitive-behavioral therapy). There were no significant differences in outcome for high psychopathology clients. Process data did not support predictions that CB treatment would focus more on psychopathology and would reduce reported psychopathology symptoms more than TS treatment. There was limited evidence that severity of psychopathology at the end of treatment predicted drinking in the following year.

No. 58E
MATCHING TREATMENTS TO ALCOHOL DEPENDENCE LEVEL

Ned L. Cooney, Ph.D., *Department of Psychiatry, VA CT Healthcare, 950 Campbell Avenue, West Haven CT 06516*

SUMMARY:

Project MATCH found significant client-treatment interactions supporting matching hypotheses related to severity of pretreatment severity of alcohol dependence. This presentation will explore process variables in the hypothetical causal chain that may have produced these matching effects. Patients in the aftercare study with lower severity of alcohol dependence had better drinking outcomes when treated with a CB (cognitive-behavior) approach than when treated with a TS (12-step) approach. There were no significant differences in outcomes for high dependence clients. Process data will be presented examining differences in the therapists' emphasis on absolute abstinence and loss of control in TS treatment and on relapse coping in CB treatment.

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1. Project MATCH Research Group, Matching Alcoholism Treatment To Client Heterogeneity: Project MATCH Post-treatment Drinking Outcomes. *Journal of Studies on Alcohol* (in press).
2. Carroll, et al: Implementing treatment and protecting the validity of the independent variables in treatment matching studies. *J Stud Alcohol, Supplement No. 12*: 149-155, 1994
3. Mattson, et al: A chronological review of empirical studies matching alcoholic clients to treatment *J Stud Alcohol, Supplement No. 12*: 16-29, 1994

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SYMPOSIUM 59—ABUSE AND MISUSE OF PSYCHIATRY IN THE UNITED STATES AND ABROAD
APA Committees on Abuse and Misuse of Psychiatry in the U.S., and International Abuse of Psychiatry and Psychiatrists, and APA Councils on International Affairs, and National Affairs

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to identify characteristics of abuse and misuse of psychiatry, recognize ethical issues in common types of cases, and be familiar with historical and current aspects of abuse of psychiatry in the U.S. and internationally.

No. 59A
CHARACTERIZATION OF UNITED STATES CASES OF ABUSE OF PSYCHIATRY

Margaret F. Jensvold, M.D., *IRWH, 1616 18th Street, NW, Ste 109, Washington DC 20009*

SUMMARY:

This presentation will discuss categorization of the nature and types of cases of abuse and misuse of psychiatry seen in the U.S., as well as comparisons to the types of cases seen internationally.

The interface between psychiatrists' obligations to patients and obligations to or pressure applied by third parties is particularly vulnerable to abuse or misuse of psychiatry. Cases will be categorized as those in which abuse or misuse of psychiatry involves (1) the psychiatrist only, (2) a third party only (e.g., employer, government), or (3) both psychiatrist and third party. Commonly seen U.S. cases are further subcategorized as those involving misuse and abuse of psychiatry as part of (a) harassment, (b) retaliation, (c) forced fitness-for-duty examinations, (d) biased forensic evaluations, and (e) miscellaneous cases. International cases of psychiatric abuse more frequently involve torture and overt, planned political repression. U.S. cases generally do not involve torture or formally organized political repression, and more frequently involve personal gain on the part of the psychiatrist or third party and/or less organized political or social oppression. Application of national and international medical ethics standards in dealing with such cases will be discussed. Relationships to current issues in the news will also be discussed.

No. 59B
POLITICAL ABUSE OF PSYCHIATRY ABROAD AND CURRENT ISSUES

D. Ray Freebury, M.D., *Department of Psychiatry, University of Toronto, 40 St. Clair Avenue East, Toronto ON M3A 3G4, Canada*

SUMMARY:

Despite the gradual emergence of democracy in the former Soviet Union and its satellite states, political abuses of psychiatry still occur sporadically. The mentality of peoples who have been subjected to years of totalitarian rule does not lend itself to sympathy for widespread reforms in mental health care. This makes it difficult to introduce modern psychiatric methods, western standards of patient's rights, and the infrastructure necessary to making even existing mental health laws operative. The door is thus left open for the recurrence of political abuses of psychiatry.

In Cuba, there is evidence that Soviet-style psychiatric abuses of dissidents continues to occur. In some Central and South American countries psychiatrists are still fearful for their own safety if they oppose mistreatment and torture of opponents of government. In China there is suspicion that political abuses of psychiatry are occurring, but these abuses pale beside the human rights abuses that are occurring daily in that country. Ongoing efforts on the part of the APA Committee on International Abuse of Psychiatry will be outlined.

No. 59C
CONCEPTS OF JUSTICE, EQUITY AND FAIRNESS IN PSYCHIATRY

Richard S. Epstein, M.D., *10401 Old Georgetown Rd, #400, Bethesda MD 20814-1911*

SUMMARY:

Modern psychiatry espouses value neutrality. A value neutral approach to psychiatric treatment is promulgated by the DSM and in psychiatric training. However, attention to boundaries, respect for patient autonomy, non-malfeasance, the Hippocratic oath and principles, and fiduciary aspects of therapy cannot be breached without jeopardizing trust by patients and the public. Concepts of justice, equity, and fairness have valuable roles in psychiatry, inspiring trust and advancing treatment. Patients and the public expect psychiatry to value such concepts.

The presenter, a general and forensic psychiatrist and chair of the APA's Ethics Committee, will discuss the important roles of goodness in psychiatry. He will also discuss relationships between ethics and abuse of psychiatry, psychiatrists, and psychiatric patients.

No. 59D
FORCED FITNESS-FOR-DUTY EXAMS: HISTORY AND STATUS

Donald R. Soeken, Ph.D., *Integrity International, 15702 Tasa Place, Laurel MD 20707*

SUMMARY:

Since the Truman administration there have been approximately 10,000 federal employees given forced psychiatric fitness-for-duty exams. These exams are initiated by an employee's supervisor who makes a psychiatric diagnosis on the employee and then refers the employee to a psychiatrist who makes an employment decision to determine whether the employee is able to perform the workload of the position.

There were Congressional hearings in 1987 where the author "blew the whistle" on this practice and assisted Congress in stopping the exams. In January 1984 these exams were discontinued for the executive branch of the government, but were continued by the legislative branch and have resulted in the Library of Congress processing 40 cases of forced exams and firings since 1994.

In 1992 the Congress without fanfare inserted a paragraph in the disability retirement regulations that allows the U.S. government to again give forced psychiatric fitness-for-duty exams. Congress ignored all previous history of these "Soviet Union style" exams and without hearings slipped in the regulations. At this time the U.S. government again allows citizens to be forced out of employment and be blacklisted as "crazy" without due process.

No. 59E
MILITARY PSYCHIATRY AND FORCED FITNESS FOR DUTY: ROLE OF APA

Jay Cutler, J.D., *Director, Government Relations, American Psychiatric Association 1400 K Street, N.W. Washington DC 20005*

SUMMARY:

In the early to mid-1980s the APA's Committee on Abuse and Misuse of Psychiatry in the U.S. received a number of reports about alleged abuses of psychiatry by the U.S. military, involving U.S. military personnel. Forced hospitalizations and forced psychiatric fitness-for-duty psychiatric examinations of healthy, nonmentally ill individuals were among the reports. The U.S. committee determined that there was credible evidence of problems, and brought the issue to the attention of the APA Medical Director's office, per the committee's charge and mandate. The APA Medical Director's office and Office of Government Relations then worked with Congress and military leaders, resulting in changes in military policy regarding use of psychiatric examinations, hospitalization, and records.

The presenter of the APA's Joint Commission on Government Relations (JCGR), will discuss the history of the APA's work with Congress and military leaders about ethical use of psychiatry. He will discuss the successes, difficulties, and process issues in working with third parties (e.g., government, military, employers) to change organizational policies regarding use of psychiatry and psychiatric information.

No. 59F
ISSUES IN PEER REVIEW OF EXPERT TESTIMONY

Robert M. Wettstein, M.D., *Department of Psychiatry, University of Pittsburgh, 401 Shady Avenue, Ste B103, Pittsburgh PA 15206*

SUMMARY:

Among the most visible and controversial functions of psychiatrists is their service as expert witnesses for the courts and administrative agencies. Psychiatrists who testify in court have been criticized as biased, unethical, mercenary, and undeserving of the expertise they claim. Psychiatrists have in fact been subjected to malpractice litigation as well as APA ethics sanctions as a result of their expert consultation and testimony.

Peer review of expert testimony has been proposed as one mechanism to improve the quality of expert testimony, as well as police its more egregious practices. Peer review can be done on a voluntary basis at the request of the testifying expert, or on a mandatory basis as required by an outside agency or employer. Each form of peer review presents a variety of technical, forensic, ethical, and legal issues, which this presentation will describe. The work of the APA Task Force on the Peer Review of Expert Testimony, and that of the American Academy of Psychiatry and the Law, will also be noted.

REFERENCES:

1. Jensvold MF: Potential for misuse and abuse of psychiatry in workplace sexual harassment. In: Shrier DK (ed.): *Sexual Harassment in the Workplace and Academia: Psychiatric Issues.* Washington, DC: American Psychiatric Press, pp. 153-180, 1996.
2. Epstein RS: *Keeping Boundaries: Maintaining Safety and Integrity in the Psychotherapeutic Process.* Washington, DC: American Psychiatric Press, 1994.
3. 5 Code of Federal Regulations Section 339.301 (Medical examination: authority to require an examination), 1992.
4. Group for the Advancement of Psychiatry, Committee on Government Policy. Mandated therapy in military settings. In: *Forced Into Treatment: The Role of Coercion in Clinical Practice. Report No. 137.* Washington, DC: American Psychiatric Press, pp. 87-98, 1994.
5. Peer review of psychiatric expert testimony. *Bulletin of the American Academy of Psychiatry and the Law* 20:343-352, 1992.

SYMPOSIUM 60—PSYCHIATRY AND THE PERFORMING ARTS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant will have a greater understanding of the broad scope and great potential for both psychiatry and the performing arts of studying their interrelationships.

No. 60A
TRAGIC DRAMA AND FAMILY CONFLICT: UNSPEAKABLE LIVES

Bennett Simon, M.D., *170 Chestnut Street, West Newton MA 02165-2711*

SUMMARY:

Tragic drama focuses on the portrayal of conflict within the family. From Aeschylus to Beckett, tragic drama deals with the terrible possibility of extinction of the family line because of intractable conflict that destroys children and/or childhood. In its origins in ancient Greece, tragedy utilized many of the same stories as Homeric and other heroic epics, but emphasized warfare within the family rather than warfare between the hero and an external enemy. Along with content about possible end of the family line, in its structure tragedy presents us with gaps, incomplete sentences, silences, —in short, lines that cannot be spoken about lines that may be never able to speak or to hear. Psychotherapists can learn much from tragic drama about thwarted family dialogues, dialogues that metaphorically are aborted or stillborn, killed almost as soon as they are born, and dialogues that themselves are murderous. There will be brief illustrations from Greek tragedy, the works of Eugene O'Neill, and Samuel Beckett.

No. 60B
MOZART'S SYMBOLIC USE OF INSTRUMENTS

Jacques Drouin, M.D., *Department of Psychiatry, University of Sherbrooke, Cuse (King), Sherbrooke QC H4K 1B6, Canada*

SUMMARY:

We put forward the principle that for Mozart, like for any other person, nothing is a coincidence; there must be, at least, an unconscious motivation for any choice that a person makes. Our hypothesis is that Mozart has used some wind instruments to represent the members of his family at some given moments of his life. Also, that some themes were chosen to depict some of his emotions or even some of his wishes. It also seems clear that his religious works show the feelings that he might have experienced at the moment of their composition. In the operas, he even more obviously presents the expression of his feelings and wishes; here we are helped by the use of words over the music. Some hypotheses are presented about the significance of certain dislikes he might have felt by way of omission of a given instrument in the orchestration. Like in psychoanalysis, the facts prove the hypothesis by repeating themselves on more than one occasion, in a very significant manner. This presentation is illustrated with slides and musical excerpts.

No. 60C
THE ENIGMA OF RICHARD STRAUSS

Eric A. Plaut, M.D., *912 Michigan Avenue, Evanston IL 60202*

SUMMARY:

No composer of genius has elicited as widely divergent assessments as Richard Strauss. Glenn Gould and Arnold Schoenberg viewed him as one of the truly greats; Ernst Bloch and Joseph Kerman thought him to be mediocre at best. Strauss's self-assessment was "I am a first-class, second-rate composer." Each had his reasons. As an artist and as a man, Strauss is hard to classify; in many ways he remains an enigma.

One key part of that enigma is his relationship to the artistry of Richard Wagner and to the person of his father. Strauss's father hated Wagner; Strauss worshipped him. Strauss's adolescent rebellion crystallized around this issue, yet he felt, throughout his life, that Wagner's genius was an insurmountable obstacle to his own creativity.

A study of Strauss's music and of his personal relationships casts some light on his enigmatic personality and his unusual position in music history.

No. 60D
SHAKESPEARE'S KING LEAR AND THE ONSET OF PSYCHOSIS

Yves Thoret, M.D., *Department of Psychiatry, Hopital Des Mureaux, Rue Baptiste Marcet, Les Mureaux 78 78130 France*

SUMMARY:

Among the performing arts, theater requests the presence of the audience and combines several art forms. Starting from the works of S. Freud, André Green, and Norman Holland about dramatic art, the author studies in detail the first scene of Shakespeare's play, *King Lear.*

The King's breaking up with his daughter Cordelia is an illustration of a mechanism called by Shakespeare "wrenching." It seems to be specific of an entry into psychosis in so far as it straight forwardly wrenches one's "frame of nature," which enables reality testing. Freud's theory of reality testing is analyzed, granting in 1921 to the ego ideal the function of "reality-vouching."

Affected by this wrenching experience, *King Lear* regresses to the anguish of a child in distress who, feeling completely helpless and at the mercy of outside forces, falls into the void before conception.

Theater expresses, on one hand, the implacable fate compulsion, and, on the other hand, the most unpredictable theatrical choices.

This "clinical" interpretation of the play may explain why Cordelia's death was, in the last century, suppressed or rather repressed in modifications of this Shakespeare play.

Thus, we may observe interesting analogies between theatrical experience and the patient's or the therapist's.

No. 60E
SEXUALITY AS PERFORMANCE: CASANOVA AND FELLINI

Nancy M. Blake, Ph.D., *Department of Comp Literature, University of Illinois, 707 South Mathews, Urbana IL 61801*

SUMMARY:

Reading the *Memoirs* of Casanova, the author whose name, known to every schoolboy, has become the eponymous hero of the phallus in our culture, one comes to see the hero, in the words of Jacques Lacan, as one who always signifies a lack not generally understood. This paper will explore two theoretical points illustrated by the text: (1) the distinction between the represented self or "I" and the subjectivity it both represents and misunderstands, and (2) the depiction of desire, especially the gap between need and desire.

Casanova, the son of actors, constantly presents his adventures by means of a theatrical metaphor. In Fellini's film the obsessions of the film's director throw unexpected light on the phallic hero. Through the use of a short clip from the film, we will study what Fellini calls the "ideological metaphor of the film": the maternal deity inhabiting each of us.

No. 60F
EARLY-MODERN CONCEPTIONS OF FANTASY IN MACBETH

David Willbern, Ph.D., *Center for Psychoanalysis, SUNY at Buffalo, Clemens Hall 413, Buffalo, NY 14260*

SUMMARY:

The paper examines Shakespeare's poetic dramatization of modes of representing and understanding pathological behaviors, especially hallucination and obsession. I focus on Lady Macbeth's sleep-walking scene in Act Five, and the response of the observing physician. I review typical early-modern (16th-17th century) ideas of psychology and theology, and suggest how contemporary psychoanalytic approaches can be used. I then propose a mode of audience response that participates in the phantasmagoric style of the play.

REFERENCES:

1. Benheti S: *Tragic Drama and the Family.* Yale Univ Press New Haven 1988.
2. Massin J, Massin B: *Wolfgang Amadeus Mozart* (Fayard) p. 1294, May 1990.
3. *Grand Opera: Mirror of the Western Mind* Ivan R. Dee, Chicago, 1993.
4. Thoret Y: *La théâtralité, étude freudienne,* (Theatrics, a freudian study), Paris, Ed. Dunod, 1993.
5. Lacon J, Sheridan A: *Ecrits* WW Norton, N.Y. 1977.

SYMPOSIUM 61—MUSIC THERAPY: AN EFFICACIOUS AND EFFECTIVE MODALITY OF CARE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to (1) Describe the development of music therapy in the United States. (2) Identify illnesses that respond to music therapy. (3) Describe the scope and structure of music therapy programs (4) Understand some of the outcome data concerning the use of music therapy.

No. 61A
MUSIC AND MEDICINE: NEW VARIATIONS ON AN OLD THEME

Bryan C. Hunter, Ph.D., *Music Department, Nazareth College, 4245 East Avenue, Rochester NY 14450*

SUMMARY:

The presenter will provide an overview of the music therapy profession, reviewing its historical roots in the treatment of mental illness and tracing its development and inclusion in modern medical practice. The presentation will include a viewing of the newly released television documentary, "Music and Medicine: Partnerships in Care." Presented by the National Association for Music Therapy in collaboration with the National Association of Music Merchants,

this film communicates the critical role that music therapy plays in the health and well-being of children and adults. The documentary explores the impact of music therapy on patients in intensive care units, cancer units, pediatric units, gerontology centers, and hospice care. Recorded at major hospitals and community-based settings in Cleveland, New York, and Boston, the program demonstrates some of the most innovative therapeutic contributions music therapy makes to the medical treatment and quality of life for a variety of individuals by decreasing depression, decreasing pain, increasing speech and motor skills, reducing requirements for medication, increasing muscle relaxation, and enhancing positive attitudes toward the hospital experience. The program also addresses critical questions related to efficacy, cost effectiveness, and third-party reimbursement.

No. 61B
MUSIC THERAPY AND PSYCHIATRY

John S. McIntyre, M.D., *Department of Psychiatry, St. Mary's Mental Health Ctr, 919 Westfall Road, Suite 210, Rochester NY 14618-2670*

SUMMARY:

Music therapy is very effective in the treatment of a wide spectrum of mental disorders. Psychiatric programs in music therapy can be divided into six major categories: recreational music, music and relaxation, music combined with other expressive arts, music and movement, music performance, and music psychotherapy. This presentation will focus on the use of music in psychotherapy. Different levels of music psychotherapeutic intervention will be explored, including listening, recreating, improvising, and composing. Description of specific clinical programs will be included.

No. 61C
MUSIC THERAPY IN CONSULTATION-LIAISON PSYCHIATRY

Paul Nolan, MCAT, *Mental Health Science, Allegheny University, MS 905 Broad and Vine, Philadelphia PA 19102;* Donald J. Kushon, Jr., M.D.

SUMMARY:

This presentation will describe the use of music therapy as a component of the consultation/liaison psychiatry service within medical units at a large urban hospital. Included in the presentation will be (1) the educational process of the consultation/liaison psychiatrists about music therapy; (2) criteria for referral and the referral process; (3) patient education about music therapy; (4) clinical goals of music therapy with the medically ill; (5) videotaped examples of music therapy interventions; (6) inclusion of the psychiatrist into the music therapy session; and (7) documentation, treatment team communication, and evaluation of patient progress.

The model of music therapy used in this setting is based upon supportive therapy foundations and usually includes patient music making with the therapist. The musical experiences are structured by the therapists and focus upon the identification of ego functions, which are then supported by the therapist's musical and verbal responses.

Taped examples and a question-and-answer period will conclude this presentation.

No. 61D
MUSIC THERAPY FOR ALZHEIMER'S PATIENTS AND FAMILIES

Suzanne B. Hanser, EDD, *Music Therapy, Berklee College, 1140 Boylston Street, Boston MA 02159*

SUMMARY:

This paper presents applications of a music listening stress reduction strategy to individuals with Alzheimer's disease and their family caregivers. The strategy was previously tested in a research protocol for older adults with depression and anxiety, many of whom were caring for family members with Alzheimer's disease. In this *Journal of Gerontology* study (Hanser & Thompson, 1994), participants in an eight-week music therapy program performed significantly better than controls on standardized tests of depression, distress, self-esteem, and mood. These improvements were clinically significant and maintained over a nine-month period.

Clinical replication of the program for groups of individuals with Alzheimer's disease and their family caregivers was begun to determine whether people in various stages of the disease could, likewise, benefit from music therapy. Using the Dementia Mood Assessment Scale (DMAS), promising results were achieved in individuals with dementia. The potential of music therapy with those who are cognitively impaired appears considerable, as this modality demands little of the participant and facilitates mood changes that may minimize agitation, pacing, and other symptoms of anxiety.

No. 61E
MUSIC THERAPY IN MEDICAL AND PALLIATIVE CARE

Barbara L. Reuer, Ph.D., *Music Works of California, 12570 Carmel Creek Road, #73, San Diego CA 92130*

SUMMARY:

Music has been called the "language of the soul." There are times when words seem inadequate to express our deepest thoughts and feelings, our pain, our fear, our joy. Through music, we have a means for connecting with these feelings in ourselves and others. Music can be a bridge, a vital meeting point, for sharing the experience of living and dying. This presentation will explore the benefit of music therapy in medical and palliative care. Didactic and experiential approaches will be used to investigate the function of music in the following areas: alleviating anxiety and restlessness, reducing perception of pain, facilitating nonverbal expression of thoughts and feelings, increasing interaction with others, providing a catalyst for release of pent-up emotions, offering opportunities for creative personal expression, exploring spiritual values, maintaining client's control as an individual by encouraging choices and decision making, providing a means of life review for client and family, and facilitating the bereavement process. A current review of the literature will be provided by the presenter to support the functions of music presented in this presentation.

REFERENCES:

1. Maranto CD, (ed): *Applications of Music in Medicine.* National Association for Music Therapy, Silver Spring, MD, 1991.
2. McIntyre J: My viewpoint. *Music Therapy Perspectives.* 12:134-135, 1994.
3. Nolan P: Music therapy with bone marrow transplant patients: Reaching beyond the symptoms. In: Spintge R, Droh R (eds): *Music Medicine.* p 209-212, 1992.
4. Hanser S, Thompson L: Effects of a music therapy strategy on depressed older adults. *J Gerontology,* 49(6), p 265-p269, 1994.
5. Standley, JM, & Prickett, CA, (eds): *Research in Music Therapy: A Tradition of Excellence,* Silver Spring, MD: National Association for Music Therapy, 1994.

SYMPOSIUM 62—THE STATE OF THE ART IN PSYCHOPHARMACOLOGY Joint Session with the American Society of Clinical Psychopharmacology, Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be familiar with the use of atypical neuroleptics in the treatment of psychosis, the use of anticonvulsants and lithium in the treatment of bipolar disorder, current treatments for panic disorder, and new developments in the treatment of chronic depression.

No. 62A
NEW DRUGS FOR SCHIZOPHRENIA

David Pickar, M.D., *ETB/DIRP, NIMH/NIH, 10 Center Dr. Bldg. 10, 4N-212, Bethesda MD 20812*

SUMMARY:

The treatment of schizophrenia, the most serious of all the mental disorders, is poised to undergo substantial improvement. Whereas conventional antipsychotic drugs have been the mainstay for the pharmacotherapy of schizophrenia for nearly 40 years, a new group of compounds, referred to as atypical antipsychotics, are rapidly replacing former treatments. There are two possibly interrelated features that underlie the importance of these new agents. First, as a group they produce low levels of extrapyramidal side effects and second, some agents have enhanced therapeutic efficacy. Two new atypical antipsychotics, sertindole and olanzapine, have now been introduced into clinical practice. The distinct therapeutic profile of these highly promising agents and an overview of their mechanism of action will be discussed in this presentation.

No. 62B
ADVANCES IN THE TREATMENT OF PANIC DISORDER

Jerrold F. Rosenbaum, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC 815, Boston MA 02114*

SUMMARY:

Benzodiazepines, tricyclics, SSRIs, anticonvulsants, antiadrenergics, and other agents have all proven useful in managing patients with panic disorder and such common comorbid conditions as agoraphobia, depression, social phobia, and OCD. The array of agents in use reflects in part the challenges of treatment: residual symptoms, treatment intolerance, recurrences, comorbidities, and psychosocial complications. Optimal treatment for many requires cognitive behavioral interventions, but emerging data suggest other psychotherapies also favorably influence course and outcome.

The 1996 FDA approval of paroxetine for a panic disorder was the first new labeling for this indication this decade and highlighted the ascendancy of SSRIs to the first line of drug therapy for this condition, with approvals pending for other SSRIs as well as the high potency benzodiazepine clonazepam. Recent data suggest that newer antidepressants may also be effective.

Earlier reports indicating efficacy of valproate have suggested a role for anticonvulsants and clinical anecdotes reinforce considering new anticonvulsants as alternative agents for some treatment-resistant patients as well.

With the goal of pursuing incremental gains to achieve optimal outcome, combination therapies, while largely unstudied, are common clinical strategies.

No. 62C
TREATMENT OF REFRACTORY BIPOLAR DISORDER

Robert M. Post, M.D., *BPB, NIMH, 10 Center Drive, MSC-1272, Bethesda MD 20892*

SUMMARY:

Not only is there increasing recognition of the inadequacy of lithium treatment even as augmented by antidepressants and neuroleptics, but also to the newer mood stabilizing anticonvulsants carbamazepine and valproate, either from the outset or via the development of tolerance. Alternative treatment strategies have involved: a) studies of potentially new treatment agents; b) augmentation strategies; and c) use of more complex multi-psychopharmacological regimens. The use of two or more mood stabilizing drugs in combination is now often utilized prior to the introduction of adjunctive treatment with unimodal antidepressant or antimanic drugs (first with high potency benzodiazepines or with neuroleptics if necessary). T_3 augmentation for bipolar prophylaxis (like that in unipolar acute depression) is widely used but little studied and might be considered before the more medically radical approach of high dose T_4 augmentation for rapid cycling or refractory depression. Early studies from Calabrese et al, and Frye et al, in our group suggest the potential utility of the newly approved add-on anticonvulsant lamotrigine, wherein 50% to 60% response rates have been observed in refractory bipolar patients; good effects on depression have been noted. Highly preliminary data also suggest the potential use of gabapentin augmentation for targeting sleep, anxiety, and mood stabilization in isolated cases. Preliminary work also suggests that the dihydropyridine L-type calcium channel blockers (nimodipine, isradipine, and perhaps amlodipine) may be more effective than the phenylalkylamine verapamil in some patients with ultra-rapid and ultradian cycling patterns. One can be hopeful that with the new range of atypical neuroleptics about to be approved by the FDA, one or more will assume a clozapine-like role in the treatment of patients with refractory rapid cycling and dysphoric mania. Thus, a large group of accepted and putative mood stabilizing agents are becoming available and much systematic work is required in order to delineate the most appropriate treatment algorithms for rapid acquisition of clinical response in otherwise refractory bipolar illness with its high potential for suffering, comorbidity, and lethality if inadequately treated.

No. 62D
TREATMENT OF CHRONIC DEPRESSION

Martin B. Keller, M.D., *Department of Psychiatry, Butler Hospital/ Brown Univ., 345 Blackstone Boulevard, Providence RI 02906*

SUMMARY:

The realization that major depression is often both chronic and recurrent has slowly begun to change the way that depression is diagnosed and treated. Despite the prevalence of chronic depression and the morbidity and social/vocational impairment associated with chronicity, there has been little systematic study of pharmacotherapy for the chronic depressions. We report data on treatment outcome for a large sample of chronically depressed outpatients participating in a double-blind, multicenter study comparing an SSRI (sertraline) with a TCA (imipramine). A total of 635 patients with double depression or chronic major depression are being studied in an integrated program of acute, continuation, crossover and maintenance studies. Patients are initially randomized to double-blind treatment with either

sertraline or imipramine (on a 2:1 allocation). Patients who respond to the initial 12-week acute phase therapy advance on to a 16-week double-blind continuation phase, whereas those who fail to respond receive double-blind crossover treatment with the alternate agent. Treatment responders to this crossover phase will be entered into a subsequent 16-week continuation phase. The early results of the crossover phase in which a significant number of patients successfully completed 12 weeks of crossover treatment, suggest that chronically depressed patients failing an adequate trial of one class of antidepressant medication may benefit from a sequential trial of an alternative class.

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SYMPOSIUM 63—DEPRESSION THROUGH ARAB EYES
Joint Session with the Arab-American Psychiatric Association

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

This symposium will help participants learn about (1) the applications of modern epidemiological and biological depression research tools in Arab populations, (2) the clinical presentation of depression among Arabs with emphasis on gender and cultural factors, and (3) caveats and pitfalls in treating Arab patients.

No. 63A
DEPRESSION SCREENING IN AN ARAB PSYCHIATRIC PRACTICE

Mehadin K. Arafeh, M.D., *Department of Psychiatry, Veterans Memorial, 1 King Place, Meriden CT 06450*

SUMMARY:

Major depression, often misdiagnosed but eminently treatable, is pervasive worldwide. In the United States alone eight million people suffer major depression in a given year, and 17% of the population will experience it during their lifetime. The usefulness of depression screening is generally well established, but the Arab world (19 countries and 230 million people) has no equivalent to Mental Health Awareness Week or large-scale depression screening.

This paper outlines responses to an inquiry sent to the chairs of departments of psychiatry in Arab medical schools, and to the directors of important psychiatric programs in Arab countries. They were asked to comment on the applicability, usefulness, and feasibility of depression screening in the identification and induction into treatment of depressed individuals. They were also asked to consider socioeconomic and cultural differences, and the paucity of precise epidemiological studies pertaining to depression screening in the Arab population.

To facilitate informed response, the correspondents received materials on depression screening and the *APA Guideline for Major Depressive Disorders* (1993).

The results will be presented and used as a springboard for suggestions and comments from a diverse audience. Recommendations on the formulation and implementation of an Arab depression screening program will be made.

No. 63B
POSTPARTUM DEPRESSION IN AN ARAB COMMUNITY

Rafia O.S. Ghubash, Ph.D., *Department of Psychiatry, UAE University, PO Box 17666, Al Ain, U. Arab Emirates;* Prof. M.T. Abou Saleh, Ph.D.

SUMMARY:

There have been numerous studies of postpartum depression, but none in the Arab culture. The study of postpartum psychiatric illness in a range of cultures offers a unique opportunity to examine the sociocultural differences in presentation, etiology, and the care and prevention of these disorders.

The Gulf region with its oil riches has undergone rapid and extensive economical and sociocultural modernization in the last three decades.

This is a prospective study that investigated the prevalence of postpartum depression among local women from the Dubai community and its sociocultural correlates. A total of 134 women were approached to take part in the study; 90 turned up for their second interview seven days after childbirth when the Edinburgh postnatal depression scale (EPDS) was administered.

Results: EPDS-defined case depression was 17.8%. This depression was associated with previous psychological illness, marital problems before delivery, ongoing marital problems, lack of assistance from husband, not living with own and husband's family, loss of father before age 13, and having a relative with alcohol problems.

Conclusion: The prevalence of postpartum psychiatric morbidity is similar to the results obtained in studies from Western Europe and North America, but its psychosocial correlates are different.

No. 63C
THE BIOLOGY OF DEPRESSION IN ARAB POPULATIONS

Prof. M.T. Abou Saleh, Ph.D., *Department of Psychiatry, UAE University, PO Box 17666, Alain, U. Arab Emirates*

SUMMARY:

Purpose: To investigate biological markers of depression in Arab populations.

Method: Groups of patients with major depressive disorders including postpartum depression (DSM-III-R) were investigated in comparison with normal control subjects. The biological data collected included amino acids, pterins, hormones, folate, immune function tests, and SPECT results. Comparisons were also made with patients with schizophrenia.

Results and conclusions: The results showed that depressed patients had significantly lower plasma amino acids, particularly tryptophan, and lower folate concentrations than control subjects. Urine pterins (neopterin/biopterin) were significantly higher than values obtained in normal controls. Immune function measures showed immune activation in depressive patients but not in schizophrenic patients when compared to values in normal controls. SPECT results showed similar blood perfusion in depressive and schizophrenic patients. These results are consistent with the results obtained by

other investigators including those obtained by the author on U.K. populations.

No. 63D
TREATMENT OF DEPRESSION IN ARAB PATIENTS

John C. Racy, M.D., *Department of Psychiatry, University of Arizona, 1501 North Campbell Avenue, Tucson AZ 85724*

SUMMARY:

Among traditional Arab patients, depression presents with symptoms referable to the lower chest and upper abdomen, an area usually described as the heart (Galb). Mental symptoms are variants of irritable boredom (Zahak). As in much of the rest of the world, depression is three to four times more common in women than in men.

In therapy, the challenges are the recognition of depression (decoding somatization), dealing with the underlying sense of shame or loss, and the necessity of preserving face. This is particularly important in men. Suicidal behavior, when it occurs, is usually in response to a sense of humiliation, family conflict, or threatened loss (divorce) and is transparently an attempt to alter the situation. Talk is rarely sufficient. Medication is expected and exerts a strong placebo effect, because it saves face, fits with somatic complaints, and is accepted readily in an authoritarian society. Large colorful pills and injections create more of an impression.

Psycotherapy works best if it is directive and prescriptive (advice, recreation, reading) rather than exploratory. Risks lie in fostering autonomy in women, rebellion among the young, and dependence among most patients.

Prognosis is generally good because of ready compliance, high suggestibility, and availability of family support. An important subset is a group of individuals, usually women, with impossible social (family) situations. For them, a chronic and stable somatization with partial relief from doctor visits and prescriptions is the best that can be hoped for and may, indeed, preserve life and self-esteem.

No. 63E
DEPRESSION IN ARAB WOMEN

Kutaiba-Salem Chaleby, M.D., *Neurosciences, King Faisal Hosp & Res Ce, PO Box 3354, Riyadh 11211, Saudi Arabia*

SUMMARY:

Women and depression is probably one of the most common subjects in psychiatry. Depression is about two to three times more common in women. One in four to five women experiences more depression when there is violence within the family. Women have more atypical depression, and one study showed 71% of patients with seasonal affective disorder were women.

There are reasons to believe that the Arab woman may be suffering from more life stressors than her Western counterpart. The anthropological and the psychosocial literature bear out this fact.

The depressed Arab woman has to deal with the stigma of mental illness over and above the already known biases. The conclusive remarks we may propose were derived from studies conducted in our clinic with data collected over the years. We chose to discuss these gender related issues under specifically observed phenomena. These were found to be: (1) Status in being a passive life partner to the man. (2) Restriction of freedom of movement. (3) Status of forced dependency. (4) Sexual segregation. (5) Physically the weaker sex. (6) Male derived self-esteem. (7) The less privileged partner. (8) Subject of bias and stereotyping.

No. 63F
AFFECTIVE TEMPERAMENTS IN NAGUIB MAHFOUZ'S CHARACTERS

Radwan F. Haykal, M.D., *Charter Lakeside Behv Hlth Ser, 6263 Poplar Avenue, Suite 402, Memphis TN 38119-4726*

SUMMARY:

Naguib Mahfouz, the Egyptian novelist enjoyed by Arab readers for more than five decades, catapulted into world fame when he received the Nobel Prize for literature in 1988. Mahfouz's literary contributions will be briefly chronicled with focus on *The Trilogy of Cairo*, his most acclaimed work. In these three books Mahfouz escorts Kamal, the main character, from childhood into middle age, using "internal monologues" to portray with utmost subtlety his brooding, indecisiveness, and pessimism. Kamal is a social phobic with shaky self-esteem who rationalizes his fears of failure and intimacy. His depressive temperament and obsessiveness are in sharp contrast to that of Yasin, his half-brother, who is hypersexual, impulsive, frivolous, and reckless. Both characters deal with stress by escapism into alcohol and sex, but in ways as different as their temperaments.

The characters of Mahfouz will be analyzed using neo-Kraeplinian operational criteria of affective temperaments and subsyndromal mood disorders. A plausible genetic hypothesis will be offered.

Although Mafouz's protagonists struggle through the social and historical change of their time, their psychological make-up is consistent and predictable. In the context of art emulating nature, Mahfouz's perceptiveness and keen observations are unparalleled.

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SYMPOSIUM 64—HISTORY, CULTURE AND CARE: DIFFERENCES BETWEEN FRANCE AND UNITED STATES
Joint Session with the Federation Francaise de Psychiatrie

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to understand the way psychiatry and psychiatric care in the United States and France have evolved from their respective cultures and histories.

No. 64A
HISTORICAL INFLUENCES ON PSYCHIATRIC CARE IN FRANCE

Jean M. Garrabe, M.D., *Riviere, Le Mesnil St Denis 78321, France;* Richard Rechtman, M.D.

SUMMARY:

The major historical events in France had always involved profound changes in psychiatric care, either in the conception or in the social management of mental illness. Pinel's famous impulse promoted modern psychiatry in our country in the context of the French Revolution by introducing medical labeling of mental illness.

World War One broke off the fruitful exchange started at the end of the 19th century between French and German psychiatry.

World War Two and the German occupation isolated France from the rest of the world. While there was no more international scientific exchange, French psychiatrists introduced a kind of community mental health care that would be the model of the mental health care of the 60's. Following the allied victory, a rich international scientific exchange took place in Paris with the organization of the First World Psychiatric Meeting in 1950. During this period radical changes in French mental health care took place that we call the third psychiatric revolution. In this paper the authors will focus on the issues raised by the influences of those major events. They will discuss from a critical point of view to what extent those events belong to the philosophy of French psychiatry or also shape a "myth of the origin."

No. 64B
HISTORICAL INFLUENCES ON PSYCHIATRIC CARE IN AMERICA

Gerald N. Grob, Ph.D., *Rutgers University, 30 College Avenue, New Brunswick NJ 08903*

SUMMARY:

Psychiatric care in America has gone through three distinct phases. In the 17th and 18th centuries responsibility for severely mentally ill persons fell upon relatives and local officials responsible for the care of dependent persons. Severe mental illness was largely a social and economic rather than a strictly medical problem, and care was provided in ad hoc and informal ways by either the family or community. In the early 19th century states began to move toward an institutional policy. Care and treatment of mentally disordered persons was placed in the hands of physicians employed in public mental hospitals. The forging of an institutional public policy also gave rise to the specialty of psychiatry, which for all of the 19th and part of the 20th century was associated with public employment. After World War II there was a move away from an institutional toward a community oriented policy, which by the 1970s became known as deinstitutionalization. At the same time psychiatry moved toward a private practice model. What accounts for these policy and occupational shifts? The answer to this question is by no means as clear as is generally believed. This paper will attempt to sketch out the complex elements both within and without the mental health arena that gave rise to policies and consequences that were often neither planned nor anticipated.

No. 64C
CULTURAL INFLUENCES ON PSYCHIATRIC CARE IN FRANCE

Suzanne Parizot, M.D., *290 Route de Vienne, Lyon 69373, France;* Jean-Charles Pascal, M.D.

SUMMARY:

Psychiatry cannot be separated from culture. It is, for that matter, society and its culture that define insanity.

The rigor of diagnoses, the effectiveness of therapies, together with a positioning which is ethically acceptable by psychiatry, all need the reference of culture. We are confronted with various problems concerning the potential of cultural evolution and the juxtaposition of cultural models which are, at times, antagonistic.

We will begin with a number of concrete examples to illustrate these propositions.

In conclusion, we will reaffirm that both first-degree courses and ongoing education for psychiatrists should integrate learning other than that which appears to be directly "technical," that is to say knowledge upon which culture is based, such as history, philosophy, literature, but also uncompartmentalized knowledge taken up in thought about complexity, thinking which echoes the cultural field.

No. 64D
CULTURAL INFLUENCES ON PSYCHIATRIC CARE IN AMERICA, 1844-1997

Eric M. Caplan, Ph.D., *University of Chicago, History, 5845 South Ellis Avenue, Chicago IL 60637*

SUMMARY:

Professedly founded on observation and clinical investigations, American psychiatry has from its inception been as sensitive to various cultural influences as is the barometer to the changes of atmospheric density. From the asylum on the hill, which dominated the iconographic landscape of 19th century psychiatry, to the "dream doctors" and other exemplars of so-called "scientific psychotherapy" who arose during the early decades of the 20th century, to our recent epoch in which "wonder drugs" have begun to replace wonderful doctors, American psychiatry has both shaped and been shaped by American culture. American psychiatry's myriad transformations have been mirrored by an equally vigorous literary and cinematic imagery. This paper will not only chronicle the above-mentioned sea of changes in both the practice and iconography associated with American psychiatry, but also examines the broader professional and cultural matrices that have contributed to these changes. By utilizing such sources as medical periodicals, motion pictures, journalism, and novels, as well as self-representations of psychiatrists both as individuals and as organized groups, this paper addresses the following question: What professional interests, cultural programs, social tensions, and media preoccupations appear to explain the evolving impact of American culture on the practice of psychiatry?

No. 64E
PSYCHIATRY IN FRANCE: PERSPECTIVES ON THE FUTURE

Jean-Michel Thurin, M.D., *9 Rue Brantome, Paris, 75003, France*

SUMMARY:

With great fervor, French psychiatry has assimilated and implemented each of the theoretical movements, institutional changes and discoveries that have marked its history. This dynamic has given rise to specific practices manifesting themselves as major currents and methods of the profession.

For several years, a two-part trend has been in evidence. On the one hand, we note the desire to keep psychiatry within a humanist perspective, thereby emphasizing the singular nature of dialogue and experience and implying the recourse to psychopathology. On the other hand, however, a renewed interest in clinical research has emerged, reflecting the attempt to pool and more effectively use

knowledge buttressed by authentication. This objective should, moreover, make therapeutic projects clearer and more understandable to patients and those persons supporting them.

The search for links between the subjective and the objective, the particular and the general, will reinvigorate studies bearing on the specific case, as this mirrors and informs epidemiological studies and basic research, while taking into account factors relating both to risk and to change and health. Rather than focusing on some ultimate key, emphasis will be placed on accounting more effectively for each of these factors and calls for professional help, in order to provide individualized care and ensure overall prevention.

The interaction between specific skills, most especially those arising from clinical experience, knowledge transfer, and the search for interdisciplinary bridges constitutes a related perspective, which will profit from new communication and data-exchange technologies.

All of these undertakings will prove meaningful only if attention is constantly paid to the ethical repercussions of any research or therapeutic project. The rise of a current of thought and practice dealing specifically with these issues will be of critical importance.

At the dawn of the twenty-first century, the possibilities are enormous, but the risks are substantial. Will the psychiatrist know how to preserve and pass on a psychiatric profession sensitive to both the individual and to generalized data obtained through knowledge of the various components of the psychic mechanisms and the ways in which they work?

REFERENCES:

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SYMPOSIUM 65—HOSPITAL SAFETY IN AN ERA OF MANAGED CARE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The goal of the symposium is to educate clinicians about the occurrence and prevention of violence in the workplace, and to highlight recent governmental and accrediting regulations relevant to this topic.

No. 65A
VIOLENCE IN EMERGENCY ROOMS

Stephen B. Goldberg, M.D., *Department of Psychiatry, University of Maryland, 645 West Redwood Street, Baltimore MD 21201;* John R. Lion, M.D.

SUMMARY:

It is generally recognized that the most dangerous area of the hospital is the emergency room (ER) where unscreened populations are brought by police. Larger, municipal ERs are at particular risk for violent occurrences. An extensive literature has now documented the ubiquity of threats and assaults within the ER, and weapons screening policies are in effect in many urban, inner-city facilities. Still, the implementation of such policies is often not carried out by the administration because of public relations concerns, and because hand-held detectors often lead to overuse in minority populations. Fixed detectors are advantageous, but more expensive. Other ER safety factors include segregating the unit from the rest of the hospital, implementing safe traffic flow, providing panic alarms in observation spaces, and placing security staff where they are visible and accessible. These parameters and architectural features will be discussed.

No. 65B
SECURITY STAFFING IN HOSPITALS

Donald Futrell, Security, *University of Chicago Hospital, 5841 South Maryland Avenue, Chicago IL 60637*

SUMMARY:

All general and psychiatric hospitals have established security personnel, though their functions vary considerably. In some facilities, hired protection services are used, while larger institutions have on-site officers, some with arrest powers. The arming of security staff is a controversial topic; standards and policies of weaponry vary enormously. The use of security staff on a psychiatric ward poses many difficulties in terms of training, philosophy, and identity. Should they assist in restraint and seclusion? Can they file charges against patients who are assaultive? How security officers should dress, and where they should be deployed throughout the hospital is important. Patient and visitor screening policies are vital, especially within the emergency room. This paper will discuss the various strategies of implementing a security program.

No. 65C
SEVERE ASSAULTS AND HOMICIDE WITHIN MEDICAL INSTITUTIONS

Brian J. Ladds, M.D., *Forensic Psychiatry, NYU Medical Center, 46 West 96th Street, #1E, New York NY 10025;* John R. Lion, M.D.

SUMMARY:

Assaults within American hospitals are common, though published figures on incidence vary considerably. This paper reviews data, focusing on type of institution, staffing patterns, and populations served. Trends are surveyed, and prevention strategies suggested on the basis of findings. Also reviewed is the problem of assaults on clinicians. Individual cases highlighting particular risk profiles are presented, such as the physician covering a large mental hospital on weekends, improper limit setting on inpatient services, and examples of deranged transference situations in the context of therapy. Some issues of predicting dangerousness are presented.

No. 65D
THE HARDWARE OF VIOLENCE CONTAINMENT

John R. Lion, M.D., *Department of Psychiatry, University of Maryland, 328 East Quad/5100 Falls Road, Baltimore MD 21210*

SUMMARY:

Most inner-city psychiatric facilities derive their inpatient populations through the emergency room which, in turn, must deal with the problem of weapons screening. Hand-held detectors tend to be used in a discriminatory fashion; a fairer method of screening is to utilize a fixed arch detector such as those seen in airports. But this involves larger costs, mostly for manpower required to operate the device. Studies of populations screened show a large amount of weaponry detected. These surveys will be reviewed, as will be the utilization of restraint and device appliances around the country. Only now are data emerging concerning the extent of seclusion and restraint implementation in private and public facilities. Litigation surrounding the use of restraint and seclusion is increasing. Nonlethal (pepper) and lethal weaponry employment by security officers will also be discussed.

No. 65E
THREATS AND ASSAULTS DURING HOSPITAL TREATMENT

William R. Dubin, M.D., *Department of Psychiatry, Belmont Center, 4200 Monument Road, Philadelphia PA 19131;* John R. Lion, M.D.

SUMMARY:

An American Psychiatric Association task force report on the subject of clinician safety has revealed a significant percentage of clinicians to be at risk for assaults and threats. Yet psychiatrists rarely receive formal training on how to protect themselves against assaults and how to manage threats. Indeed, workplace violence has only recently become formally recognized as an occupational hazard. Violence to clinicians can occur at any time during hospital and emergency room work. This paper will present a teaching syllabus for hospital employees, including psychiatrists. The focus of this syllabus will be the management of threatening patients, countertransference issues in treatment, and the prosecution of assaultive and destructive hospitalized patients. The "hardware" of violence containment such as restraint appliances will also be discussed.

No. 65F
A HOSPITAL-WIDE PROGRAM TO REDUCE VIOLENCE

Landy F. Sparr, M.D., *Department of Psychiatry, Oregon Health Sciences Univ, PO Box 1034/VA Med Ctr, 116A, Portland OR 97207;* David J. Drummond, Ph.D.

SUMMARY:

Prevention programs for violence are rare in American psychiatry. One group of workers in an Oregon VA hospital setting has set in motion a facility-wide system of identifying previously violent patients and computer flagging them. This enables clerks to alert clinicians and security staff to the presence of potentially dangerous persons. Implementation of this system has led to a dramatic decline in assaults and threats, but the methodology requires marked cooperation with security staff and risks stigmatizing certain patients as "disruptive." The computerization of patient data and implementation of computer facilities within hospital has made this program possible. Problems in setting up the program are discussed.

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SYMPOSIUM 66—DILEMMAS IN SCHIZOPHRENIA: MANAGING OBSTACLES TO RECOVERY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant will become familiar with the concept of recovery in schizophrenia and with the management of several common clinical dilemmas that, if not managed appropriately, can become obstacles to the recovery process.

No. 66A
"I DON'T THINK I NEED THIS MEDICINE"

David G. Greenfeld, M.D., *Psychiatry, Yale University, 25 Park Street Room 611, New Haven CT 06519*

SUMMARY:

A consumer who informs his clinician about a wish to reduce or discontinue medication may be unwisely risking a relapse. The fact that the consumer raises the issue within the treatment context, rather than simply stopping the medication without discussion, indicates sufficient trust in the clinician to engage in an ongoing dialogue. This dialogue is the crucial element in any strategy to deal with this challenge. Several concepts should form the basis of the clinician's approach: (1) The clinician should solicit the consumer's views in detail, exploring his or her ideas about the illness and its treatment and, in particular, about the purposes and actions of the medication. If the consumer appears to be misinformed or unrealistic about these issues, it is also important to determine the degree of rigidity with which these ideas are held. (2) A dialogue should follow and, if possible and necessary, a negotiation about how to proceed together. If significant differences of opinion exist between clinician and consumer, they might both devise a plan to test these differences (which might include a decrease or discontinuation of medication), enabling them to learn together about the importance of medication in the treatment process.

No. 66B
EMPLOYMENT: WHAT ARE REALISTIC GOALS?

Ronald J. Diamond, M.D., *Department of Psychiatry, University of Wisconsin, 6001 Research Park Boulevard, Madison WI 53719*

SUMMARY:

Work in American society is much more than just a source of money. It is an important part of how we define ourselves, a primary way for us to meet friends, structure our time, and gain a sense of accomplishment. For many people with serious and persistent mental illness, any kind of job is challenge enough. A variety of support strategies have proven effective in helping people with serious psychiatric impairment achieve some level of competitive employment. For others with issues of self-definition and self-esteem, however, the only acceptable employment is at a professional level that may seem unrealistic to treating clinicians or family members. This vignette will explore the dilemma of a person who continues to hold on to professional aspirations to work as an engineer, despite persistent psychotic symptoms that seem to make such a goal extremely unlikely, if not impossible.

No. 66C
"I DON'T WANT TO LIVE LIKE THIS": SUICIDALITY IN SCHIZOPHRENIA

Kimberly Littrell, A.P.R.N., *Schizophrenia Treatment, 208 Church Street, Decatur GA 30030*

SUMMARY:

A diagnosis of schizophrenia conjures up feelings of hopelessness and despair in clients, family members, and even clinicians. Afflicting 1% of the U.S. population, schizophrenia can ruin lives and leave individuals with unfulfilled dreams and a shattered existence. Historically, the treatment of schizophrenia has focused on the control of psychoticism and the prevention of hospitalization, while less attention was paid to the discouragement and demoralization that many of these individuals experience. It is not surprising then that suicidality is a major problem in this population, with 20% to 50% attempting and 10% successfully completing suicide. These numbers are 20 times greater than suicidality in the general population.

In the past decade, numerous scientific reports from 18 different countries have addressed the issue of suicidality and schizophrenia. A review of this literature reveals several consistent associations between suicide and schizophrenia. The most predictive factor is past suicide attempts. Other correlates include history of depressive episodes, severe and progressive impairment, substance abuse, duration of illness, living alone, young age, and multiple hospitalizations. Most studies noted that clients were not psychotic at the time of their suicide. Findings from these studies suggest that the most critical period for suicide among persons with schizophrenia is the time following recovery from the illness.

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SYMPOSIUM 67—RECENT ADVANCES IN MOLECULAR PSYCHIATRY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of the presentation the participant should be able to understand key new developments in the field of molecular psychiatry and should be able to integrate those to the practice of psychiatry and psychopharmacology.

No. 67A
ROLES OF CORTICOTROPIN RELEASING FACTOR AND UROCORTIN, THEIR RECEPTORS AND BINDING PROTEIN

Wylie Vale, Ph.D., *Clayton Lab, The Salk Institute, 10010 North Torrey Pines Road, La Jolla CA 92037;* Joan Vaughan, Ph.D., Marilyn Perry, Ph.D., Jean-Michel Aubrey, Ph.D., Giacomo Pozzoli, Ph.D., Jean Rivier, Ph.D., Paul Sawchenko, Ph.D., Kuo-Fen Lee, Ph.D.

SUMMARY:

Corticotropin releasing factor (CRF) is the key neuroregulator of the hypothalamic-pituitary-adrenal axis (HPA) and mediates numerous complementary stress-related endocrine, autonomic, and behavioral responses. The central and peripheral distribution of CRF and its receptors when considered with biological actions support the notion that CRF is a key local regulator within the central nervous, immune, and other systems. CRF antagonists block many stress-induced physiologic and pathophysiologic responses in animals and perturbations of the CRF system have been reported in affective disorders. The effects of CRF within the CNS may be anatomically and temporally limited by a high affinity binding protein (CRF-BP). The actions of CRF are mediated by seven transmembrane domain G-protein coupled receptors (CRF-R) derived from two genes, each of which has alternative splice variants. The first receptor (CRF-R1) binds CRF with high affinity, is coupled to adenylate cyclase, and is distributed in pituitary corticotropes and throughout the CNS. Two variants of the second receptor (CRF-R2) differ from CRF-R1 with respect to anatomic distribution and pharmacologic specificity; particularly, the structurally related lower vertebrate peptides sauvagine and urotensin-I are more potent than CRF on CRF-R2. Fish urotensin I and amphibian sauvagine were considered to be homologs of CRF until peptides even more closely related to CRF were identified in these same vertebrate classes. Looking for an additional mammalian member of this family, we have identified a novel urotensin and CRF-like peptide, named urocortin, in the rat brain and the human genome that has very high affinity for CRF-R1 and R2 as well as for CRF-BP. Synthetic urocortin has potent biological actions on both CRF-R1 (pituitary ACTH release) as well as R2 (vasodilation, reduction of vascular permeability) mediated events. The coincidence of urocortin-like projections with CRF-R2 and observations that synthetic urocortin is more potent than CRF for binding and activating these receptors, as well as for inducing c-Fos in regions enriched in CRF-R2, are consistent with the hypothesis that this novel peptide is an endogenous ligand for CRF type 2 receptors.

No. 67B
CORTICOTROPIN RELEASING FACTOR RECEPTORS: FROM GENE TO THERAPY

Errol B. De Souza, Ph.D., *Neurocrine Bioscience, 3050 Science Park Road, Ste 100, San Diego CA 92121*

SUMMARY:

Corticotropin-releasing factor (CRH) is part of a complex system consisting of two ligands, CRF a urocortin, a mammalian urotensin-like peptide, as well as multiple CRF binding sites, such as CRF receptors and CRF binding protein. The characteristics of CRF receptors and CRF binding protein including their sequence homologies, pharmacological profiles, and second messenger activities will be presented. This presentation will focus on novel pharmacological approaches based on interventions aimed to modulate the effects of CRF receptor activity in the central nervous system. One of these approaches has been focused on Alzheimer's disease (AD). In AD there are reductions in the content of CRF, reciprocal increases in CRF receptors, and morphological abnormalities in CRF neurons. Moreover, there is an association between cognitive impairment in AD patients and lower cerebrospinal fluid concentration of CRF, which is known to induce increases in learning and memory in experimental animals. Based on those data, we have proposed that CRF deficits contribute to cognitive impairment. The identification in post-mortem brain of CRF-binding protein (CRF-BP), a high-affinity binding protein that inactivates CRF, and the differential distribution of CRF-BP and CRF receptors, provides the potential for improving learning and memory without stress effects of CRF receptor agonists. We will present data showing that ligands that dissociate CRF from CRF-BP increase brain levels of "free CRF" in AD to control levels and show cognition-enhancing properties in models of learning and memory in animals without the characteristic stress effects of CRF receptor agonists.

No. 67C
THE SOMATIC CONSEQUENCES OF DEPRESSION

Philip W. Gold, M.D., CNE, NIMH, *Bldg 10/2D46, 10 Center Drive, Bethesda MD 20892-1284;* Constantin Stratakis, M.D., Lauren Hill, B.Sc., Elise Galliven, B.Sc., George P. Chrousos, M.D., David Michelson, M.D.

SUMMARY:

We are currently studying the somatic consequences of depression. Depression is associated with alterations in behavior and neuroendocrine systems that are risk factors for decreased bone mineral density. We have recently conducted a study to determine whether women with past or current major depression have demonstrable decreases in bone density. Bone mineral density was measured at the hip, spine, and radius in 24 women with past or current major depression and in pair-wise controls matched for age, body mass index, menopausal status, and race using dual energy x-ray absorptiometry. We also evaluated cortisol and growth hormone secretion, bone metabolism, and vitamin D receptor alleles. As compared with normal women the mean (±SD) bone density in the women with past or current depression was 6.5% lower at the spine (depressed women 1.00 ± .15 g/cm^2, normal women 1.07 ± .09 g/cm^2, P = 0.02), 15.7% lower at the femoral neck (0.76 ± 0.11 vs. 0.88 ± 0.11 g/cm^2, P < 0.001), 13.5% lower at Ward's triangle (0.70 ± 0.14 vs. 0.81 ± 0.13 g/cm^2, P < 0.001), and 10.8% lower at the trochanter (0.66 ± 0.11 vs. 0.74 ± .08 g/cm^2, P < 0.001). Additionally, women with past or current depression had higher urinary cortisol excretion (71 ± 29 vs. 51 ± 19 μg/d [196 ± 80 vs. 141 ± 52 nmol/d], P = 0.006), lower serum osteocalcin concentrations (P = 0.04), and lower urinary deoxypyridinoline excretion (P = 0.02). We conclude that past or current depression in women is associated with decreased bone mineral density. These and other somatic sequelae of depression will be discussed from clinical, neuroendocrine, and molecular perspectives.

No. 67D
IMMUNE-CNS INTERACTIONS: MOLECULAR MECHANISMS

Ma-Li Wong, M.D., CNE, *NIMH Intramural, Bldg 10/2D46, 10 Center Drive, Bethesda MD 20892-1284;* Peter B. Bongiorno, B.Sc., Amer Al-Shekhlee, M.D., Anna Esposito, B.Sc., Pooja Khatri, B.Sc., Julio Licinio, M.D.

SUMMARY:

Communication systems between the brain and the periphery are important for behavior and for physiological regulation. The mechanism by which the peripheral immune mediator interleukin 1β (IL-1β) exerts its actions in the brain during systemic inflammation is not fully understood, as neither IL-1 receptor gene expression nor IL-1 binding have been identified in significant levels in key areas that respond to IL-1β. Having hypothesized that perivascular nitric oxide (NO) might modulate the effects of systemic IL-1β in the brain, we studied the expression of the genes encoding for IL-1β, the signal-transducing IL-1 receptor type I (IL-1RI), and inducible nitric oxide synthase (iNOS) constitutively and during systemic inflammation in vascular and perivascular regions of the rat brain. Our results show that IL-1RI is constitutively expressed at the interface of the vascular wall and perivascular glia. During systemic inflammation there is induction of IL-1β gene expression in the vascular wall, accompanied by perivascular induction of iNOS mRNA. We conclude that during systemic inflammation, vascular IL-1β, binding to vascular and perivascular IL-1RI receptors, may induce perivascular iNOS gene expression, leading to the production of NO and modulation of the effects of IL-1β in the brain. We propose that the vascular and perivascular induction of iNOS mRNA by IL-1β might represent a mechanism by which peripheral inflammatory mediators can affect complex functions of the central nervous system such as behavior.

No. 67E
TRANSGENIC MODELING OF NEUROPSYCHIATRIC DISORDERS

Iain Campbell, Ph.D., *Neuropharmacology, Scripps Research Institute, 10666 North Torrey Pines Road, La Jolla CA 92037*

SUMMARY:

Genetic engineering in the mouse by transgenesis has emerged as a popular and effective tool in neuropsychiatric research. The power of this approach lies in its ability to introduce a specific and stable gene mutation in the germline, thereby allowing for the dissection of the molecular, pathological, electrophysiological, neuroendocrinological, and behavioral processes associated with that gene. Gene-disrupted (or "knockout") or overexpressing transgenic mice have been developed with varying degrees of success to recapitulate diverse neuropsychiatric disorders from the dementias to behavioral abnormalities. In many cases these models highlight the potential for plasticity in the developing nervous system giving particular insights into how the CNS responds to genetic perturbation and how specific molecular changes are manifest as alterations at the cellular, circuit, and functional levels. Significant recent technical developments offer the promise of exquisite fine tuning that will permit controlled genetic modification in a specific region of the brain and at a defined period in the lifetime of an animal. Against this positive background, many important caveats are associated with transgenic mice in particular in the interpretation of phenotypic alterations that may be observed. What seemed a Pandora's box can quickly turn out to be a can of worms. Notwithstanding these pitfalls, transgenic modeling of neuropsychiatric disorders has assumed a pivotal position in the armory of neuropsychiatric research and in many instances has advanced our understanding of how altered gene function influences behavior. Moreover, these animal models offer a valuable resource for the development and preclinical testing of corrective strategies.

No. 67F
ASSOCIATION OF DOPAMINE D4 RECEPTOR GENE AND ADHD

James L. Kennedy, M.D., *Neurogenetics, Clarke Institute, 250 College Street, Toronto ON M5T 1R8, Canada;* Peggy Richter, Ph.D., James Swanson, M.D., Tim Wigal, Ph.D., Gerald LaHoste, Ph.D., Glen Sunohara, M.D.

SUMMARY:

Attention-deficit/hyperactivity disorder (ADHD) is the most prevalent psychiatric disorder of childhood, affecting an estimated 3% to 9% of school-age children. The disorder is characterized by problems in attention, overactivity, and impulse control. Cosiderable evidence has accumulated from family, twin, and adoption studies supporting a major genetic component to the etiology. The most common treatments for the disorder are stimulant medications, which act primarily on the dopaminergic and noradrenergic systems. As a result, dopamine has long been believed to play an important role in the manifestation of the disorder. We have recently reported (LaHoste et al, 1996) an association of the variable 48 bp repeat in the dopamine D4 receptor gene (DRD4) and ADHD using carefully matched controls (n = 39). We have increased the sample size by 50% and the effect still holds (2 = 9.70, p = 0.01), with the seven-fold repeat allele occurring significantly more frequently in the ADHD group. This result is interesting due to the functional rele-

vance of the polymorphism and the association of this seven-repeat allele with novelty seeking behavior (Ebstein et al, 1996; Benjamin et al, 1996). Furthermore, we observe a nonsignificant trend toward lower rates of the seven-repeat allele in obsessive-compulsive disorder. This finding is consistent with the overall notion that the seven-repeat allele modifies risk for mental disorders that involve the range of behaviors from novelty seeking and rapidly changing attention to the other extreme of attention being fixed in a compulsive way on one or a few preoccupations. However, further study with increased sample sizes is still needed. Since ADHD is likely to be polygenic, the examination of further candidate genes should also be considered.

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SYMPOSIUM 68—BEYOND AXIS I: SYMPTOMATIC SUBSYNDROMAL DISORDERS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the end of this symposium, participants will be able to identify common psychiatric conditions that cause significant suffering and functional impairment, yet are not part of the traditional Axis I terminology. As well as learning to recognize and evaluate these disorders, and differentiate them from Axis I pathology, participants will learn about current concepts of management of subsyndromal and comorbid conditions.

No. 68A
RELEVANCE OF SUBSYNDROMAL MOOD DISORDERS

Lewis L. Judd, M.D., *Department of Psychiatry, UCSD School of Medicine, 9500 Gilman Drive, La Jolla CA 92093-0603*

SUMMARY:

This presentation will cover data from three different investigations designed to determine the clinical significance of subsyndromal depressive symptoms in the course of unipolar depression. These studies show that the course of unipolar depression is highly variegated, in that there is a continuous flow, by patients, in and out of the various depressive subtypes and symptom severity levels across time. These levels include asymptomatic status, subsyndromal depressive symptoms, symptoms at the threshold for minor/intermittent depression, and symptoms at threshold for major depression. They were examined on a weekly basis to determine the percent time patients spent at each symptom severity level during 12 years of follow-up. Patients spend only 41.4% of their time asymptomatic, 25% of their time experiencing subsyndromal depressive symptoms, 17.9% of their time at the minor or intermittent depression level, and only 15.4% meeting symptom criteria for major depressive disorder. Approximately 98% of the patients spend some time at three or four of the depressive symptom levels, indicating that the course of unipolar depression is a dynamic, changing process moving in and out of various symptom severity levels over time. In addition, patients, during the time they are free of depressive symptoms, are significantly less impaired, compared to the time they are experiencing subsyndromal depressive symptoms or depressive disorders. These data suggest the course of unipolar disorders, classically defined by major depressive episodes, is dominated by subsyndromal and more minor levels of symptomatology. Further, subsyndromal depressive symptoms are the most prevalent inter-episode symptom level in the course of illness, are associated with significant functional impairment, and when presenting as residual symptoms are a very strong predictor of early episode relapse.

No. 68B
GOOD GRIEF/BAD GRIEF: DEPRESSIONS OF BEREAVEMENT

Sidney Zisook, M.D., *Department of Psychiatry, University of CA at San Diego, 9500 Gilman Drive, La Jolla CA 92093;* Stephen R. Shuchter, M.D., Martin Paulus, M.D.

SUMMARY:

Grief and depression are not the same. Despite symptomatic overlap between grief and major depressive episodes (MDE) such as dysphoria and sleep and appetite disturbances, only a minority of bereaved individuals experience a full MDE, and even fewer require treatment. Yet, bereaved individuals are at risk for the exacerbation or onset of not only MDEs, but also minor (MIN DEP) and subsyndromal symptomatic (SSD) depressions. This study looks at the prevalence, risk factor, course, and consequences of a spectrum of unipolar depressive disorders following bereavement.

Method: 350 widows and widowers completed comprehensive grief questionnaires 2, 7, 13, 19, and 25 months following their spouses' deaths. On the basis of selected items from the questionnaire, subjects were divided into the following groups: those who meet DSM-IV criteria for MDE or MIN DEP, those with SSD, and those with no depression (NO DEP).

Results: (1) Risk factors for depression include prior personal and family history of MDE, youth, and poor general medical health; (2) at two months, about 50% of widows and widowers suffer from a unipolar depressive spectrum disorder; (3) over time, bereaved individuals often move from one depression category to another, each depression category being a risk factor for the others; and (4) MDE is associated with the greatest levels of psychosocial impairment, NO DEP the least, and MIN DEP and SSD with intermediate levels.

Conclusion: Even when MDE occurs in the context of a severe life stress event, such as spousal bereavement, it is associated with the same additional risk factor as other forms of MDE, runs a similarly chronic and/or recurrent course, and is associated with impaired functioning. It is probably wise to think of depression as a spectrum disorder with variable levels of intensity and symptomatic expression over time.

No. 68C
PREMENSTRUAL DYSPHORIC DISORDER

Barbara L. Parry, M.D., *Department of Psychiatry, University of California, 9500 Gilman Drive, La Jolla CA 92093*

SUMMARY:

Premenstrual dysphoric disorder (PMDD) is the rigorous DSM-IV terminology for what historically has been referred to as premenstrual syndrome (PMS). It requires prospective longitudinal documentation of primarily affective symptomatology severe enough to impair social or occupational functioning that occurs exclusively in the luteal menstrual cycle phase and remits in the follicular menstrual cycle phase. An increasing database links PMDD to major mood disorders in terms of clinical phenomenology, course, and treatment response. Therefore, PMDD was categorized as a depressive disorder, NOS in DSM-IV. The research criteria are listed in the appendix. A review of the biological differences in PMDD compared with healthy comparison subjects supports deficiencies in serotonergic metabolism in PMDD. Recent clinical trials support the safety and efficacy of selective serotonin reuptake inhibitors (SSRIs) in treatment. Experimental trials utilizing sleep and light interventions also will be presented.

No. 68D
TEMPERAMENT: SOME HAVE IT, SOME DON'T

Hagop S. Akiskal, M.D., *Department of Psychiatry, Univ. of California, San Diego, 9500 Gilman Drive, La Jolla CA 92093-0603*

SUMMARY:

For at least 2,500 years, the concept of temperament has referred to constitutionally based, "hard-wired" mechanisms of affective reacting, their intensity, variability, and amplitude. Temperaments are distinguished from personality, which refers to traits that are more "soft-wired" and involve interpersonal operations. Psychiatry and psychology today tend to overemphasize personality at the expense of temperament. Temperament is, indeed, a poorly understood concept. One of its virtues is that it refers to continually distributed traits that are pathological only in the extreme; in their more common optimal expressions, they refer to affective styles, which are adaptive, defensive, or useful. Just to name a few, the melancholic (dysthymic) temperament oscillates in a sad range, the sanguine (hyperthymic) in an upbeat range, the choleric in an irritable/dysphoric range, the cyclothymic in all three spheres, and the generalized-anxious temperament in a free-floating fashion. Curiously, there are individuals who are unemotional and rational, lacking passion, and have been described as "phlegmatic." This presentation, based on a new instrument for measuring these temperaments, describes the various temperaments in life and affective illness, in achievement and tragedy, in creativity and routine.

No. 68E
DUAL DIAGNOSIS: HOW ALCOHOL, DRUGS, AND MOOD DISORDERS MIX

Marc A. Schukit, M.D., *Department of Psychiatry, VA Medical Center, 3350 La Jolla Village Drive, San Diego CA 92161;* Jayson E. Tipp, M.A., Tom L. Smith, Ph.D.

SUMMARY:

This presentation is based on a series of recent analyses carried out over 9,000 personally interviewed alcohol-dependent men and women, their relatives, and controls. This Collaborative Study on the Genetics of Alcoholism (COGA) uses a valid and reliable semi-structured research interview to establish the onset of any substance-dependent syndromes, subsequent periods of abstinence, and the ages of onset as well as clinical characteristics of 17 Axis I major psychiatric disorders. Thus, the prevalence and clinical characteristics of each major psychiatric syndrome could be evaluated, analyzing data separately for those conditions observed only in the context of substance use disorders, as compared to those psychiatric conditions observed independently of substance-related problems. While the specific characteristics differ with the varying disorders, a substantial proportion of psychiatric syndromes observed among alcoholics were temporary and substance induced, and in general only those individuals with independent psychiatric disorders (e.g., major depressive episodes) demonstrated an increased risk for these disorders among their relatives. The clinical implications of these results will be discussed.

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SYMPOSIUM 69 CYTOCHROME P-450S: BEYOND THE SSRIS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to recognize the importance that the cytochrome P-450 enzymes play in substance abuse, the pharmacoogy of antipsychotics, endogenous neurotransmitter metabolism, and ethnic variation in psychotropic response.

No. 69A
ETHNICITY AND THE CYTOCHROME P-450 SYSTEM

Ricardo P. Mendoza, M.D., *Department of Psychiatry, Harbor-UCLA Medical Center, 1000 West Carson Street, D-5, Torrance CA 90502*

SUMMARY:

Inter-ethnic differences in phenotypic expression or functional enzyme activity of several cytochrome P-450 (CYP) enzymes have been widely reported. Since the functional activity of the drug metabolizing enzymes can be influenced by many environmental factors, pharmacogenetic researchers have turned to studying the molecular structure of these enzymes with new gene sequencing technologies. Using restriction fragment length polymorphism (RFLP) and polymerase chain reaction (PCR) methodologies, numerous CYP mutations have been identified among various ethnic minority populations. Some of these mutations appear to be ethnic-specific and are correlated with poor, slow, and ultrarapid metabolism of many psychotropic agents, most of which are metabolized by CYP enzymes. This presentation will describe the clinical implications of the findings obtained from research conducted on CYP enzymes in ethnically diverse populations. The difficulties in interpreting these data given (1) the significant heterogeneity that characterizes ethnic minority patients, (2) the influence of environmental factors (e.g.,

diet) and, (3) the lack of standardization in research methodology, will be emphasized.

No. 69B
ANTIPSYCHOTICS AND THE P-450 ENZYME SYSTEM

Michael W. Smith, M.D., *Department of Psychiatry, Harbor-UCLA REI, 1124 West Carson Street/B4 S, Torrance CA 90502*

SUMMARY:

A number of therapeutic agents exist that are effective in controlling psychotic symptomology. Antipsychotic agents can unfortunately produce discomforting, crippling, and even life-threatening side effects in certain patients, while other patients fail to respond despite aggressive treatment. Our ability to predict treatment response, as well as our ability to establish optimal dosing strategies for many psychotropic agents remains limited. Numerous in vitro and in vivo studies (largely with normal volunteers) have demonstrated that the cytochrome P-450 enzyme system is responsible for the metabolism of the majority of antipsychotic agents currently in use, as well as those scheduled for market release in the near future. The P-450 isozymes have recently become the focus of investigation for many pharmacogenetic researchers. The data from this research indicate that the efficiency of these enzymes may be associated with risks for conditions ranging from extrapyramidal symptoms and tardive dyskinesia to parkinsonism and certain malignancies. The P-450 isozymes also appear to be responsible for a large number of drug-drug interactions that have previously baffled clinicians and endangered patients. This presentation will review the role of P-450 enzymes in determining treatment response (both therapeutic and toxic) in patients receiving traditional and newer antipsychotic agents.

No. 69C
DRUG METABOLISM IN THE BRAIN: A STUDY OF CYP2D6 IN THE CNS

Rachel F. Tyndale, Ph.D., *Pharmacology, University of Toronto, Medical Sciences Bldg, Rm 4336, Toronto M5S 1A8, Canada;* Ny Li, Ph.D., Y. Rao, M.Sc., S. Miksys, Ph.D., E. Hoffman, Ph.D., E.M. Sellers, M.D.

SUMMARY:

For many centrally acting drugs, effective brain concentrations can be altered by the genetically and/or environmentally variable enzymes that metabolize them. These enzymes are present in the liver, but also in the brain, where they have specific, individualized patterns of distribution and regulation. CYP2D6 is a genetically variable enzyme (lacking in 7% of Caucasians) that metabolizes a large number of clinically-used, centrally-acting drugs (e.g. opiates, amphetamines, tricyclic antidepressants, serotonin uptake inhibitors) and is potently inhibited by (–) cocaine.

Catalytic activity, immunological, and molecular techniques were used to study rat CYP2D1 (homolog of the human CYP2D6) in brain tissue. We found significant regional variation in mRNA levels, catalytic activity, western blotting, and immunolocalization in rat brain (e.g. cerebellum displays higher levels than the frontal cortex) as well as brain-specific gender differences in activity (not in liver). Chronic drug treatment studies suggest that CYP2D1 is regulatable in some brain regions in a gender-specific manner. We are currently assessing CYP2D6 in human and monkey brain. These findings suggest that there may be pronounced inter-individual differences in brain drug metabolism that may contribute to inter-individual differences in drug response, propensity to drug dependence, and/or neurotoxicity.

No. 69D
CYTOCHROME P-450 ISOENZYMES AND DRUGS OF ABUSE

Kotra Ajir, M.D., *Department of Psychiatry, UCLA-REI, 1130 Wilshire Blvd, Bldg 257, Torrance CA 90073;* Michael W. Smith, M.D., Keh-Ming Lin, M.D.

SUMMARY:

Recently, cytochrome P-450 isoenzymes have been studied in many different capacities. This paper discusses the activity of the various cytochrome P-450 isoenzymes involved in the metabolism of drugs of abuse. The differential activity of these enzymes is valuable in predicting effects of the drug on individuals. For example, codeine is metabolized by cytochrome P-450 2D6 (CYP2D6) to morphine. Individuals who lack the activity of CYP2D6 (approximately 7% of Caucasians), do not derive analgesic or euphoric effects from codeine. In fact, studies show absence of poor metabolizers among codeine dependents. The activity of these enzymes also has implications in treatment. Recent studies have shown ethnic variations in the metabolism of substrates of CYP3A4, suggesting differential activity of this enzyme. Methadone is known to be primarily metabolized by CYP3A4. This paper discusses current studies which are assessing ethnic variations in methadone metabolism. Some of the isoenzymes are involved in formation of toxic metabolites. CYP2E1 is known to form active radicals that cause cellular injury. Alcohol is an inducer of CYP2E1. Concomitant use of alcohol and other drugs in light of CYP2E1 activity is discussed. The metabolism of cocaine, amphetamines, benzodiazepines, and MDMA are also included in this discussion.

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SYMPOSIUM 70—PSYCHOANALYTIC ASPECTS OF VIOLENCE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to discuss multiple psychodynamic dimensions of violence including describing transference dynamics of filicidal women, recognizing the role of fatherhood in altering a prisoner's sense of self, and identifying psychodynamic mechanisms for violence prevention in latency-aged children through storytelling and group psychotherapy.

No. 70A
PSYCHODYNAMIC PERSPECTIVES ON FILICIDAL WOMEN

Catherine F. Lewis, M.D., *Law and Psychiatry, Yale University, 34 Park Street/PO Box 1842, New Haven CT 06508;* Catherine F. Lewis,

MD *Yale Department of Psychiatry, 34 Park Street, New Haven, CT 06511*

SUMMARY:

The murder of a child by its mother is a horrific and evocative act. In a previous study, we developed a typology for filicidal women using cluster analysis. That typology described women who kill associated with: feeling overwhelmed/unable to care for their child, delusions about the victim, psychotic symptoms without delusions about the victim, severe family system conflict, a long-standing pattern of abuse, or a physical/mental defect in the victim. The characteristics of women in the different clusters were quite distinct. Not surprisingly, the psychodynamic aspects of the clusters were similarly diverse. This paper will examine ego strength, defense mechanisms, capacity to form loving relationships, and aggressive drives among the various clusters of women in our sample. Implications for treatment and prevention will be discussed. Countertransference feelings evoked by the various clusters will be illustrated with clinical material.

No. 70B
A PSYCHODYNAMICALLY INFORMED STRATEGY FOR VIOLENCE PREVENTION: STORYTELLING IN LATENCY-AGED CHILDREN

Thomas L. Reynolds, M.D., *21 Church Street, Dedham MA 02026-4315*

SUMMARY:

This presentation will explore a psychodynamically informed strategy for violence prevention in school-age children. Violence is a complex biopsychosocial interaction with many determinants. Psychiatry has rich experience in explaining and modifying human interactions. Much research effort has focused on using biology, psychoeducation, behavior modification, and group therapy as a means of preventing violence in children, particularly adolescents. This presentation will explore a different, developmentally targeted strategy: using storytelling in latency-aged children for primary prevention of violence. The presenter will share his experiences using this technique in a classroom of 6- and 7-year-olds. He will use psychodynamic theory and many examples to explore how modern storytelling can create an affectively charged immediate experience in which children can symbolically explore their beliefs and fantasies of interpersonal aggression. Much national attention has criticized the role of media in exposing children to violence with no acknowledgment of the emotional context or impact of the violence, or of providing alternate methods for responding to conflict. This intervention attempts to harness latency-aged children's natural affinity for symbolic play and drama to expand children's repertoire of experiencing and expressing emotions during conflict. The presenter will delineate the psychodynamic dimensions of how storytelling fosters affective competency and interpersonal restraint in childhood.

No. 70C
FATHERS IN JAIL

Andrew B. Clark, M.D., *Law and Psychiatry, Massachusetts General Hospital, 598 Peakham Road, Sudbury MA 01776*

SUMMARY:

This paper will explore the importance of paternal attachment among incarcerated men in helping to modulate aggression and facilitate change. Some violent men in prison continue to grant exceptional importance to their roles as fathers, and maintain a significant emotional involvement with their children even while separated. Detailed case material from a few such prisoners will be presented to illustrate the complex dynamics of such attachments. It will be suggested that some men can use their roles as fathers to help them keep control over their own violent impulses, and are capable of growing toward their child's vision of what a father should be. At the same time, such parenting relationships are often marked by failures and disappointments, along with the reenactment of traumatic experiences from generation to generation. Conditions which allow for the creation of a positive and useful attachment in this context will be explored.

No. 70D
THE TRAUMA/GRIEF FOCUSED GROUP PSYCHOTHERAPY MODULE OF AN ELEMENTARY SCHOOL-BASED VIOLENCE PREVENTION/ INTERVENTION PROGRAM

Lisa Murphy, Ph.D., *Trauma Psychiatry Program, UCLA, 300 Medical Center Plaza, Los Angeles CA 90024;* C. Boyd James, Ph.D., Robert S. Pynoos, M.D.

SUMMARY:

This paper will present a clinical description of a multifaceted elementary school-based therapeutic program for children exposed to violence and traumatic loss. Program components include systematic screening for at-risk children, a sequence of child interventions including individual and group psychotherapy, mentorship, and interventions to improve classroom milieu and parental functioning. The participation of community-based police officers will be described. This program integrates a developmental model of traumatic stress with a social historical view of children's emerging awareness of, and participation in, the social contract. The following processes of group therapy will be discussed: 1) forging a therapeutic ambience that promotes the sharing of traumatic narratives; 2) identifying intervention fantasies and traumatic expectations that mediate aggressive or withdrawal responses to traumatic cues; 3) enhancing appreciation of how post-traumatic stress and grief reactions interfere with peer relationships, family and academic functioning; 4) promoting understanding of the links between current behavior and violent exposures; 5) addressing loss and grief issues; 6) identifying the most intense negative emotions, including guilt, shame, humiliation and revenge and exploring the fantasy accompaniment of these self-attributions; 7) legitimizing the underlying concern and reframing the children's experiences to ameliorate the excessive self-blame, and to improve affective regulation; and 8) addressing termination issues.

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SYMPOSIUM 71—EATING DISORDERS: VULNERABILITIES AND INTERVENTIONS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

Following this symposium, participants should be able to describe patterns of familial transmission of obsessionality in anorexia nervosa

and parental intrusiveness in bulimia nervosa, the impacts of varied diet composition and of pregnancy on eating disorder patients, and correlates and predictors of response to cognitive-behavior therapy in bulimia nervosa.

No. 71A
FAMILY TRANSMISSION OF OBSESSIONAL BEHAVIOR IN ANOREXIA

Walter H. Kaye, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh PA 15213-2593;* Lisa R. Lilenfeld, Ph.D., Toshihiko Nagata, Ph.D., Kathleen R. Merikangas, Ph.D., Katherine H. Plotnicov, Ph.D., Christine Pollice, B.A.

SUMMARY:

The obsessional nature of anorexia nervosa has been evident for more than 50 years. People with anorexia nervosa have high rates of both obsessive-compulsive disorder (OCD) and obsessive-compulsive personality disorder (OCPD). Understanding the relationship between AN and OCD or OCPD may be confounded by malnutrition, which may exaggerate symptoms of obsession behavior. One strategy that can be used to evaluate the etiological importance of comorbid disorders is a study of patterns of familial aggregation of comorbid disorders among relatives of probands with the disorder of interest.

We assessed 24 women with restricting anorexia nervosa (AN) and 44 comparison women (CW) with no history of an eating disorder and 278 of their first-degree relatives. We used contemporary family epidemiological methodology, including face-to-face interviews of first-degree relatives who provided information about themselves and their family members, trained and clinically experienced blind interviewers, and blind diagnoses. We also identified anorexic probands who were of sufficient age and duration of diagnosis to constitute a relatively "pure" diagnostic group. Finally, we recruited a control group of women matched by socioeconomic factors, but who never had stigmata of an eating disorder.

We found that OCD and AN were independently transmitted in families. In other words, OCD was elevated primarily among the relatives of those AN probands who themselves had OCD. In contrast, we found that rates of OCPD were elevated among relatives of anorexic probands, irrespective of the presence of OCPD among the probands themselves. This study raises the provocative question of whether OCPD is a vulnerability transmitted in families that contributes to the pathogenesis of AN.

No. 71B
PARENTAL INTRUSIVENESS IN BULIMIA NERVOSA

Marcia Rorty, Ph.D., *Department of Psychology, Claremont McKenna, 850 Columbia Avenue, Claremont CA 91711;* Joel Yager, M.D., Elizabeth Rossotto, M.A., Ruchi Garg

SUMMARY:

We describe the development and initial validation of the Parental Intrusiveness Rating Scale (PIRS), a self-report instrument for retrospectively assessing intrusive parental behavior experienced by female subjects during adolescence. Women with bulimia nervosa (BN) often describe invasions of psychological and physical privacy, breakdown of generational boundaries, and parental overconcern with their daughter's physical appearance as central factors in the onset of their disorders. These observations led us to attempt to systematically assess intrusive overinvolvement.

The PIRS consists of 20 maternal items and 20 paternal items. Maternal subscales include invasion of privacy, jealousy and competition, and overconcern with daughter's weight and shape. Paternal subscales include invasion of privacy, seductiveness, and overconcern with daughter's weight and shape. We will present psychometrics and information regarding reliability and validity of the PIRS.

BN subjects (n = 86) scored significantly higher than comparison subjects (n = 573) on all subscales except paternal intrusiveness. Features of intrusiveness correlated significantly with disturbed relationships in the family of origin in BN. The PIRS promises to enrich our understanding of problematic parental behaviors and familial risk factors related to BN. We anticipate that the PIRS will also be useful for assessing parental behaviors in other female populations as well.

No. 71C
DOES DIET MATTER IN EATING DISORDERS?

Katherine A. Halmi, M.D., *Department of Psychiatry, Cornell Medical College, 21 Bloomingdale Road, White Plains NY 10605-1504;* Suzanne Sunday, Ph.D.

SUMMARY:

Eating preferences, attitudes, and behavior are well documented in eating disorder patients. The effect of diet composition such as macro-nutrient (fats, carbohydrates, protein) content on eating behavior has received little research scrutiny in patients with eating disorders.

In this study, 100 women from the following five groups: anorectic-restrictors (AN-R), anorectic-bulimics (AN-B), normal weight bulimics (BN), normal weight restrained (RC), and unrestrained eaters (UC), ate meals of different fat and carbohydrate proportions. The food rested on hidden Ohaus balances connected to an IBM computer that recorded all changes in weight for each scale separately. Micro- and macro-analyses of eating behavior were thus possible.

The proportion of calories from fat during the first quarter of the meal significantly correlated with total meal intake only for AN-B ($r = 0.79$) and BN ($r = 0.41$). The proportion of calories from carbohydrates in the first quarter was not associated with total intake for any group. BN had greater hunger and less satiety after high fat meals compared with high carbohydrate, low fat meals. This phenomenon did not occur with AN-R or controls. A high carbohydrate, low fat diet may be useful for stabilizing eating behavior in BN.

No. 71D
THE IMPACT OF PREGNANCY ON EATING DISORDERS SYMPTOMS

David B. Herzog, M.D., *Department of Psychiatry, Harvard Medical School, 15 Parkman Street, EDU 725-ACC, Boston MA 02146;* Anne E. Becker, M.D., Karin M. Nussbaum, B.A., Rebecca A. Burwell, B.A., Ana Richards, A.B.

SUMMARY:

Eating disorders commonly affect women of childbearing age. Little is known about the impact of pregnancy and the postpartum on eating disorder symptomatology. Studies to date have generally found that women improve symptomatically during pregnancy although some studies have noted a worsening of symptoms. Studies show a range of symptom relapse or sustained remission in the postpartum. We will report on the first prospective longitudinal study of anorexic and bulimic women who became pregnant.

Forty-two subjects (27 BN, 2 AN-restricting type, and 13 AN-binging/purging type) who self-reported 56 pregnancies (24 live births, 19 elective abortions; 9 miscarriages, and 4 pregnancies continuing beyond the time frame of the study) during participation in this nine-year study were identified from a sample of 250 eating disordered treatment-seeking women.

In this presentation we will compare data on binging and purging frequency, restrictive eating, exercise, weight, and cognitive symptoms for three distinct periods: one year prior to conception, pregnancy, and one year postpartum. A better understanding of the course of eating disorder symptomatology during pregnancy may suggest appropriate measures for intervention in this clinical situation.

No. 71E
CORRELATES AND PREDICTORS OF RESPONSE TO COGNITIVE BEHAVIOR THERAPY IN BULIMIA NERVOSA

James E. Mitchell, M.D., *NRI, 700 First Avenue, South, Fargo ND 58107;* Ross Crosby, Ph.D., Stephen A. Wonderlich, Ph.D., Pamela Keel, A.B.

SUMMARY:

Cognitive behavioral psychotherapy has come to be regarded as one of the treatments of choice for bulimia nervosa (BN). Despite the wide acceptance of this therapy for BN, very few predictive factors have been identified for its use. For example, in the 15 studies that have examined comorbid depression as a prognostic variable, only four have found depression to have a negative impact on outcome; of the five that have examined previous substance abuse problems as a correlate, only one has found evidence of a negative impact. The best established negative predictors include personality disturbances (negative impact in 11 of 14 studies), and duration of symptoms (negative impact in 4 of 7 studies). The current paper will focus on a review of this literature, synthesize the available information on the long-term outcome of bulimia nervosa, and discuss data from a recent large CBT trial. Correlates and predictors of both treatment compliance and treatment success will be presented.

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SYMPOSIUM 72—ACUTE STRESS REACTIONS TO TRAUMATIC EVENTS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to recognize and interpret the significance of acute stress reactions occurring in the immediate aftermath of traumatic events.

No. 72A
PERITRAUMATIC DISSOCIATIVE EXPERIENCES

Charles R. Marmar, M.D., *Department of Psychiatry, Langley Porter Institute, 401 Parnassus Avenue/BoxF-0984, San Francisco CA 94143;* Daniel S. Weiss, Ph.D., Thomas J. Metzler, M.A., Kevin L. Delucchi, Ph.D.

SUMMARY:

There has been a resurgence of interest in a linkage between dissociation at the time of trauma, a phenomenon we characterize as "peritraumatic dissociation" and the subsequent development of PTSD. Adults exposed to trauma may experience immediate dissociative responses at the time of traumatic incident exposure, including feelings of detachment, derealization, depersonalization, and out of body experiences. In male Vietnam theater combat veterans, we have reported that peritraumatic dissociation was strongly associated with level of PTSD symptoms, after controlling for level of stress exposure and general dissociative tendencies. In a replication of this finding in a study of 439 male and female emergency services personnel, we have shown that peritraumatic dissociation was predictive of current PTSD symptoms, after controlling for level of exposure, adjustment, social support, years of experience, and locus of control. We replicated these findings in a study of 77 female theater veterans. We have most recently investigated individual differences in the vulnerability to dissociate during acute stress reactions. In a sample of 358 rescue workers, we found that those who are shy, inhibited, uncertain about their identity, or reluctant to take leadership roles, who have global cognitive styles, who believe their fate is determined by factors beyond their control, and who cope with trauma by wishful thinking are at risk for acute dissociative responses to trauma. Implications of these findings for a model of normal and pathological acute stress response will be discussed.

No. 72B
ACUTE STRESS DISORDER FOLLOWING BURN INJURY

Jo Ann Difede, Ph.D., *Department of Psychiatry, NY Hospital-Cornell Med Ctr, 525 East 68th Street/Box 200, New York NY 10021;* Daniel A. Barocas, Ph.D., David Eskra, Ph.D., Ari Jaffe, M.D., Jennifer Roberts, M.A., Roger W. Yurt, M.D.

SUMMARY:

Objectives: (1) To identify variables that predict acute stress disorder (ASD) following burn injury. (2) To determine if ASD predicts chronic PTSD.

Method: To accomplish our aims, consecutively admitted hospitalized adult burn patients were assessed with the Structured Clinical Interview for the DSM-IV and previously validated self-report measures that assess perceived social support, coping style, cognitive schemas, and trauma history. Patients were interviewed within two weeks of the injury and after discharge at six months post-burn.

Results: The results of this ongoing study (n = 66) suggest that about 23% of those interviewed had ASD. ASD was not associated with objective indices of the trauma, including body surface area burned, disfigurement, property damage, financial loss, site of the accident, injury of loved ones, or prior burns. ASD was associated with perceived social support ($r = -.42$, $p < .001$), coping style, ($r = .68$, $p < .0001$), and cognitive schemas concerning the randomness of life events ($r = -.28$, $p < .04$). All those who had ASD also had chronic PTSD at follow-up.

Conclusions: Our results suggest that psychological variables may be better predictors of ASD following burn injury than objective indices of the trauma. Early results from the six-month evaluation suggest that ASD predicts chronic PTSD.

No. 72C
ACUTE STRESS DISORDER IN CANCER PATIENTS

Randolph J. Canterbury, M.D., *Department of Psychiatry, University of Virginia, Blue Ridge Hospital/Box 16, Charlottesville VA 22901-8619;* Elizabeth L. McGarvey, Ed.D., Cheryl Koopman, Ph.D., David Spiegel, M.D., Gail Clavet, Ph.D.

SUMMARY:

Objective: To investigate the occurrence of clinically significant psychological trauma following a diagnosis of cancer in a sample of patients.

Method: A consecutive sample of patients who have been recently diagnosed with cancer of various cell types receive mailed information about the study and are asked to participate. Participants complete a set of four questionnaires: Stanford Acute Stress Reaction Questionnaire, Communication of Diagnosis, Social Network & Social Assessment, and the Behavioral Change Questionnaire.

Results: The sample was 80% female; and 20% minority; 28% under age 40.

Findings: To date, 35% of patients (10% of men and 42% of women) report symptoms that meet DSM-IV criteria for acute stress disorder (ASD) following diagnosis of cancer. Significantly more patients age 40 and under (60%) meet criteria for ASD than those over the age of 40 (25%). Of those who meet criteria for ASD, 50% report that "religion/spiritual commitment" is "extremely important" compared to 80% of those who *do not* meet criteria. Participants who meet criteria for ASD are more than twice as likely as those who do not meet criteria to report being less satisfied with the way they were informed of their diagnosis. There was no significant difference in reported satisfaction with the delivery of the diagnosis based on gender, age, or race.

No. 72D
VALIDITY AND RELIABILITY OF THE STANFORD ACUTE STRESS REACTION QUESTIONNAIRE

Etzel Cardena, Ph.D., *Department of Psychiatry, USUHS, 11804 Bunchberry Lane, Gaithersburg MD 20878;* Cheryl Koopman, Ph.D., Catherine Classen, Ph.D.

SUMMARY:

The Stanford Acute Stress Reaction Questionnaire (SASRQ) in its current form is the only self-report instrument that addresses the context and gamut of acute stress disorder symptoms, including dissociative, re-experiencing, numbing, and hyperarousal symptoms. In this presentation we review the development of the instrument, describe results obtained with earlier versions of the instrument, and present statistical data on the SASRQ's reliability and validity. Published and unpublished studies using a wide array of datasets show that the SASRQ has good internal consistency, and good face, construct, and convergent validity. Use of a standardized instrument with good statistical properties will greatly enhance our knowledge of the nature and process of acute stress disorder.

No. 72E
ACUTE STRESS REACTION TO POLITICAL ASSASSINATION

Jose R. Maldonado, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, MC: 5546, Stanford CA 94305;* Kathy Page, M.S., Heather Stein, Cheryl Koopman, Ph.D., David Spiegel, M.D.

SUMMARY:

Objective: To determine the severity of acute stress reactions to the assassination of a presidential candidate. Our goal was to examine the relationship of these reactions to several factors including: the severity of this event, methods used for emotional coping, and exposure of self and family and friends to a previous traumatic event.

Methods: Participants included 92 adults who completed the Spanish version of the Stanford Acute Stress Reaction Questionnaire (SASRQ), the Impact of Event Scale (IES), and measures of demographic characteristics, severity of the traumatic event, emotional coping, and a measure of exposure to a previous traumatic event.

Results: Over half of the variance on the SASRQ total acute stress reactions score was accounted for primarily by the use of emotional coping strategies and exposure of family and friends to a previous traumatic event. Severity of this event and use of emotional coping strategies also accounted for significant variance in the IES overall score.

Conclusions: These results suggest that acute stress reactions occur in response to national events, and that those who are particularly susceptible are those who are most emotionally invested, use emotional coping strategies, and whose lives have been affected by a previous traumatic event.

No. 72F
ACUTE STRESS DISORDER IN SEXUAL ABUSE SURVIVORS

Cheryl Koopman, Ph.D., *Department of Psychiatry, Stanford Medical School, 401 Quarry Road, MD: 5544, Stanford CA 94305;* Cheryl Gore-Felton, M.A., David Spiegel, M.D.

SUMMARY:

Objective: This exploratory study examined the prevalence of acute stress disorder (ASD) symptoms and their relationships to sexual abuse history, causal attributions for the distress, and social support among women seeking treatment for childhood sexual abuse.

Methods: Participants were 32 women recruited for a pilot study of group treatment for childhood sexual abuse. Each participant completed self-report and interview measures of demographic characteristics, acute stress reactions, sexual experiences as a child, causal attributions for the abuse, distress, and social support.

Results: Many participants (37.5%) met criteria for all ASD symptoms. Also, ASD symptoms were significantly related to seeing the self as the causal locus of the abuse, forgetting the abuse for a period of time, number of abusers, distress of a recent life event, other forms of distress, both trauma-specific (PTSD and the Trauma Symptom Checklist 40) and general (depression, anxiety, and dissociative experiences), and poor social support (having fewer close friends and relatives and being dissatisfied in relationships with relatives).

Conclusions: Acute stress disorder may occur frequently among sexual abuse survivors seeking treatment, requiring special intervention to help these patients to manage their reactions to ongoing stresses.

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SYMPOSIUM 73—ATYPICAL DEPRESSION: NEW DIAGNOSIS AND TREATMENT

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to recognize the diagnostic features of atypical depression, the clinical and biological evidence of its validity as a syndrome, and understand the relative efficacy of pharmacotherapy with different classes of antidepressant medication and psychotherapy with interpersonal psychotherapy and cognitive behavior therapy for this disorder.

No. 73A
A HISTORICAL PERSPECTIVE OF ATYPICAL DEPRESSION

Jonathan W. Stewart, M.D., *Department of Psychiatry, NYS Psychiatric Institute, 722 West 168th Street, New York NY 10032;* Patrick J. McGrath, M.D., Frederic M. Quitkin, M.D.

SUMMARY:

An overview of the psychopharmacologic literature of the '60s and '70s suggested that there was a heterogeneous patient population that appeared to benefit from monoamine oxidase inhibitors. There appeared to be at least two patient types: the V type, with vegetative symptoms such as hypersomnia, hyperphagia, lethargy, and reversed diurnal variation; and the A type, in which depressive symptoms and anxiety, panic, and phobia were present. Patients with reactive mood meeting DSM-III criteria for depressive illness who had associated atypical features (hyperphagia, hypersomnolence, leaden paralysis, and rejection sensitivity) were randomized to imipramine, phenelzine, and placebo. Nonresponders were crossed over, and in all there were over 400 patient trials. Phenelzine consistently was found to be superior to imipramine. Only in trials that included patients lacking atypical, vegetative symptoms was imipramine found to equal phenelzine. This is one piece of evidence that supported the validity of atypical depression. This has played a role in including atypical as parenthetical modifier in DSM-IV. Although some open anecdotal trials suggest the utility of SSRIs in atypical depression, there have been no definitive studies that have established their role. This material will be reviewed.

No. 73B
ANTIDEPRESSANT TREATMENT OF ATYPICAL DEPRESSION

Michael E. Thase, M.D., *Department of Psychiatry, Western Psychiatric Institute, 3811 O'Hara Street, Pittsburgh PA 15210*

SUMMARY:

The so-called atypical depressions, particularly those characterized by hypersomnia and/or increased appetite or weight gain, respond poorly to tricyclic antidepressants and favorably to the older irreversible and nonselective monoamine oxidase inhibitors (MAOIs). This is one of the few robust examples of differential pharmacotherapy response in the mood disorders area. The current presentation will review data from controlled and "crossover" studies of phenelzine, tranylcypromine, and isocarboxazid treatment of both atypical and more classical depressive disorders. In addition, newer data on the efficacy of reversible/selective MAOIs, bupropion, and selective serotonin reuptake inhibitors as treatments of atypical depression will be considered. Lastly, the relationship between antidepressant response and changes in electroencephalographic sleep profiles will be discussed, with particular emphasis on suppression of REM sleep and changes in hypersomnolence during MAOI therapy. As epidemiologic data suggest that the atypical symptom constellation is becoming the norm for early-onset chronic and recurrent depressions, these findings have important implications for psychiatrists and other mental health professionals.

No. 73C
BIOLOGICAL DISTINCTIONS IN ATYPICAL DEPRESSION

Gregory M. Asnis, M.D., *Department of Psychiatry, Montefiore Medical Center, 111 East 210th Street, Bronx NY 10467;* Lata K. McGinn, Ph.D.

SUMMARY:

Introduction: It has been proposed that atypical depression (AD) is a unique syndrome with specific symptoms, treatment response, genetic history, and biological functioning. This study was designed to clarify whether AD differed from nonAD (depressed patients without AD) on a number of HPA axis measures in order to further validate this relatively new diagnostic category.

Method: 72 depressed outpatients, separated into AD and nonAD using the Atypical Depressive Disorder Scale, were evaluated on their cortisol response to 75 mg IM desipramine (DMI), a relatively specific noradrenergic reuptake inhibitor. Of the 72 patients 33 also received 1 mg DST and 1 p.m. to 4 p.m. plasma cortisol.

Results: Patients with AD (N = 9) and nonAD (N = 24) did not differ on 1-4 plasma cortisol nor did they differ on the DST test. However, patients with AD (N = 15) and nonAD (N = 55) exhibited a significantly different cortisol response to the DMI challenge ($F = 7.5$, df = 1,66, $p = .008$). Specifically, AD had higher DMI cortisol levels than nonAD.

Discussion: Our study demonstrates that AD and nonAD do not differ on global measures of the HPA axis (DST and plasma cortisol), but do exhibit significant differences with specific challenges of the HPA axis (DMI challenge). We suggest that AD has a less dysfunctional noradrenergic system than nonAD. Further studies are recommended.

No. 73D
PHARMACOTHERAPY AND PSYCHOTHERAPY RESPONSE IN ATYPICAL DEPRESSION: FINDINGS FROM THE NIMH TREATMENT OF DEPRESSION COLLABORATIVE RESEARCH PROGRAM

Stuart M. Sotsky, M.D., *Department of Psychiatry, George Washington Medical Ctr, 2150 Pennsylvania Avenue, NW, Washington DC 20037-2396;* Sam Simmens, Ph.D.

SUMMARY:

Diagnostic criteria and efficacy of pharmacotherapy and psychotherapy for atypical depression were studied in the NIMH Treatment of Depression Collaborative Research Program. Outpatients with major depressive disorder ($N = 239$) entered a 16-week clinical trial and were randomly assigned to interpersonal psychotherapy, cognitive-behavior therapy, and imipramine or placebo with clinical management. Features of atypical depression were rated on the SADS and ISI and clinical outcome was measured on the HRSD, GAS, and BDI. Atypical features of mood reactivity and at least one

reversed vegetative symptom of hypersomnia, hyperphagia, or weight gain (25.2% patients) were predictive of pharmacotherapy nonresponsiveness with imipramine compared to placebo. The additional features of diurnal mood variation, "leaden paralysis," and "rejection sensitivity" did not further distinguish an imipramine nonresponsive subgroup. Both interpersonal psychotherapy and cognitive-behavior therapy achieved significantly better remission of depression among atypical patients, whereas both imipramine and interpersonal psychotherapy showed significant effectiveness compared to placebo among non-atypical patients, on both measures of depression remission and mean symptom change.

No. 73E
ATYPICAL DEPRESSION AND COGNITIVE THERAPY

Robin B. Jarrett, Ph.D., *Department of Psychiatry, UT Southwestern Medical Center, 5323 Harry Hines Boulevard, Dallas TX 75235-9149;* Martin H. Schaffer, M.D., Donald McIntire, Ph.D., Amy Witt-Browder, M.A., Catherine Judd, PA-C, Dolores Kraft, Ph.D.

SUMMARY:

Atypical depression is a common, chronic, disabling illness that responds to treatment. We will present results from a double-blind, randomized controlled trial comparing cognitive therapy (CT), phenelzine (a monoamine oxidase inhibitor [MAOI]) and pill placebo in acute phase treatment for 108 outpatients with DSM-IV major depressive disorder, with atypical features at any time during the presenting episode. Atypical features require reactive mood and at least two of the following symptoms: hypersomnia, hyperphasia, leaden paralysis, and a lifetime sensitivity to interpersonal rejection.

Although many patients with atypical depression receive psychotherapy in clinical practice, this trial is the first to prospectively evaluate a psychotherapy for atypical depression. It is the first comparison of CT and a MAOI, and one of the few CT trials that includes a pill placebo control and an evaluator blind to treatment assignment.

According to a repeated measures analysis of covariance using the blind evaluator's 21-item Hamilton Rating Scale for Depression (HRSD-21) completed after 10 weeks of acute phase treatment or when the patient withdrew, phenelzine and cognitive therapy reduced depressive symptoms significantly more than pill placebo. The final HRSD-21 scores from patients treated with cognitive therapy did not differ significantly from those treated with phenelzine. Results from a random regression analysis will also be presented. Findings suggest that cognitive therapy may offer an effective alternative to standard acute phase MAOI treatment for outpatients with major depressive disorder and atypical features.

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SYMPOSIUM 74—MELATONIN IN PSYCHIATRY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation the participant should be able to describe the effects of melatonin on human circadian rhythms which will include areas such as winter depression, ECT treatment, insomnia, and sleep disorders in major depression.

No. 74A
EFFECTS OF MELATONIN ON HUMAN CIRCADIAN RHYTHMS

Josephine H. Arendt, Ph.D., *Biological Sciences, University of Surrey, Guildford Surrey GU25XH, United Kingdom*

SUMMARY:

The pineal hormone melatonin appears to serve similar functions in all vertebrates. By its pattern of secretion it conveys information about phase, duration, and strength of the daily photoperiod for the organization of seasonal and circadian physiology. In humans, melatonin, suitably timed, will phase shift the endogenous melatonin rhythm and core body temperature, validated markers of the endogenous biological clock, together with sleep timing, cortisol, and prolactin. Melatonin acutely suppresses core body temperature. When it is timed to phase advance, the degree of temperature suppression is closely related to the magnitude of induced phase shift and changes in temperature may be an integral part of the phase-shifting mechanism. Evidence for complete entrainment of free-running rhythms by melatonin is not substantial and largely based on entrainment of sleep-wake cycles in some blind subjects. However, when used in such a way as to reinforce ambient time cues such as in adaptation to simulated or actual time zone change or shift work, it is clearly able to enhance the rate of adaptation of many behavioral and hormonal circadian rhythms. Adaptation of sleep, mood, and performance, can precede resynchronization of endogenous melatonin. Acute effects of melatonin include transient sleepiness and/or loss of alertness. It is likely that its ability to improve sleep, mood, and performance after forced shift of ambient time cues involves both acute effects and circadian phase shift. In both controlled and uncontrolled studies of this nature in healthy adult volunteers (N > 500) no significant incidence of serious side effects has been found to date. However, when used to entrain sleep in sighted individuals free running in constant dim light a substantial proportion (25%) of subjects show fragmented sleep patterns during melatonin ingestion compared to placebo. Suitably timed melatonin and bright light are likely to provide optimum conditions for normalizing rhythm disturbance. Melatonin may, as a coordinator of biological rhythms, help to maintain structured rhythmnicity and thereby influence many aspects of health.

No. 74B
MELATONIN AND WINTER DEPRESSION

Alfred J. Lewy, M.D., *Department of Psychiatry, Oregon Hlth Science University, 3181 SW Sam Jackson Park Road, Portland OR 97201-3098;* Robert L. Sack, M.D., Vance K. Bauer, M.A., Neil L. Cutler, B.A.

SUMMARY:

After successfully treating the first patient with winter depression with bright light, we proposed the phase shift hypothesis (PSH) of winter depression to explain the antidepressant effect of bright light.

According to the PSH, patients have delayed rhythms when depressed in the winter, which advance in response to morning light. Due to the large placebo component of light treatment, light exposure at any time of day might appear antidepressant. However, morning light exposure, which would provide a corrective phase advance, should be most antidepressant. We recently completed a double-blind, randomized crossover study (51 patients; 49 controls). Morning light was more antidepressant than evening light. The average dim light melatonin onset (DLMO) of patients was not delayed compared to that of controls. However, the DLMO advanced with morning light and delayed with evening light. The evidence strongly supports the PSH but is not conclusive. Based on our recently discovered melatonin phase response curve, winter depressives should phase advance with afternoon melatonin administration and phase delay with morning administration. Afternoon melatonin should, therefore, be more antidepressant than morning melatonin. Such a study might help to resolve remaining problems with the PSH.

No. 74C
MELATONIN AND FLUOXETINE IN THE PREVENTION OF DEPRESSIVE RELAPSES AFTER SUCCESSFUL ECT TREATMENT

Leon J. Grunhaus, M.D., *Department of Psychiatry, Sheba Medical Center, Ramat Gan 52621, Israel;* Schmuel Hirschmann, M.D., Ornah T. Dolberg, M.D.

SUMMARY:

Electroconvulsive therapy (ECT) is a commonly used strategy in the treatment of medication-resistant or delusional major depressive disorder. Traditional studies suggest that 60% to 80% of patients will respond to a course of ECT; however, approximately 50% of the patients will demonstrate relapse or recurrence of depression within one year. Epidemiological studies have suggested that sleep disturbances may be forerunners of the recurrence of depressive symptoms. We have found that approximately 70% of patients refered for ECT demonstrate sleep-onset REM periods, and that these sleep-onset REM periods persisted in 50% of the patients even after clinical recovery with the ECT treatments. Most importantly, we found that sleep onset REM periods were significantly more frequent in patients with a more severe illness and in those who demonstrated the re-occurrence of depressive symptoms within six months. Thus, dysregulation of sleep mechanisms seems to associate to poor response to ECT, to severe illness, and to early re-occurrence of depressive symptoms. To explore this hypothesis further we tested the effects of melatonin on the course of the depressive illness in patients treated with ECT. Melatonin, a hormone secreted by the pineal body and believed to be involved in circadian rhythm regulation, has been shown to promote sleep continuity and sleep efficiency. We hypothesized that melatonin, coadministered with fluoxetine, would enhance sleep regulation in patients treated with ECT and thus, lead to a better clinical outcome. Thirty-five patients with MDD successfully treated with ECT were included in this study. All patients signed an informed consent for participation in the study. All patients received a standard course of fluoxetine treatment and were in addition randomly assigned to receive slow-release melatonin (5-10 mgs) or placebo. In addition, patients performed a 24-hour urine collection for melatonin metabolites and were monitored with an activity monitor for eight full days. Patients were monitored on a weekly basis for a three-month period by "blind" clinical staff.

During this presentation we will discuss the relevance of sleep disturbances to the course of the depressive illness in patients treated with ECT. In addition, we will present the data exploring the impact of melatonin on the course of the depressive illness.

No. 74D
A RATIONAL APPROACH TO THE USE OF MELATONIN FOR INSOMNIA

Nava Zisapel, Ph.D., *Neurobiochemistry, Tel Aviv University, Tel Aviv 69978, Israel*

SUMMARY:

Melatonin is nocturnally produced by the pineal gland and exerts a weak hypnotic effect when given at daytime. In addition, melatonin can reset sleep onset in blind people, in jet lag, or in delayed sleep phase syndrome through its synchronizing effect on the internal biological clock. The ability of melatonin to improve sleep in insomniacs who have normal melatonin rhythms is equivocal.

The production of melatonin decreases with advancing age. In addition, various medications (e.g., beta blockers and benzodiazepines) can produce hypomelatoninemia. Melatonin is short-lived (serum half-life in humans 35-45 min.). Controlled-release formulations, which circumvent the fast clearance of the hormone, thus provide a better solution for replacement therapy, rather than administration of high doses or repeated doses. We have investigated the ability of melatonin replacement therapy to improve sleep and life quality in elderly insomniacs with blunted melatonin rhythms and in benzodiazepine users. These studies demonstrate that melatonin replacement therapy significantly improves sleep initiation and maintenance in these populations.

A rational diagnostic and therapeutic approach to the use of melatonin for improvement of sleep should start with a 24-hour assessment of melatonin output (preferably urine testing). When nocturnal melatonin output is found to be normal, but delayed, an evening dose of regular acting melatonin seems appropriate. If, however, hypomelatoninemia is diagnosed, replacement of the deficient endogenous melatonin profile by controlled-release melatonin is preferable.

No. 74E
MELATONIN FOR THE TREATMENT OF SLEEP DISORDERS IN MAJOR DEPRESSION

Ornah T. Dolberg, M.D., *Department of Psychiatry, Sheba Medical Center, Ramat Gan 52621, Israel;* Schmuel Hirschmann, M.D., Leon J. Grunhaus, M.D.

SUMMARY:

Insomnia is a frequent complaint among patients with major depressive disorder. Several pharmacological agents have been used for hypnotic purposes in these patients. Commonly used medications are the benzodiazepines. However, concerns exist among clinicians regarding habituation, tolerance, and dependence, especially among the elderly. Melatonin, a hormone secreted by the pineal gland, seems to play a critical role in the synchronization of body rhythms regarding day-night cycles. In this study, we have attempted to examine the hypnotic effect of melatonin versus placebo in 19 patients with major depressive disorder, treated with fluoxetine. Sleep was assessed using the Pittsburgh Sleep Quality Index (PSQI). No difference was noted on the Hamilton Rating Scale for Depression between those treated with melatonin versus placebo ($p = 0.86$). However, a statistically significant difference was found regarding the improvement in sleep, on the PSQI ($p = 0.009$). Further studies are required in order to evaluate the hypnotic effects of melatonin on the sleep of patients with various psychiatric disorders.

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SYMPOSIUM 75—WOMEN AND SYSTEMS OF PSYCHIATRIC CARE
Joint Session with the Association of Women Psychiatrists

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to recognize the unique issues for women psychiatrists in all areas and aspects of managed systems of care and know effective coping strategies.

No. 75A
INTEGRATED DELIVERY SYSTEMS: A WOMEN'S IMPRIMATUR

Kelley L. Phillips, M.D., *Principal Behavior Hlth Care, 1601 Rockville Pike, Ste 400, Rockville MD 20852*

SUMMARY:

There are disproportionately few women leaders in managed care, which makes traditional ways of networking difficult. The author will describe her strategic and tactical concepts of clinical directions for integrated delivery systems (IDS). These include linkage of behavioral health with primary care, a women's model of clinical practice guidelines for the treatment of women, a collaborative model of organizational development and a public health perspective of early intervention, consumer education and advocacy.

IDSs are large clinical delivery systems, where a majority of care is being delivered today. It is critical that IDSs have a clinical mission that has integrity, is considered state-of-the-art and, provides optimally matched services for the entire population, rather than using a male model, which works adequately only for half the population.

Collaborative models work more creatively than hierarchical models and use resources more effectively. A status report of one IDS will be described.

No. 75B
AFRICAN-AMERICAN WOMEN IN PSYCHIATRIC ADMINISTRATION

Altha J. Stewart, M.D., *7150 Crittenden Street, Philadelphia PA 19119*

SUMMARY:

The African-American female professional was once described as "the product of the confluence of unique sociohistorical, economic, and psychological factors." Despite major advances made during the last three decades in mental health administration, minority women in top level positions still face problems that others do not. African-American women, while believed to have a "double advantage" over others, in reality face a double burden. Unfortunately, not much has been written about the fact that the double negative statuses of being African-American and female frequently do not lead to a positive professional experience. The changes occurring presently in behavioral health care highlight once again some of the unique and difficult issues facing African-American women in mental health administration.

This presentation will review the experiences of some African-American women in mental health administration, including specific examples used to illustrate institutionalized racism and sexist perceptions of the African-American woman administrator as "mother," and the importance of mentors in the development of leadership and management competencies. It will also dispel some myths related to the "superior and privileged status" of African-American women over other minorities and offer recommendations for unlocking their untapped and underutilized leadership potential.

No. 75C
ONE WOMAN'S PROFESSIONAL EXPERIENCES WITH HMOS

Dorothy E.G. Dugger, M.D., *671 Saint Mathews Road, Chester Springs PA 19425-3719*

SUMMARY:

I will present my experiences as a female psychiatrist in psychiatric and medical surgical leadership roles in the insurance and managed care industries. Included are issues of tokenism, the "old boy" network, glass ceilings, financial equality, and prejudice against the medical profession. I will discuss the contributions of our lack of business training, the negative effect of our medical training on our attitudes and perspectives, and the "toxic doc syndrome." Success strategies, such as appropriate education, change in orientation, foot in the door techniques, mentoring, and making the system work for you will be addressed.

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SYMPOSIUM 76—CULTURE AND PSYCHOTHERAPY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to recognize how and when culture influences the psychotherapeutic process in individual, family, and group therapy, and with regard to special populations such as the elderly.

No. 76A
ETHNIC IDENTITY AND TRANSFERENCE IN THERAPY

Junji Takeshita, M.D., *Department of Psychiatry, University of Hawaii, 1356 Lusitana Street, 4th Flr, Honolulu HI 96813*

SUMMARY:

The ethnic and cultural background of both patients and psychotherapists significantly affect the therapeutic relationship and the process. Transference and countertransference may be particularly influenced by such factors. Some of these aspects will be illustrated using a case vignette of a patient of mixed ethnicity who struggles with ethnic identity, an interracial marriage, and racial identification with the therapist. Pitfalls in cultural transference and countertransference that need to be addressed in therapy include overidentification by the patient with the therapist (and vice-versa), as well as the reverse problem of denying or devaluing ethnic issues, particularly on the part of the therapist.

No. 76B
CULTURALLY SENSITIVE THERAPY OF A DYING PATIENT

Jon M. Streltzer, M.D., *Department of Psychiatry, University of Hawaii, 1356 Lusitana Street, 4th Flr, Honolulu HI 96813-2427*

SUMMARY:

Psychotherapy with a dying patient and the family may be influenced by culture in ways much more subtle than normal grieving variations. A 47-year-old, second-generation, Japanese man was dying of stomach cancer. He traveled to Japan to find a cure. During his terminal hospitalization he remained obsessed with being cured by his special medicines. His second-generation Okinawan wife was overwhelmed with anger and guilt toward her husband because he ignored her attempts to care for him (in favor of his elder sister), and also failed to recognize his wife's and daughter's need to prepare for his death. Although the wife believed it would be impossible to communicate these issues to her distant Japanese husband, psychotherapy with the husband allowed him to reveal his feelings of inadequacy in any role other than that of provider. His psychiatrist led him to realize that he could still provide for the emotional well-being of his family, and a remarkable transformation occurred during a family therapy session. The psychiatrist had to unlock the differing cultural beliefs of the husband and wife, and find common ground that fulfilled both of their needs, resulting in a healthy resolution of the dying process.

No. 76C
CULTURAL ISSUES PRECIPITATED BY TRAUMA

Alan A. Buffenstein, M.D., *Department of Psychiatry, University of Hawaii, 1356 Lusitana Street, 4th Flr, Honolulu HI 96813*

SUMMARY:

A 48-year-old, second-generation, Japanese woman who had been married to a Caucasian husband for 28 years without major difficulties, sought psychiatric treatment for the first time because of sleeplessness, poor concentration, and rageful feelings. The symptoms began two months previously when the patient lost her son who had been murdered during an armed robbery. Complicating her grief reaction was the fact that her husband responded differently to the son's death. At the time of the patient's marriage, her family warned her about leaving her traditional culture to marry a Caucasian man. But she rebelled, and, thus, somewhat alienated her family. Now her rage was partially displaced onto her husband and his culture. The therapist's foreign background was important in the transference. He had to allow the resentment against the husband to be both expressed and understood at several levels, before effective grieving for the son could develop. The therapist had to guard against the countertransferential desire to "rescue" the patient by providing a more "sensitive" alternative to the husband. Cultural differences, which seemed so black and white and insurmountable during her period of rage, resumed a more subtle level by the conclusion of therapy.

No. 76D
CULTURE AND AGING: INTERACTIONS IN PSYCHOTHERAPY

Iqbal Ahmed, M.D., *Department of Psychiatry, University of Hawaii, 1356 Lusitana Street, 4th Flr, Honolulu HI 96813*

SUMMARY:

Culture as well as aging have been reported to influence attitudes toward and utilization of psychotherapy. In addition, specific techniques of psychotherapy, specific therapeutic issues including transference, and specific types of psychotherapy have been described for different cultures, ethnic groups, and the elderly. Given the current state of knowledge in these areas, some of the challenges of providing psychotherapy to the ethnic minority elderly will be discussed. These challenges will be approached from a model of interactional effect of culture, ethnicity, and aging. Interactional mechanisms described would include the possible "double-jeopardy" of being older and an ethnic minority. The elderly could be considered a "sub-cultural" group. The aging culture interacts with the culture of the ethnic minority group in complex ways. Understanding of these interactions will assist in developing more accessible, culturally sensitive, and effective psychotherapy services for this group. Using clinical examples and literature review, guidelines will be presented to assist in reaching this goal.

No. 76E
MULTIETHNIC GROUP PSYCHOTHERAPY

Leslie A. Matsukawa, M.D., *Department of Psychiatry, John A. Burns School of Med, 1356 Lusitana Street, 4th Flr, Honolulu HI 96813*

SUMMARY:

In a society of racial and ethnic diversity, group therapists are increasingly in need of an understanding of how to work with a group made up of members of different ethnic and cultural backgrounds. Members of various ethnic groups may bring differing value systems into the social microcosm of the group, especially in regard to status, roles and power, and individualism versus group-mindedness. This will directly impact on the formation of the group and the process of group interaction. How to self-reveal, how to maintain a certain hierarchy within the group, and the purpose and goals of therapy are all issues that need to be considered, discussed, and managed in a culturally informed way. The fact that members of different ethnic groups may approach these issues in different ways should be addressed as soon as possible, so that any potential barrier or conflict can be worked out, without leading to major resistance in the working alliance, and thus sabotaging the group process. Culturally informed modifications of technique arising out of such discussion will aid the group therapist in promoting therapeutic factors in a multi-ethnic group. The therapist's position of cultural neutrality will facilitate group members' understanding and respect for their differences.

No. 76F
OVERVIEW OF CULTURE AND PSYCHOTHERAPY

Wen-Shing Tseng, M.D., *Department of Psychiatry, University of Hawaii, 1356 Lusitana Street, Honolulu HI 96813-2427*

SUMMARY:

Methods of studying the impact of culture on psychotherapy have included: examining indigenous healing practices, analyzing culture-

specific psychotherapies developed in a particular society, and assessing the influence of cultural differences between therapist and patient on the psychotherapeutic process. Based on such studies a number of issues are important to carry out culturally relevant psychotherapy. These are:

(1) Thoughtful consideration of the sociocultural setting within which the therapy takes place;

(2) Full attention to patient's cultural orientation, understanding, and expectation toward psychotherapy;

(3) Careful adjustment of culturally suitable therapist-patient relationship;

(4) Relevant modification of communication style to fit the culture of the patient;

(5) Appropriate understanding of the patient's personality and behavior with culturally adjusted theories;

(6) Suitable selection of therapeutic models that match the patient's culture style;

(7) Maximal utilization of universal therapeutic techniques as well as culture-specific approaches;

(8) Constant assessment and regulation of the potential impact of the therapist's value system on therapy;

(9) Careful evaluation of the goals of therapy in relation to the needs of the individual, family, community, and culture.

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SYMPOSIUM 77—ACUTE BIOLOGIC RESPONSE TO TRAUMA MAY PREDICT PTSD

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to recognize that chronic PTSD may be predicted on the basis of how individuals respond biologically to trauma. Further, it will be clear that biological studies suggest that chronic PTSD may represent a very unusual response that is not simply a continuation of the normal acute stress response.

No. 77A
THE BIOLOGY OF TRAUMA, PTSD AND RISK FOR PTSD

Rachel Yehuda, Ph.D., *Department of Psychiatry, Mt. Sinai School of Medicine, 130 West Kingsbridge Road, Bronx NY 10468*

SUMMARY:

New data suggest that there are at least some biological variables that are associated with risk for developing PTSD, whereas others are associated with the actual presence of PTSD, and others still with the severity of trauma. In this presentation, an overview of biological findings in PTSD will be presented with the intention of classifying biologic findings into these three categories. The purpose of this classification is to begin to differentiate between biologic alterations that might be expected at earlier phases of the acute stress response from those that might be associated with later responses, or those that would predict the subsequent development of PTSD. This will provide a context for the studies to be presented in the symposium. Strategies for evaluating prospective, longitional biological data in studies of trauma survivors will be presented.

No. 77B
ACUTE POST-RAPE CORTISOL, MHPG AND THYROID HORMONE

Heidi Resnick, Ph.D., *Department of Psychiatry, Medical University of SC, 171 Ashley Avenue, Charleston SC 29425;* Rachel Yehuda, Ph.D., Ron Acierno, Roger K. Pitman, M.D., David Foy

SUMMARY:

Previously we reported on associations between acute post-rape plasma cortisol levels, number of hours post-rape, rape stress characteristics, prior assault history, and PTSD diagnosis at three months follow-up assessment within a sample of 37 women for whom plasma cortisol was measured within 72 hours post-rape. We now report differential associations between these variables and acute post-rape plasma MHPG and TT4 that were obtained for subsets of the larger sample. MHPG and HVA levels were available for a subset of 20 individuals (19 of whom had symptom data available) while TT4 levels were obtained from 36 cases. Data indicate that both cortisol and TT4 levels were negatively associated with prior history of assault. There was a main effect association between MHPG and rape stress characteristics. Controlling for time post-rape, levels of MHPG were higher in the group of 12 women whose assaults included either presence of receipt of injury during assault, or multiple types of penetration M = 7.46, SD = 4.3, compared with eight women whose assaults included neither characteristic M = 3.71, SD = 1.49 ($F = 6.5$, $df = 1,19$, $p < .05$). Differential patterns of associations between these variables and three-month post-rape symptom profile will also be discussed.

No. 77C
THE DST IN FEMALE ASSAULT AND RAPE VICTIMS

Michael Griffin, Ph.D., *Department of Psychology, University of Missouri, 8001 Natural Bridge Road, St. Louis MO 63121;* Patricia Resick, Ph.D., Rachel Yehuda, Ph.D., Mary Ulmansick

SUMMARY:

The low dose dexamethasone suppression test (DST) (0.5mg) was used to test for an enhanced suppression of cortisol in female assault and rape victims with post-traumatic stress disorders at two weeks post-rape and then again three months later. These biochemical measures were collected as part of a larger multimodal assessment battery that included: self-report measures of PTSD symptoms, cognitions, and social support; diagnostic interviews to assess PTSD (Clinician Administered PTSD Scale) and other Axis I psychophathology (using the SCID). Preliminary results suggest that rape and assault victims with PTSD show an enhanced suppression of cortisol in response to dexamethasone administration as early as two weeks post-rape. Results will be discussed in terms of the implications for the longitu-

dinal progression of the disorder and biological theories of PTSD. In addition, cross-trauma specificity will be studied by comparing findings with those from the combat PTSD literature.

No. 77D
ACUTE CORTISOL RESPONSE TO STRESS AND LATER PTSD AND MDD

Alexander MacFarlane, M.D., *Department of Psychiatry, University of Adelaide, Queen Elizabeth Hospital, Woodville 5011, South Australia;* Michelle Atchison, M.D., Rachel Yehuda, Ph.D.

SUMMARY:

The relationship between the acute stress response and the subsequent emergence of post-traumatic stress disorder (PTSD) is of particular relevance to an understanding of the onset of this disorder. The earlier work of Yehuda of the HPA axis in chronic PTSD has suggested that there is a pattern of enhanced negative feedback. This study examined motor accident victims at the time of the trauma and six months later. In the immediate aftermath of the accident, blood samples were drawn for cortisol determination within two hours of the motor vehicle accident on 40 subjects. At six months subjects were evaluated for psychiatric diagnosis. The data showed a group difference in cortisol levels between those who went on to develop post-traumatic stress disorder, no disorder, or major depression, with the PTSD group having the lowest cortisol at the time of the trauma and the major depressive disorder (MDD) group having the highest cortisol levels at the time of the trauma. The relationship between the acute cortisol rise and the dexamethasone suppression test was subsequently examined. The data suggest that the acute stress response may have a range of dimensions that are important to understanding the later emergence of psychiatric symptoms.

No. 77E
PREDICTING PTSD IN RECENT TRAUMA SURVIVORS

Arieh Y. Shalev, M.D., *Department of Psychiatry, Hadassah University, PO Box 12000, Jerusalem 91120, Israel;* Tuvia Perl, Dalia Brandes, Tall Sahar, Scott P. Orr, Ph.D., Roger K. Pitman, M.D.

SUMMARY:

Objective: To prospectively study the development of PTSD in recent trauma survivors.

Method: 270 individuals were recruited from Hadassah University Hospital's emergency room (ER) following events meeting DSM-III-R PTSD criterion "A." Psychometrics and psychophysiological measures (auditory startle response and response to mental imagery) were recorded one week, one month, and four months after trauma. PTSD and other mental disorders were assessed by structured clinical interviews. A total of 235 (87%) subjects completed the study and 41 (17.4%) had PTSD at four-month's assessment. Clinician-administered instruments had better predictive value than self-report psychometrics. PTSD patients had higher heart rate levels upon ER admission and one week after trauma (for ER: 95 BPM vs 83 BPM, $p < .001$) that were not explained by trauma severity, age, and initial distress and disappeared at the one-month and four-month's assessment (ANCOVAR $p < .02$ for time x group interaction). Differences in response to startle (mean HR, EMG, and skin conductance, EMG and SC habituation) developed across time, but were not present on the one-week and one-month's assessments. HR and EMG responses to mental imagery of the trauma were higher in PTSD four months after the trauma.

Conclusion: While initial arousal differentiates those who develop PTSD from those who do not, psychophysiological responses to challenge develop with time in PTSD patients and may represent a growing neurophysiological impairment.

No. 77F
AROUSAL, SLEEP AND THE ACUTE PATHOGENESIS OF PTSD

Thomas A. Mellman, M.D., *Department of Psychiatry, Veterans Affairs Medical Ctr, 1201 NW 16th Street, 116A, Miami FL 33125;* Daniella David, M.D., Patricia Byers, M.D., Jeffrey Augenstein, M.D.

SUMMARY:

Chronic PTSD is associated with additional morbidity and treatment refractiveness. This has led to an interest in pathogenic mechanisms and possible interventions during acute stages. Peri-traumatic dissociation and acute reactions featuring psychic and somatic anxiety symptoms are predictive of developing PTSD. A common link for these states may be heightened psychophysiologic arousal. Sleep is a necessary and restorative state of diminished arousal. Sleep is frequently disrupted following traumatic events and sleep disturbances are prominent symptoms of PTSD.

We studied self-report ratings of sleep disturbance in 60 subjects exposed to a natural disaster, and 42 victims of severe motor vehicle accidents. Ratings of current sleep disturbances, as well as ratings for before the traumatic incidents, were increased in association with active PTSD.

Among the hospitalized accident victims, peri-accidental intoxication had a strong negative relationship to acute PTSD symptoms.

We recently conducted a preliminary, open-label trial of a brief course of hypnotic medication during an acute stage of trauma response. All four subjects endorsed increased amounts of consolidated sleep and reduced PTSD severity one week after discontinuing the medication, compared to the pretreatment baseline.

These observations support there being relationships of arousal level, sleep disturbance, and the early pathogenesis of PTSD.

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SYMPOSIUM 78—COMPETENCE TO CONSENT TO RESEARCH

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to demonstrate understanding of the current controversies surrounding psychiatric patients' consent to research, and to understand

relevant research findings and their implications for the protection of impaired subjects.

No. 78A
COMPETENCE TO CONSENT TO PSYCHIATRIC RESEARCH: AN OVERVIEW

Paul S. Appelbaum, M.D., *Department of Psychiatry, University of Massachusetts, 55 Lake Avenue North, Worcester MA 01655*

SUMMARY:

Recent events have raised questions regarding the capacity of mentally ill persons to consent to participation in research. Allegations have been made that the use of certain categories of patients as research subjects—including patients with schizophrenia and major depression—may be unfair, because such patients lack the capacities to make autonomous decisions about participation in research projects. Questions have also been raised about the recruitment of any involuntarily committed patients for research purposes. This presentation reviews the roots of the recent controversy, tracing it back to questions left unresolved when the current Federal regulations for oversight of research were developed in the 1970's. The empirical data addressing these issues are limited, leaving policymakers without a great deal of guidance in choosing among alternative approaches. A conceptualization of competence to consent to research drawn from widely accepted models of competence to consent to treatment will be presented. This conceptualization has been embodied in an instrument, the MacArthur Competence Assessment Tool - Clinical Research (MacCAT-CR), now being used to begin to answer several important questions regarding patients' competence to participate in research. Data from several of the sites where the MacCAT-CR is in use will be described in the following presentations.

No. 78B
COMPETENCE TO CONSENT TO RESEARCH IN SCHIZOPHRENIA

William T. Carpenter, Jr., M.D., *Department of Psychiatry, MD Psychiatric Research Ctr, PO Box 21247, Baltimore MD 21228;* Adrienne C. Lahti, M.D., Robert R. Conley, M.D., John J. Bartko, Ph.D., Robert W. Buchanan, M.D., Paul S. Appelbaum, M.D.

SUMMARY:

An important public debate has emerged regarding the adequacy of informed consent in research studies concerned with schizophrenia populations. There is relatively little empirical data regarding competency and capacity to consent to research in these populations and almost no data that specifically address these capacities in subpopulations selected for actual research participation. The link between assessment of competency and subjects' actual processing of informed consent information has not been directly addressed in schizophrenia.

Inpatient and outpatient research cohorts at the Maryland Psychiatric Research Center participated in an evaluation of capacity for informed consent. These same subjects also were tested for adequacy of the informed consent process during protocol participation. Analyses will describe the nature and frequency of impairments in capacity to consent as measured with the MacCAT-Schizophrenia in hospitalized and outpatient research subjects. A second analysis will address the adequacy of the informed consent process during real protocol participation. Finally, the relationship between the evaluation of capacity to consent and the empirical data on the adequacy of the informed consent process will be examined.

Data collection is in progress. Analyses in April will be discussed in the initial presentation of this material in May.

No. 78C
SCHIZOPHRENIA SUBJECTS' COMPETENCE TO CONSENT TO PSYCHIATRIC RESEARCH

Jeffrey A. Kovnick, M.D., *Department of Psychiatry, University of Utah, 501 Chipeta Way, Salt Lake City UT 84108;* Steven K. Hoge, M.D., Robert A. Leadbetter, M.D.

SUMMARY:

Objective: Questions have been posed regarding the competence of subjects with serious mental illness to consent to participate in clinical research. In this study we compare the competence related abilities of hospitalized schizophrenics to consent to participate in clinical research with those same abilities in a matched sample of community controls.

Method: Patients meeting DSM-IV criteria for schizophrenia who were patients on a state hospital research ward were recruited to participate in a study in which they were administered the MacCAT - CR, a structured instrument designed to assess the competence of persons to consent to clinical research. Twenty-eight subjects were compared to 24 controls matched on age, gender, race, and SES.

Results: Comparisons will be presented regarding performance on four dimensions of competence as measured by the MacCAT - CR: (1) ability to understand disclosed information about the nature of the research project and its procedures, (2) appreciation of the effects of research participation on their own situation, (3) ability to reason and rationally think about alternatives in light of their consequences, and (4) communication of a decision about research participation.

Conclusions: The implications of our findings will be discussed.

No. 78D
COMPETENCE OF DEPRESSED PATIENTS FOR RESEARCH CONSENT

Thomas Grisso, Ph.D., *Department of Psychiatry, University of Massachusetts, 55 Lake Avenue North, Worcester MA 01655;* Paul S. Appelbaum, M.D., David J. Kupfer, M.D., Sandra O'Donnell, R.N.

SUMMARY:

This study was designed to assess the capacities of patients with major depression to make decisions about their participation in a research treatment study. By January 1997, 25 women with recurrent unipolar depression will have been enrolled in a research study ("Maintenance Psychotherapy in Recurrent Depression") involving weekly psychotherapy for four to six months, followed by randomized assignment to maintenance psychotherapy sessions once weekly, biweekly, or monthly. Subjects are being administered the MacArthur Competence Assessment Tool - Clinical Research (MacCAT-CR) at enrollment and again after eight weeks of research participation. The MacCAT-CR is a new instrument patterned after an extensively researched instrument to assess competence to consent to treatment (Appelbaum and Grisso, 1996). It assesses *understanding* of the informed consent disclosure regarding the study protocol, *appreciation* of the benefits and risks of participation for one's own circumstances, and the subject's ability to *reason* about participation in the study. Results will be reported in the form of MacCAT-CR scores on each of these three abilities, as well as the consistency of performance between first and second administration of the MacCAT-CR. Implications will be discussed for routine assessment of patients with mental disorders enrolling in treatment research studies.

No. 78E
REGULATORY RESPONSES

Steven K. Hoge, M.D., *School of Law, University of Virginia, 602 Red Maple Drive, Manakin VA 23103*

SUMMARY:

Questions have been raised about the adequacy of existing protections of mentally ill individuals who are potential subjects of research. This presentation discusses possible regulatory responses in light of emerging research on the competence of mentally ill individuals. The implications of the data on patients with schizophrenia and depression and the possible utility of the MacArthur Competence Assessment Tool - Clinical Research will be discussed. Three areas will be discussed: (1) identification of impaired subjects, (2) alternative methods of obtaining consent, and (3) oversight of research involving incompetent subjects.

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SYMPOSIUM 79—SEX HORMONES, DEPRESSION AND SEXUAL BEHAVIOR: TREATMENT IMPLICATIONS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium the participant will have a better understanding of the complexity of sexual function during the course of depressive illness and antidepressant treatment, and will be aware of recent findings that suggest that sex hormones are useful antidepressants for some patients.

No. 79A
ANDROGENS AND MAJOR DEPRESSION IN MEN: CLINICAL IMPLICATIONS

Stuart N. Seidman, M.D., *Clinical Psychopharm, NYS Psychiatric Institute, 722 West 168th Street, New York NY 10032*

SUMMARY:

Background: The relationship of the hypothalamic-pituitary-gonadal (HPG) axis to depressive illness in men is poorly understood, and the role of exogenous androgens in treatment is unclear.

Objective: The purpose of this review is to describe and organize the data on these relationships in a way that is clinically useful.

Method: We will review data from all English-language studies that have assessed testosterone (T) secretion in depressed men, and from all clinical trials of androgen treatment for depression. We will also present preliminary data from a trial of T in hypogonadal men with refractory depression.

Results: In many though not all studies, a subgroup of depressed men (particularly older men) have reduced T levels and blunted T secretion while depressed, which normalizes when they recover. Exogenous androgen treatment consistently elevates mood, libido, appetite, and energy in hypogonadal men, and this treatment appears to be an effective antidepressant for certain subgroups of depressed men (e.g., HIV positive, SSRI refractory, hypogonadal).

Conclusion: There are indications that in some depressed men there is HPG axis disturbance, and that exogenous T may be an effective antidepressant treatment.

No. 79B
ESTROGEN AS A TREATMENT FOR DEPRESSION IN WOMEN

Mary F. Morrison, M.D., *Department of Psychiatry, University of Pennsylvania, 3400 Spruce Street/1 Maloney, Philadelphia PA 19104*

SUMMARY:

Objective: The purpose of this review is to describe the clinical data on the role of estrogen as a treatment of depressive symptoms in women.

Method: We will review data from studies that assessed the relationship between reduced estrogen level and depressive symptoms, and clinical trials of estrogen treatment for depressive symptoms. We will also present preliminary data from a trial of estrogen in peri-menopausal women.

Results: Much of the data on natural and surgical menopause, as well as clinical observations of women on anti-estrogen therapy for breast cancer, suggest that estrogen deficiency may contribute to depressive symptoms and lack of response to antidepressants. In peri-menopausal women with depression, results of a prospective trial of estrogen replacement suggests significant improvement in symptoms of tearfulness, mood instability, and depression. There is also evidence that estrogen replacement can prevent depressive symptoms and improve quality of life in post-menopausal women, but the effect has been inconsistent. Some preliminary evidence suggests that estrogen's antidepressant effect is mediated through serotonin, and that the SSRI-estrogen combination may be particularly effective for some patients.

Conclusion: The available evidence suggests that estrogen replacement therapy may lead to an improvement in depressive symptoms in some women.

No. 79C
SEXUAL FUNCTION IN DEPRESSED MEN

Eric A. Nofzinger, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh PA 15213;* Charles F. Reynolds III, M.D., Michael E. Thase, M.D.

SUMMARY:

Alterations in sexual function are among the classic neurovegetative symptoms of depression. Given known associations between brain structures that regulate mood, motivation, adaptive behavior, homeostatic regulation, and sexual function, we explored behavioral, cognitive, and nocturnal penile tumescence (NPT) measures of sexual function in 40 depressed men before and after treatment with cognitive behavior therapy. Contrary to expectation, sexual activity per se was not reduced during the depressed state. Rather, loss of sexual interest appeared to be related to the cognitive set of depression, i.e., loss of sexual satisfaction that then improved with remission from depression. Depressed men were heterogeneous, however, with respect to sexual behavior, e.g., an anxious and more chronically depressed subgroup of men who did not have remissions with therapy reported increased sexual interest and sexual activity. Also contrary to expectation, nocturnal penile tumescence abnormalities in depressed men did not reverse when measured in early remission. In this group of outpatient depressed men, therefore, there appears to be a separation between the cognitive features of depression, (i.e., the loss of satisfaction), waking sexual behavior, and physiological indices of sexual function (i.e., NPT).

No. 79D
SEXUAL BEHAVIOR AND DEPRESSION: DRUG EFFECTS

R. Taylor Segraves, M.D., *Department of Psychiatry, Case Western, 2500 Metro Health Drive, Cleveland OH 44109-1998*

SUMMARY:

Background: A limited number of studies have investigated the influence of antidepressant pharmacotherapy on human sexual behavior.

Objective: The purpose of this review is to organize the data on the relationship between psychopharmacologic treatments, sexual behavior, and depression.

Method: We will review data from studies that have assessed changes in sexual functioning during psychopharmacologic treatment, and highlight methodologic issues.

Results: Serotonin reuptake inhibitors are associated with a high incidence of delayed orgasm and delayed ejaculation. Methodologic difficulties include the separation of drug effects from the effects of affective disorder on sexual behavior, the absence of valid measurements of some aspects of sexual behavior, and the unknown reliability of patient self-report.

Conclusion: There are indications that in some individuals, antidepressants impair sexual function. Yet persistent methodologic problems preclude definitive conclusions regarding such effects.

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SYMPOSIUM 80—STOPPING THE MANAGED DESTRUCTION OF MENTAL HEALTH CARE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the end of this presentation the participant will be able to identify: ethical, economic, and functional problems in managed mental health care; researched shortcomings of time-limited and ultrabrief therapy; strategies to contain managed care abuses; and cost-containment alternatives to managed care.

No. 80A
MANAGED CARE IS HERE TO STAY

Karen Shore, Ph.D., *1966 Ashley Place, Westbury CT 11590*

SUMMARY:

This presentation challenges the oft-heard statement that "managed care is here to stay." It will detail the irresolvable problems of managed care and will demonstrate that managed care has the potential to destroy our medical and mental health care systems and professional education, trivializing quality mental health care in the process.

There will be an emphasis on the powerlessness of the consumer in managed care through the loss of the three basic rights of choice, privacy, and decision making, and on the forces that may lead clinicians and health care facilities to choose between compromising their ethics or compromising their ability to survive economically. The presenter will list current managed care practices that put patients at risk of harm and even death.

This discussion will make clear why we must work in an alliance with consumers to expose, regulate, and eventually replace managed care and managed competition. The presenter argues that we must design a health care system based on freedom with responsibility for patients and clinicians, and on the value of cooperation rather than competition. Such an alternative would induce a cost-consciousness in patients yet guarantee high quality and the integrity of the professions.

No. 80B
STOP THE MANAGED DESTRUCTION OF MENTAL HEALTH CARE

Ivan J. Miller, Ph.D., *350 Broadway, Suite 210, Boulder CO 80303*

SUMMARY:

This presentation will examine managed care and demonstrate that its economics are a distortion of the free market system and are prone to inefficiencies and abuse. As a result of these economics, drastic quantities of service must be eliminated in order to subsidize the administration, profits, and inefficiency of managed care.

The research and theory of managed care time-limited, and ultrabrief therapy will be examined, and the presenter will demonstrate that this therapy relies heavily on the placebo effect of ventilation and high rates of spontaneous remission. Research demonstrates that managed care psychotherapy is inferior to traditional *clinically determined treatment*, and both managed care cost containment, and treatment are *invisible rationing*. Moreover, invisible rationing is prohibited by the ethics of mental health professionals and has serious liability consequences.

A strategy and legislation for ending the managed destruction of mental health care will be recommended. This strategy includes requiring full disclosure of managed care policies, disclosure of the quantity of service actually provided through managed care, and disclosure of how managed care handles money entrusted to them. Once this information is disclosed to consumers, the desirability of alternatives will be apparent, and a more compassionate system can be developed.

No. 80C
THE AMERICAN MENTAL HEALTH ALLIANCE

Peter Gumpert, Ph.D., *150 Clark Road, Brookline MA 02146*

SUMMARY:

This presentation analyzes managed behavioral health care organizations and shows that they are incapable, by virtue of their nature and structure, of meeting their stated quality and cost-containment goals. The presenter will explain that the quality assurance methods of managed behavioral health care are versions of inspection systems that have been abandoned by manufacturing industries because they are costly, ineffective, and destructive to morale. The managed care methods of selecting professionals are also flawed and undermine rather than enhance service quality.

An alternative mental health system, the American Mental Health Alliance, will be presented. This is a cooperative model in which cost containment is achieved without restricting outpatient services or curtailing patient choice. It contains no requirement for the prior authorization or utilization review bureaucracies that undermine pa-

tient-professional relationships. Costly inpatient treatment is managed in novel ways, including empowering the patient-professional dyad and making expert consultation resources available. All major aspects of this new model will be described, including instructions for setting up the model in states where it is not yet organized.

In addition, all three presenters will briefly describe other cost-containment alternatives to managed care.

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2. Shore K: Managed care: The convergence of industrialization and totalitarianism. *Psychologist Psychoanalyst*, Vol. 15:(4) pp. 15-19 Fall 1995.
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SYMPOSIUM 81—REGIONAL PRIORITIES ON MENTAL HEALTH IN THE AMERICAS Joint Session with the InterAmerican Council of Psychiatric Organizations

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

In this symposium, problems will be addressed and experiences will be shared in order to enrich the efforts of those searching for possible solutions in the near future of the difficulties confronted by mental health workers in the Americas.

No. 81A
PSYCHIATRY PRIORITIES: PROPOSALS FOR SOUTH AMERICA

Rodolfo D. Fahrer, M.D., *Mental Health, University of Buenos Aires, J Salguero, 2436-8th, 1425 Buenos Aires 1425, Argentina;* Fernando Lolas, M.D., Enrique P. Dinerstein, M.D.

SUMMARY:

In this study, we will discuss three psychiatric priorities in South America:

(1) Training faculty within a biopsychosocial conception.

(2) Developing habits and skills for research and scientific thinking.

(3) Development of epidemiological research.

We will explain the current state of curricular changes and the development of main research projects that are being carried out in our countries.

We believe that if these three projects are effectively completed in this area, psychiatry in the southern cone of the Americas will be able to confront the 21st century in conditions more comparable to those of the more developed countries in the world.

No. 81B
MENTAL HEALTH PRIORITIES IN BRAZIL

Miguel R. Jorge, M.D., *Department of Psychiatry, Fed University of Sao Paulo, Rua Botucatu 740, Sao Paul SP 04023, Brazil*

SUMMARY:

Brazil, as other Latin American countries, has centered its mental health policy at psychiatric hospitals. This situation began changing 10 years ago in some states, and at the national level in the last 5 years. This has resulted in a decrease of psychiatric hospital beds, an increase of psychiatric units (wards, emergency rooms, consultation-liaison services) in general hospitals, and creation of community centers for psychosocial attention. A global mental health policy is being discussed with participation of lay (patient's) organizations and mental health workers (psychiatrists, psychologists, social workers, etc.). According to this policy, mental health care is intended to be carried out at the municipality level.

No. 81C
ISSUES FACING MENTAL HEALTH IN THE CARIBBEAN

Sharon C. Harvey, M.D., *Brigade House, The Garrison, Christ Church, Barbados, W.I.*

SUMMARY:

Historically the development of psychiatric services in the English-speaking Caribbean, followed that of Britain, as the islands were all colonies of Britain until the move toward independence in the 1960s. There were large mental hospitals established on three of the more populous islands, and these institutions encouraged centralized inpatient custodial care, the effects of which continue to be felt.

This presentation will look at the need to develop community-based care, as the establishment of residential and support facilities in the community has not kept pace with the increasing admissions to hospital and a growing "new long-stay" population. Also the scourge of illicit drug abuse has escalated since the 1980s with the introduction of "crack" cocaine, contributing to the increase in admissions to the psychiatric hospitals. Child psychiatric care has been long neglected and increasing awareness of the needs of children has not been paralleled by the provision of service. All of these services will require manpower, and the Caribbean is actively moving toward having trained psychiatrists in all the territories.

Therefore, our task is to move away from an inherited system of mental health services, and progress creatively toward a format that reflects the needs of our communities.

No. 81D
PRIORITIES IN MENTAL HEALTH IN THE ANDEAN REGION (SOUTH AMERICA)

Carlos Leon-Andrade, M.D., *Department of Psychiatry, Metropolitan Hospital, Mariaan a D Jesus y Occidental, Quito, Ecuador;* Roberto E. Chaskel, M.D., Antonio Pacheco-Hernandez, M.D., J. Alberto Perales, M.D.

SUMMARY:

On the eve of the 20th anniversary of the Alma ata Agreement, "Health for All," and entering the 21st century, the goals are far away from having been met.

From the public health point of view in the region, the situation as a whole has improved, but mental health has lagged in progress. The increase in the life expectancy and the reduction in the infant mortality rate pose new challenges for the mental health field. The demands will increase particularly with 50% of the population under age 15. With almost half of the population under the poverty level, violence, mental retardation, malnutrition, alcohol and drug abuse among others, will become even more important issues. With a noticeable decline in doctors entering the field of psychiatry, the scenario becomes increasingly difficult. Processes to tackle these enormous problems and possible remedial actions will be presented and discussed.

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1. Schechtman A, Alves DSN, Silva RC: Política de saúde mental no Brasil. *Jornal Brasileiro de Psiquiatria* 45 (3):127-128, 1996.
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3. Levav I: Primary prevention in mental health programs. Possible or impossible now or later? *Acta Psiq. America Latina* 38(1) 31-34 1992.
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SYMPOSIUM 82—A WIDE GAP: UNMET NEED FOR CHILD MENTAL HEALTH SERVICES

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to become familiar with how individual, clinical, and service system characteristics may relate to unmet need for child mental health services.

No. 82A
CHILDREN IN SPECIAL EDUCATION: ADHD AND UNMET NEEDS

Regina Bussing, M.D., *Department of Psychiatry, University of Florida, Box 100234, UFHC, Gainesville FL 32610-0234;* Bonnie T. Zima, M.D., Amy R. Perwien, B.A., Thomas R. Belin, Ph.D.

SUMMARY:

Objectives: Attention deficit hyperactivity disorder (ADHD), a common psychiatric condition, may impair a child's ability to learn and form social relationships, tasks critical to healthy development. This study describes the prevalence of ADHD among children in special education programs, and identifies the extent and predictors of unmet service needs.

Methods: A two-stage screening protocol of a county-wide population of second to fourth grade students in special education was conducted: (1) to screen for ADHD employing standardized parent and teacher questionnaires, and determine health services use (N = 499); and (2) to perform diagnostic assessments of ADHD (N = 318).

Results: Almost half of the children qualified for a diagnosis of ADHD, yet only half of those were reportedly receiving care for the condition, mainly in the general health care sector. Females were over three times as likely to have unmet services needs; minority status, low income, and HMO coverage also emerged as possible risk factors.

Conclusions: ADHD is a common yet often untreated condition among children in special education. Child mental health services for ADHD should be integrated with general health care and special education programs.

No. 82B
HOMELESS CHILDREN: UNMET SPECIAL EDUCATION NEEDS

Bonnie T. Zima, M.D., *Department of Psychiatry, UCLA-NPI, 300 Medical Plaza, Box 956967, Los Angeles CA 90095;* Regina Bussing, M.D., Steven R. Forness, Ed.D., Bernadette Benjamin, M.Sc.

SUMMARY:

Objectives: The purpose of this study is to describe the proportion of homeless children who are eligible for special education evaluations due to a probable behavioral disorder, learning disability, or mental retardation, and to explore their level of unmet need for special education services.

Methods: A cross-sectional study of 118 parents and 169 children, age 6-12 years, living in 18 emergency homeless family shelters in Los Angeles County. Parents and children were interviewed using standardized mental health and academic skill measures in English and Spanish.

Results: Almost one-half (45%) of children met criteria for a special education evaluation, yet less than one quarter (22%) had ever received special education testing or placement. The main point of contact for children with behavioral disorders and learning problems was the general health care sector.

Conclusions: School-age homeless children have a high level of unmet need for special education evaluations, the first step toward accessing special education programs. Interventions for homeless children should include integration of services across special education, general health care, and housing service sectors.

No. 82C
VIOLENCE EXPOSURE IN IMMIGRANT LATINO ADOLESCENTS

Edgardo J. Menvielle, M.D., *Department of Psychiatry, Children's Hospital, 111 Michigan Avenue, NW, Washington DC 20010;* Bonnie T. Zima, M.D.

SUMMARY:

The growing number of Central American immigrant youth in the U.S. constitutes an understudied and at-risk population.

Objective: Because of a high probability for exposure to war violence, parent-child separations, and cultural strain, we explored the risk for post-traumatic stress, depression, and anxiety in this group.

Method: We conducted a cross-sectional study of 135 recently immigrated Salvadoran and Guatemalan youth ages 12 to 18. We assessed risks factors and mental health status using standard instruments.

Results: Boys and younger children reported higher levels of pre-migration violence. Boys and older children reported higher levels of post-migration violence. Levels of distress, depression, and anxiety were predicted by amount of violence and cultural strain. When post-migration violence was factored in, the effect of pre-migration exposure lost statistical significance. These two exposures were substantially correlated. The majority of children had prolonged separations from their parents due to migrating years after their parents. Duration of separation did not predict symptoms.

Conclusion: Past exposure to violence and acculturation strain are associated with symptoms of PTSD, anxiety, and depression, even when traumatic events occurred years ago. Health care providers need to be aware of these risks when dealing with children coming from areas with high levels of violence.

No. 82D
HELP SEEKING IN PARENTS OF VULNERABLE CHILDREN

William P. McMiller, M.D., *Department of Psychiatry, University of Illinois, 907 South Wolcott, Chicago IL 60612;* John Wiesz, Ph.D.

SUMMARY:

Objective: To test the hypothesis that African-American and Latino families would report significantly *fewer* occurrences of professional and agency contact prior to their child's admission to a mental health clinic than would Anglo-American families.

Method: On parental reports of professional or nonprofessional help-seeking contacts, we tested a model including demographic factors and parental perceptual factors of problem severity and treatment benefit. Logistic regression analysis with Anglo-Americans as the contrast group tested the likelihood of parents seeking professionals first.

Results: Our primary hypothesis was supported. Logistic regression analysis revealed that African-American (18% of sample) and Latino-American (22%) parents first contacted significantly fewer professional type resources than Anglo-Americans, (Total N = 181). Other demographic variables, including family income, did not significantly predict type of contacts. Parents' perceived severity of the problem significantly predicted that they would contact a professional first.

Conclusion: This study focuses attention on the process by which ethnic minority children make their way into mental health services. African- and Latino-American parents may tend to perceive professionals and agencies as risk factors to their children being inappropriately labeled, medicated, or hospitalized.

No. 82E
WHO GETS REFERRED FOR SERVICES IN JUVENILE JUSTICE?

Kenneth M. Rogers, M.D., *WS Hall Psychiatric Institute, 1800 Colonial Drive, Columbia SC 29202;* Elaine Powell, Ph.D.

SUMMARY:

Objective: The purpose of this study is to examine factors that are associated with detained youth being referred for mental health evaluation/treatment.

Method: Regression analyses, applied to a sample of 244 detained youth who were referred for mental health evaluation assessed the association of demographic, service use, and juvenile justice history on the reason for referral and assigned primary diagnosis.

Results: Seven and one-half percent of all detained youth were referred. Females were more likely to be referred than males. Latino youth were less likely to be referred for mental health services, while both African-American and Latino were more likely to receive a diagnosis of conduce disorder than Caucasian youth.

Conclusion: The decision to refer a youth for mental health services is often made in a random and haphazard manner by individuals who have gender, ethnic, and other biases. Because of the lack of objective screening measures, many youth, especially ethnic minorities, may underutilize clinical services in a juvenile detention setting. In order to appropriately identify youth who could benefit most from services, appropriate mental health screening must be used.

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SYMPOSIUM 83—ARE THERAPISTS FROM VENUS, PHARMACOLOGISTS FROM MARS?

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The relevance of a dynamic perspective in treatment of patients where the primary modality is medication will be discussed. The clinician will learn about how to effectively combine medication and psychotherapy.

No. 83A
PSYCHODYNAMIC PERSPECTIVES IN PSYCHIATRY

Robert Michels, M.D., *Department of Psychiatry, Cornell Medical College, 525 East 68th Street, Box 170, New York NY 10021*

SUMMARY:

Psychodynamic psychiatry began with Freud's discovery that his patient's symptoms were related to psychological meanings and life experiences. The patients he treated had what we would today call Axis I disorders, and like most patients today with Axis I disorders, they also had Axis II disorders. Today psychodynamically based treatments have differentiated and evolved. Some have become more focused and specific, and are used to treat Axis I disorders such as depression or panic disorder. Several of these have been evaluated with methodologic rigor and have passed with flying colors. Other psychodynamically based psychotherapies, including contemporary psychoanalysis, have focused on character pathology—Axis II phenomenology. These treatments are widely regarded as the treatment of choice for many patients. Psychodynamic therapies are often valuable adjuncts in the treatment of patients who have both Axis I and Axis II syndromes, whether or not another specific treatment is used for the Axis I syndrome. Finally, psychodynamic psychotherapy is a valuable treatment for patients who have neither Axis I nor Axis II disorders, but whose lives are challenged by biologic or social problems, and whose adaptation can be enhanced by psychodynamic interventions.

No. 83B
AFFECTIVE DISORDERS AND PSYCHODYNAMIC TREATMENT

Susan C. Vaughan, M.D., *Columbia University, NY State Psychiatric Institute, 722 West 168th Street, Box 63, New York NY 10032;* Steven P. Roose, M.D., Randall D. Marshall, M.D., Roger A. MacKinnon, M.D.

SUMMARY:

If psychotherapists and psychopharmacologists are indeed from different planets, each group needs to remember that their patients are from Earth. This presentation will review data from the study of 45 patients in long-term psychodynamic treatment, 30 in psychoanalysis, and 15 in twice-weekly psychodynamic therapy. At baseline 60% of patients had a current Axis I disorder as determined by SCID interview, with the majority meeting criteria for a current major depressive episode. In contrast, only 16% had an Axis II disorder alone at presentation.

Two different theoretical perspectives on patients with Axis I disorders who are engaged in long-term psychodynamic treatment will be discussed: (1) painful negative affects can be viewed as signals of intrapsychic conflicts, which must be analyzed or (2) affective symptoms can be considered from a DSM-IV-based phenomenological point of view and specific treatment prescribed. Two psychodynamically relevant measures (psychological mindedness and locus of control of behavior) suggest that a patient's capacity to utilize insight-oriented dynamic treatment may be impaired by current affective illness.

No. 83C
INTEGRATED PSYCHOTHERAPY AND PHARMACOTHERAPY: EARLY DATA

William H. Goldman, M.D., *Medical Affairs, US Behavioral Health, 425 Market Street, San Francisco CA 94105*

SUMMARY:

Data will be presented from a study in progress in which U.S. Behavioral Health is investigating whether there are differences in episode lengths and treatment outcome between cases where a psychiatrist provides integrated pharmacotherapy and psychotherapy and where the treatment is split and the psychiatrist provides only the pharmacotherapy. U.S. Behavioral Health claims data for episodes of care opened and closed in 1996 will be analyzed in conjunction with follow-up member survey findings. Two samples will be drawn from cases in San Francisco and New York City as well as Houston and Hartford. These regions were selected after a survey of psychiatrists (N = 5,043) indicated that they contained the highest and lowest percentages of psychiatrists in the U.S. Behavioral Health network practicing psychotherapy.

No. 83D
SEQUENCING MEDICATION AND PSYCHOTHERAPY TREATMENTS

Steven P. Roose, M.D., *Clin. Psychopharmacology, NY State Psychiatric Institute, 722 West 168th Street, PI 98, New York NY 10032*

SUMMARY:

Psychodynamic psychiatrists and psychoanalysts are prescribing antidepressant medication in combination with psychodynamic treatment with increasing frequency. Studies from the Center for Psychoanalytic Training and Research at Columbia University reported that 20% of patients in treatment with training and supervising analysts were also prescribed antidepressant medication, and 60% of the psychoanalysts had at least one patient on medication. The psychoanalytic candidates reported that 30% of the psychoanalytic training cases were also receiving antidepressant medication.

In these studies the medication and dynamic treatments were invariably combined. Rarely does a psychodynamic clinician give a medication trial first and then initiate psychotherapy. There may be important advantages in sequencing treatments, in particular identifying medication responsive symptoms in patients with affective and anxiety disorders. An effective medication trial can clarify whether there is a need for a dynamic treatment and, if so, allows that dynamic treatment to begin more focused on content-related psychodynamic problems.

In the current era, a sophisticated knowledge of pharmacologic treatments, and the openness to begin treatment of patients with an affective or anxiety disorder with a pharmacological trial, may be one of the most effective ways to develop a psychodynamic practice.

No. 83E
PHARMACOTHERAPY: MIND AND BRAIN-BODY

Jan A. Fawcett, M.D., *Department of Psychiatry, Rush-Presbyterian Medical Cntr, 1725 West Harrison, Suite 955, Chicago IL 60612*

SUMMARY:

In what ways must the psychiatrist employing psychopharmacotherapy address the mind while administering medications, which are presumed to have their primary effects on brain-body function? This question will be discussed in terms of diagnostic and treatment process. Diagnostic issues will include a determination of DSM-IV diagnoses, symptom-severity dimensions appropriate for pharmacotherapy (target symptoms), other factors such as comorbid Axis II disorders, situational factors, interpersonal factors, personality and temperament dimensions, past experience of medications, attitude of patient and patient's social network toward medications, and patient's motivations for treatment, plus other factors. Will the patient require concomitant or subsequent formal psychotherapy and if so, what type? Treatment process issues include appropriate choice of medication(s), psychoeducational needs, patient expectations, building trust and confidence, building a therapeutic alliance, addressing issues that may interfere with treatment, maintaining hope, reinforcing improvement, and addressing dynamic issues which threaten effective treatment and maintenance of improvement. Except for the everyday, moderate to mild uncomplicated depressive or anxiety disorder, which responds well to monotherapy that can be prescribed by a primary care physician, effective psychopharmacotherapy demands a careful attention to "mind" as well as "brain-body" issues.

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SYMPOSIUM 84—ADVANCES IN TELEPSYCHIATRY 1997
APA Committee on Telemedical Services

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium the participant should be able to describe (1) recent advances in telemedical technology, (2) national initiatives in telepsychiatry, and (3) validation and outcome studies in telepsychiatry.

No. 84A
EVALUATION OF TELEMEDICINE TECHNOLOGIES IN BOSNIA

Brigadier General Russ Zajtchuk, M.D., *US Army Medical Research, & Mat.,Comm Inst: ATT MCMR-ZA (BGZajtchuk) 504 Scott St. Fort Detrick, MD 21702-5012*

SUMMARY:

The U.S. military has executed real world missions with telemedicine technologies in a wide variety of contingency operations. Recently, telemedicine technologies were deployed to Bosnia to augment medical units supporting NATO peacekeeping forces, including high-resolution still imaging, full-motion video teleconferencing, digital radiography, computed tomography, real time ultrasound, teledentistry, laparoscopy telesurgery, telepsychiatry, electronic mail, Internet-worldwide access, and integrated hospital information systems. The most widely used application was digital radiography where the existence of a radiologist at only one of two deployed hospitals resulted in over 800 x-rays being transmitted, read, and results transmitted back via teleradiology in the first four months of the operation. Prior to deployment, a comprehensive evaluation plan that established performance metrics and a strategy to measure clinical-technical effectiveness and efficiency was designed. Among the initial lessons learned was the importance of clinical and technical training and the establishment of uniform telemedicine consultation protocols and procedures at both the sending and receiving ends. We are learning that time-rapid prototyping and metrics organizational approaches that leverage distributed expertise, while minimizing organizational mass, can be effective at responding to rapidly changing requirements. Perhaps, most importantly, we learned that it is important not to underestimate the work required to manage human factors that ultimately determine whether telemedicine will be used to its full advantage to improve access to care, decrease cost of delivery, and improve quality.

No. 84B
ARMY MEDICAL READINESS IN THE DIGITAL AGE

Joan T. Zajtchuk, M.D., *University of Hlth Serv, Uniformed Services, 4301 Jones Bridge Road, Bethesda MD 20814;* Russ Zajtchuk, M.D.

SUMMARY:

The U.S. Military Services are exploiting the capabilities of information-based systems to "digitize the battlefield." Force XXI is the U.S. Army's lead effort to prepare for the digital battlefield using computer-based systems of simulation, including virtual simulation, to improve soldier skills for modern systems of warfare. The application of medical information technology use and its integration with the Force XXI concept is in a transitional stage.

Medical readiness, the critical arena specific to the military, prepares personnel for global missions under varying mission requirements. Military medical requirements in deployments now demand a more highly flexible readiness posture that must be maintained under various circumstances. For example, U.S. Army operational units are presently deployed in more than 70 geographic locations worldwide using fewer medical manpower resources. Therefore, these units must depend heavily on advanced telecommunications technology to deliver seamless medical care. Global missions such as these demand research efforts to modify current peacetime medical technology in order to insure that medical practice during deployments is integrated with the digitized battlefield. The Army Medical Department is meeting this challenge and incorporating up-to-date clinically based digital technology and telemedicine practices in their day-to-day work. Examples of medical practice for deployment medicine will be discussed.

No. 84C
VALIDATION STUDIES IN TELEPSYCHIATRY

Joseph T. Coyle, Jr., M.D., *Department of Psychiatry, Harvard Medical School, 115 Mill Street, Belmont MA 02178-2828;* Lee Baer, Ph.D., Carl Salzman, M.D., John O'Laughlen, M.A., Carlos A. Zarate, Jr., M.D., Peter Cukor, Ph.D.

SUMMARY:

At this time of rapid advances in our understanding of the causes and treatments of mental disorders, momentum can be maintained only by ensuring the preservation of clinical research centers that bring together a critical mass of clinicians and scientists with patients. However, with the rapid expansion of managed care and the attendant loss of clinical revenues to support psychiatric centers of research excellence, it is imperative to explore new opportunities to dispersing clinical expertise to remote sites in a cost-effective manner. The Harvard telepsychiatry initiative has been studying the reliability and acceptability of a data compression model for interactive television (Picture Tel) that utilizes transmission over ISDN telephone lines. Our studies have defined the reliability for diagnosing obsessive-compulsive disorder and schizophrenia with this technology. We have also examined the acceptability of this format for educating primary care physicians at remote sites on psychiatric diagnosis and treatment. The studies indicate that this technology offers a cost-effective, reliable, and acceptable method for linking an academic center to remote sites for the purpose of diagnosis, consultation, and education.

No. 84D
OUTCOMES IN RURAL TELEPSYCHIATRY

M. Anthony Graham, M.D., *Chief, Telemedicine, Veteran's Administration 810 Vermont Ave., N.W., Washington, DC 20402-0002*

SUMMARY:

This paper describes the clinical outcomes of patients seen during the first year of operation of a rural telepsychiatry network.

APPAL-Link, the Southwestern Virginia Telepsychiatry Project, provides aftercare psychiatric services to the chronically mentally ill population residing in Appalachian Southwestern Virginia. These services are provided via a compressed digital two-way videoconferencing system which lines psychiatrists of Southwestern Virginia Mental Health Institute with patients and mental health nurses at remote clinic sites.

During the first year of operation, 126 patients received various mental health services over this network with 311 separate patient contacts. Seventy chronically mentally ill patients (average hospitalization 2.6) were followed over the network. Outcome data for this population include information on rehospitalization (9 readmissions

in first year), consumer satisfaction data, and assessment of the experience of telepsychiatry as compared to in-person contact.

During the first year of operation, 125 joint case conferences were held between inpatient and outpatient staff via this network. In addition, 10 involuntary commitment hearings were conducted using this equipment.

The specific protocols for these clinical activities will be presented along with costs of the network system.

No. 84E
INITIATIVES FROM THE NATIONAL TELEPSYCHIATRY CENTER

Jane H. Preston, M.D., *Center for Telepsychiatry, Menninger Clinic, 5800 SW 6th Avenue/PO Box 829, Topeka KS 66601*

SUMMARY:

Telemedicine impacts, and then becomes yeast to move broad and diverse fields: public policy, health care, clinical research, teaching, and service. In this symposium technology, service, and important quality and economic considerations are projected across the year ahead. The presentation describes a planning complementarity that supports the outflow of services, education, research, quality and economy at all ends of networked transmission.

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1. Baer L, Cukor P, Jenike M, et al: Pilot studies of telemedicine for patients with obsessive-compulsive disorder. *Am J Psychiatry* 152:1383-1385, 1995.
2. Perednia DA, Allen A: Telemedicine technology and clinical applications *JAMA*, 273(6), 483-488, 1995.
3. Preston J: Texas telemedicine project: A viability study. *Telemedicine Journal*, 1(2):125-132, 1995.

SYMPOSIUM 85—AUTONOMOUS DRUG-INDUCED PSYCHOSIS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation the participant should be able to describe how drug use may precipitate psychotic disorders that are virtually identical in their presentation to psychotic disorders not associated with drug use. This presentation will describe increasing evidence that drugs may interact with genetic vulnerability for psychotic disorders, and in some instances drugs may trigger psychoses which then become autonomous.

No. 85A
RELATIONSHIP OF DRUG ABUSE TO PSYCHOTIC SYMPTOMS

Ming T. Tsuang, M.D., *Department of Psychiatry, Harvard Medical School, 74 Fenwood Road, Boston MA 02401;* Michael J. Lyons, Ph.D., John W. Tsuang, M.D., Seth Eisen, M.D., William True, Ph.D.

SUMMARY:

The purpose of this presentation is to examine the relationship between abuse of various illicit drugs and the occurrence of psychotic symptoms in response to these drugs. We collected data from 3,226 pairs of male twins from the Vietnam Era Veteran Twin Registry. Twins were personally interviewed by telephone using the DSM Diagnostic Interview Schedule about their abuse of marijuana, amphetamines, cocaine, opiates, sedatives, and psychedelic drugs. They were also asked about their reactions to these drugs, including the occurrence of psychotic symptoms such as delusions and hallucinations. Our results address the relative influence of genetic factors and the family environment on the occurrence of psychotic symptoms in response to drug abuse. Results will be discussed in light of current research on schizophrenia.

No. 85B
STIMULANT PSYCHOSIS: THE EVOLVING PROCESS

Everett H. Ellinwood, Jr., M.D., *Department of Psychiatry, Duke University Medical Ctr, PO Box 3870, Durham NC 27710*

SUMMARY:

The later stages of amphetamine psychosis demonstrate a considerable heterogeneity even though the most prominent form is a paranoid psychosis. The evolving form of the emerging psychosis is not only dependent on the progression of dosing regimes, but also on the individual and his environmental setting and mind set. The development of delusional systems from intense, even pleasurable, curiosities or suspiciousness (from suspicio: to look underneath the surface) to the well organized delusional systems is a difficult subject and not often studied. Fairly constricted, or monodelusional systems are more instructive. One such delusional syndrome is the delusion of parasitosis, which evolves from an initial intense probing of a sensation of itch or small skin blemishes to stereotyped forefinger/pincer repetitive picking resulting in multiple punctate skin lesions. Within this context, the individual develops delusions of infestation with microorganisms, sometimes manifested as a sudden delusional enlightenment. Secondary documentation and other delusions confirm the original delusion. Skin debris pieces are examined with magnifying glass in one process of confirmation. This intense stereotypical exploration may expand to examination of dust particles and other specs leading to ancillary delusions about the microscopic world unrelated to parisitosis. Other examples of delusional types and their progression over time will be discussed. We further question the extent to which latent delusions during long-term drug-free periods have a propensity to re-emerge in full bloom with subsequent doses of stimulants.

No. 85C
LATE-ONSET AND RESIDUAL PSYCHOSIS IN STIMULANT PSYCHOSIS

Mitsumoto Sato, *Department of Psychiatry, Tohoku University, 1-1 Seiryo-Machi Aoba-Ku, Sendai Miyagi 980-77, Japan*

SUMMARY:

There are two different disease concepts of amphetamine-induced psychosis: the Connell's definition and the definition traditionally used in Japan. Connell described in 1958 that, if the psychotic state continues after cessation of drug excretion in the urine, it is regarded not as amphetamine psychosis but as of possible schizophrenic etiology, the symptoms being exacerbated by amphetamine. Contrary to this, a number of evidences reported during two epidemics of methamphetamine (MAP) abuse since 1954 in Japan have indicated consistently that chronic abuse of MAP may produce a lasting change in the brain, which causes the emergence and recurrence of late-onset and/or residual psychotic disorders of ICD-10. Our previous study was designed to find whether stimulant-induced psychosis is acute intoxication or late-onset psychosis, and found that the psychotic state similar to acute schizophrenia continued for more than 10 days in 36%, and for more than one month in 18% of the cases examined, while MAP is excreted in the urine for up to five days after discontinuation. A representative case of late-onset and residual psychotic disorders in MAP psychosis with MAP-induced predispo-

sition to psychotic relapse will be demonstrated with data of MAP test from the urine and hair. WE need a common internationally accepted disease concept of stmulant-induced psychosis.

No. 85D
DEVELOPMENT OF PSYCHIATRIC ILLNESS IN SUBSTANCE ABUSERS

Thomas McLellan, Ph.D., *University of Pennsylvania, Building 7, University Avenue, Philadelphia PA 19104*

SUMMARY:

This presentation will report two studies that evaluated the relationship between use of specific types of drugs of abuse and the long-term development of particular forms of psychiatric illness. Specifically, patients who initially showed no evidence of long-term psychiatric illness were divided into those who used combinations of amphetamine but no other substances, barbiturates and benzodiazepines but no other substances, and opiates but no other substances. Six years following continued use of these specific substances the patients showed differential psychiatric profiles. Amphetamine users were uniformly diagnosed (blind) as having schizophrenia (usually paranoid form). Benzodiazepine users were ten times more likely to have attempted suicide, showed clear evidence of cognitive impairment, and were given diagnoses of depression (usually MDD or IDD). Opiate addicts showed no change in psychiatric symptoms over the 10 years, despite the same amount and severity of drug use. Results are discussed in terms of the neurochemistry of psychiatric illness.

REFERENCES:

1. Mathers DC, Ghodse AH: Marijuana and psychotice illness. *Br J Psychiatry* 161:648-653, 1992.
2. Sato M, Numachi Y, Hamamura T: Relapse of paranoid psychotic state in methamphetamine model of schizophrenia. *Schizophrenia Bull*, 18:115-12: 1992.
3. Bowers Jr MB: The role of drugs in the production of schizophreniform psychoses and related disorders. ACNP Generation of Progress Volume, In: Meltzer HY (ed): *Psychopharmacology the 3rd Generation of Progress*, Chapter 81; 819, 1987.
4. Bitton RN, Schneider BS: Endocrine, metabolic and nutritional effects of psychotropic drugs, in *Adverse Effects of Psychotropic Drugs*. Kane J, Lieberman J (eds): Guilford Press, NY 1992.

SYMPOSIUM 86—WOMEN PRISONERS: PSYCHIATRIC DISORDERS AND HIV INFECTION

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to recognize: (1) the nature and prevalence of psychiatric disorders and mental health service use among women prisoners in Maryland, (2) the nature and prevalence of HIV-high risk behaviors, and their relationship to PTSD, and (3) psychiatric and psychological characteristics of women prisoners who are HIV-infected.

No. 86A
THE PREVALENCE OF PSYCHIATRIC DISORDERS AND MENTAL HEALTH SERVICE USE AMONG WOMEN PRISONERS IN MARYLAND

Constantine G. Lyketsos, M.D., *Department of Psychiatry, Johns Hopkins University, 600 North Wolfe St, Osler 320, Baltimore MD 21287;* Heidi E. Hutton, Ph.D., Newton Kendig, M.D., Wayne Hunt, Ph.D., Glenn J. Treisman, M.D., Anthony Swetz, Ph.D.

SUMMARY:

Few studies have examined the prevalence of psychiatric disorders among women prisoners. None have ascertained mental health service use in this setting. As part of the Hopkins Women Prisoners Study (HWPS), 177 women prisoners were examined using the SCID-IV. Their prison medical/mental health records were also reviewed. The lifetime (current) prevalences of specific mental disorders were as follows: major depression 36% (10%), dysthymia 7%, substance induced mood disorder 14%, bipolar I 8% (5%), bipolar II 2% (1%), other bipolar disorder 4% (4%), panic disorder 2% (1%), post-traumatic stress disorder 33% (15%), generalized anxiety disorder 2%, OCD 2% (2%), specific phobia 14% (7%), alcohol dependence 32%, sedative/hypnotic dependence 15%, marijuana abuse 21%, stimulant dependence 8%, cocaine dependence 64%, opioid dependence 46%, cocaine/heroin dependence 37%, polysubstance dependence 19%. Of those with any lifetime (current) mental disorder above (excluding substance use disorders and specific phobias) 40% (49%) sought treatment for their disorder. Only 29% with current, and 21% with lifetime mental disorders were receiving specific pharmacologic treatments. Women prisoners exhibit high rates of mental disorders but only a minority is receiving appropriate treatment.

No. 86B
RATES OF HIV-TRANSMITTING BEHAVIORS AMONG WOMEN PRISONERS IN MARYLAND AND THEIR ASSOCIATION WITH PTSD

Heidi E. Hutton, Ph.D., *Department of Psychiatry, Johns Hopkins School of Med, 600 North Wolfe Street, M4-119, Baltimore MD 21287;* Constantine G. Lyketsos, M.D., Wayne Hunt, Ph.D., Anthony Swetz, Ph.D., Newton Kendig, M.D., Glenn J. Treisman, M.D.

SUMMARY:

The practice of HIV-transmitting behaviors among women prisoners has not been examined systematically despite the fact that the prevalence of HIV infection in this setting is well above population estimates, and almost twice the prevalence of men prisoners. We investigated these behaviors in 177 participants in the Hopkins Women Prisoners Study (HWPS). The NIDA Risk Behavior Assessment, a widely used and well validated instrument, was the primary measure of HIV-transmitting behaviors. Forty-two percent of study participants were injection drug users (IDUs) and of these 72% had shared their paraphernalia. The following HIV-transmitting behaviors were practiced by study participants: 42% had sex partners who were IDUs (11% exclusively had sex with IDUs), 46% had sex when high on substances, 56% rarely used condoms, 19% engaged in anal intercourse, 30% engaged in prostitution, and, 5% had over 100 sexual partners. The association between psychiatric disorders and HIV-transmitting behaviors was examined. Only PTSD was associated with the practice of specific high-risk behaviors, namely prostitution ($p = 0.03$) and the practice of anal intercourse ($p = 0.01$). We conclude that high-risk behaviors are very common among women prisoners and that they are associated with PTSD. It is important to investigate whether specific treatment for PTSD will lead to commensurate reductions in the practice of HIV-transmitting behaviors.

No. 86C
PERSONALITY TRAITS AND HIV-TRANSMISSION BEHAVIORS

Glenn J. Treisman, M.D., *Department of Psychiatry, Johns Hopkins School of Med, 600 North Wolfe Street, M4-119, Baltimore MD*

21287; Heidi E. Hutton, Ph.D., Constantine G. Lyketsos, M.D., Wayne Hunt, Ph.D., Anthony Swetz, Ph.D., Newton Kendig, M.D.

SUMMARY:

Few studies have investigated the association between enduring personality dimensions and the practice of HIV-transmitting behaviors. We examined the correlation between scores on the Eysenck Personality Questionnaire or the Time Perception Test and the frequency of HIV-transmitting behaviors among women prisoners. On the Eysenck, high neuroticism was correlated with number of sexual partners ($p = 0.02$), frequency of intercourse when high on drugs or alcohol ($p = 0.004$), and with prostitution ($p = 0.02$). High psychoticism was correlated with number of sexual partners ($p = 0.003$), and with frequency of intercourse when high ($p = 0.02$). High lie scores were correlated with a lower likelihood of having an IDU as a sexual partner ($p = 0.02$), a lower frequency of intercourse when high ($p = 0.002$), and a lower likelihood of prostitution ($p = 0.003$). On the Time Perception Test, high scores on present-time orientation were correlated with frequency of intercourse when high ($p = 0.03$), and likelihood of prostitution ($p = 0.03$). High scores on future orientation were correlated with a lower likelihood of having an IDU as a sexual partner ($p = 0.006$), and a lower frequency of intercourse when high ($p = 0.0005$). The identification of women prisoners using these personality dimensions and the provision of specific interventions in accordance with these dimensions may produce reductions in the practice of HIV-transmitting behaviors.

No. 86D
PSYCHIATRIC AND PSYCHOLOGICAL CHARACTERISTICS OF HIV-INFECTED WOMEN PRISONERS

Marc Fishman, M.D., *Department of Psychiatry, Johns Hopkins School of Med, 600 North Wolfe Street, M4-119, Baltimore MD 21287;* Heidi E. Hutton, Ph.D., Constantine G. Lyketsos, M.D., Wayne Hunt, Ph.D., Glenn J. Treisman, M.D., Newton Kendig, M.D.

SUMMARY:

The prevalence of HIV infection among women prisoners is many times higher that of the US general population. No published studies have investigated psychiatric and psychological morbidity among HIV-infected women prisoners. In the Hopkins Women Prisoners Study (HWPS), 36 (24%) women were confirmed to be HIV-infected. We compared HIV-infected and -uninfected study participants on demographic parameters, prevalence of HIV-transmitting behaviors, psychiatric diagnoses, and a series of psychological state and trait measures. HIV-infected women reported higher rates of injection drug use ($p = 0.0001$), and were more likely to have had an IDU sexual partner ($p = 0.03$), and intercourse while high ($p = 0.009$). SCID-IV ascertained psychiatric disorders were no more common in the HIV-infected women. HIV-infected women also scored higher on the Beck Hopelessness Scale ($p = 0.004$), and on the extroverted dimension (impulsive, present oriented, and thrill seeking) of the Eysenck Personality Questionnaire ($p = 0.008$). There were no differences between the two groups on the Beck Depression Inventory, the Brief Symptom Inventory, the Center for Epidemiologic Studies Depression scale, the Time Perception Test, and the other dimensions of the Eysenk Personality Questionnaire. HIV-infected women prisoners differ from their uninfected peers on a limited number of psychological measures, in their past practices of HIV-transmitting behaviors, but not in psychiatric morbidity.

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1. Jordan K, Schlenger W, Fairbank J, Caddell J: Prevalence of psychiatric disorders among incarcerated women. *Arch Gen Psychiatry* 53:513-519, 1996.
2. Edlin BR: Intersecting epidemics: Crack cocaine use and HIV infection among inner city young adults. *N E J Medicine* 31:1422-1427, 1994.
3. Treisman GJ, Lyketsos CG, Fishman M, et al: Psychiatric care for patients with HIV-infection: The varying perspectives. *Psychosomatics* 34:432-439, 1993.
4. Lyketsos CG, Federman EB: Psychiatric disorders and HIV-infection: Impacting one another. *Epidemiol Rev* 17:152-164, 1995.

SYMPOSIUM 87—INTERNATIONAL PERSPECTIVES ON SKILLS TRAINING
Joint Session with the Association for Clinical Psychosocial Research

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to identify the key attributes of social skills training with the seriously mentally ill,; recognize cultural influences on the modality, and decide on its efficacy.

No. 87A
A DECADE OF EXPERIENCE OF SKILLS TRAINING IN JAPAN

Nobuo Anzai, M.D., *Department of Psychiatry, Matsuzawa Hospital, 2-1-1 Kamikitazawa, Setagayaku Tokyo 156, Japan;* Emi Ikebuchi, M.D., Shin-Ichi Niwa, M.D., Naoki Kumagai, M.D.

SUMMARY:

Recent developments in psychosocial therapies for chronically mentally ill patients in the United States have influenced the corresponding psychiatric services in Japan. In particular, social skills training (SST), as developed by Liberman and colleagues at UCLA, has been disseminated widely in Japan during the past eight years. In this presentation, we will describe the strategies for adapting and disseminating new psychiatric treatment methods into a different culture.

SST began in Japan in 1988 when Dr. Liberman spent a month there giving lectures and workshops on SST. Using "live demonstrations" of SST with Japanese schizophrenic patients, these workshops made a favorable, strong impact on Japanese mental health professionals. SST offered a pragmatic and effective method to Japanese clinicians who were in the throes of moving from hospital-based to community-based service systems. SST is now accepted as a means to empower chronic mental patients to live in the community independently.

The following four factors were crucial in the development of SST in Japan: (1) sharing information through a quarterly SST newsletter, (2) getting financial benefits for SST through the Japanese national health insurance, (3) the establishment of the Japanese Association of SST, and (4) teaching many professionals about SST through workshops by certified lecturers of the association.

No. 87B
A FRENCH-CANADIAN TRIAL OF THE SYMPTOM AND MEDICATION MODULES

Hugues Cormier, M.D., *Department of Psychiatry, University of Montreal, 7331 Hochelaga, Montreal QC H1N 3V2, Canada;* Gerard Leblanc, M.D., Francis Picher, Lise Lachance, M.Sc.

SUMMARY:

A randomized, multicenter, two-year trial (N = 83) was carried out in Quebec City to study the effects of psychoeducation in schizophrenia. The French version of the Medication and Symptom Management Modules, developed at the UCLA Clinical Research Center for Schizophrenia, were used for the patients (N = 29) in the psychoeducation group. The psychoeducation program consisted of bi-weekly, one-and-a-half-hour sessions during 20 weeks. The skills areas were: identifying warning signs of relapse, managing warning signs, coping with persistent symptoms, obtaining information about antipsychotic medication, knowing correct self-administration and evaluation of medication, identifying side effects of medication, negotiating medication issues with health care providers.

Two control groups consisted of (N = 25) patients who participated in small group, 90-minute, bi-weekly leisure activities for 20 weeks; and (N = 29) patients in a second control group who participated in their usual follow-up activities of supportive therapy and neuroleptic medication. Analyses showed that the three groups were similar regarding sociodemographic variables like sex, age, marital status, and income. Two-year results showed significantly greater improvements in the psychoeducation group for knowledge regarding medication and symptoms (P = 0.001) and behavioral skills as measured through role play tests (p = 0.001).

No. 87C
CHANGE IN ATTRIBUTIONAL STYLE BY SKILLS TRAINING

Annette Schaub, Ph.D., *Department of Psychiatry, University of Munich, Nussbaumstr 7, Munich 90336, Germany;* Bernd Behrendt, Ph.D.

SUMMARY:

Though long neglected in psychiatry, importance of patients' subjective experiences, understanding of their illness, and sense of personal self-control has recently been given increased recognition. The expectation that one can control events in one's life, termed internal locus of control, might favorably affect the long-term course of schizophrenia. This presentation will focus on the: (1) locus of control as influenced by social skills training and in persons with schizophrenia, and (2) treatment outcome at one-year follow-up.

Forty-nine patients at the Bern, Switzerland, psychiatric clinic, diagnosed as having schizophrenia or schizoaffective disorder were treated with a modified version of the Symptom Management Module developed and validated at the UCLA Clinical Research Center for Schizophrenia. This module focuses on teaching patients how to identify and cope with early warning signs of relapse and persistent symptoms of psychosis. Results included a significant decrease in psychopathology (e.g., BPRS) as well as increases in psychosocial functioning (GAF), in knowledge about psychosis, and in internal locus of control from pre- to post-treatment. The findings replicate in a German language sample earlier results with the Symptom Management Module in the USA.

No. 87D
TWO-YEAR EFFECTS OF PSYCHOSOCIAL TREATMENT ON RELAPSE OF CHRONIC SCHIZOPHRENIA

Chul Kim, M.D., *Yangsan Neuropsychiatry Hosp, San 12-1 Joojin Woongsang-up, Kyung Sang-Up 626-840, Korea;* Doag-Ho Kang, M.D., Jung Hee Jang, M.D., Jin Seok Cho, M.A., Suk J.A. Youn, M.S.W., Kyung Soo Shim, M.S.W.

SUMMARY:

To evaluate the clinical efficacy of psychosocial skills training on the relapse rate among Korean schizophrenics, 67 patients with DSM-IV schizophrenia who received family psychoeducation, patient psychoeducation, social skills training, maintenance chemotherapy, and supportive psychotherapy after discharge from hospital were compared with a control group of 84 chronic schizophrenic outpatients who received only maintenance chemotherapy and supportive psychotherapy. The psychosocial skills training was conducted using the modified UCLA Symptom & Medication Management Modules twice weekly for 90 minutes each for six months. In addition, the skills group received an individualized form of personal effectiveness and problem-solving training twice weekly for 90 minutes each for six months. Family psychoeducation was conducted weekly for 150 minutes for three months and provided formal education about the disorder and strategies for managing and coping with common and difficult situations. Maintenance chemotherapy and supportive psychotherapy were continuously conducted weekly for 20 minutes in both groups.

During the two years of follow-up, 23 of 67 patients relapsed in the skills training group versus 79 of 86 patients in the control group. During the first year of follow-up six patients in the skills training group versus 33 patients in the control group relapsed. The average number of hospitalized days decreased in the skills training group but increased slightly in the control group. From these results, we can conclude that psychosocial treatment when applied in the context of maintenance chemotherapy and supportive psychotherapy, can significantly reduce schizophrenic relapse and admission days.

No. 87E
LANGUAGE ABNORMALITIES IN SCHIZOPHRENIA: A FOCUS FOR REHABILITATION

Lucien F. Barrelet, M.D., *Hospital Psychiatry Ue Canton, Perreux NE 2017, Switzerland;* Sonia Corradini, M.E., Jerome Favrod

SUMMARY:

Current empirical evidence from linguistic analysis suggests that the thought disorder often found in schizophrenia represents defects at the syntactic, semantic, discourse, thematic, and pragmatic levels for language. These deficits appear to be related to abnormalities in information processing and brain structure and function.

There is a body of evidence that persisting language abnormalities in schizophrenia that are unresponsive to antipsychotic drug treatment might be remediable if highly structured, intensive, and systematic methods of behavior analysis and therapy are used. An innovative, new skills training module for the rehabilitation of language and discourse in thought disordered schizophrenics will be presented. The preliminary results of the first three groups of patients will be presented and discussed.

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1. Liberman RP, et al: Innovations in skills training for the seriously mentally ill. *Innovations and Research*, 2:43-60, 1993.
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3. Zarin DA, Pincus HA, McIntyre JS: Editorial on practice guidelines. *Am J Psychiatry* 150:2, 1993.
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SYMPOSIUM 88—ETHICAL DILEMMAS IN THE ERA OF MANAGED CARE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, participants will be able to identify major ethical dilemmas and conflicts presented by the era of managed care. Participants will also gain knowledge and skills in basic principles of medical ethics to address and solve these dilemmas.

No. 88A
THE INTRINSIC IMMORALITY OF CAPITATION

Edwin H. Cassem, M.D., *Department Of Psychiatry, Massachussets General Hospital, Boston MA 02114*

SUMMARY:

In the system of health care capitation, large groups of persons, referred to as "lives," are assigned to a group of care providers. The providers agree to care for the sick within the insured group for a certain price per life per month. Since money left over in the system = total – amount spent on health care, care givers' monetary rewards are inversely proportional to the amount spent on care. That is, reward is contingent on rationing care. In the individual encounter of doctor and patient, avoidance of tests, drugs, procedures, care– and even time spent with the person—is rewarded.

Reward involuntarily activates the septal reward circuits in the CNS, according to the physiology established by James Olds and his studies of the "Do it again" center. To manipulate a physician's behavior without consent is immoral. If the physician knowingly signs a capitation contract with the understanding that financial reward results from exclusion of care in any form, the contract is immoral for both parties.

Insurers or employers who arrange for care by capitated contracts engage in immoral activity. Insurers or carve-out companies who compete for contracts with the purpose of making huge short-term capital gains are unethical. Unless the incentive structure of capitation is changed, capitation is immoral and should be stopped.

No. 88B
ETHICS AND MANAGED CARE IN CHRONIC MENTAL ILLNESS

Mary L. Dell, M.D., *Department of Psychiatry, Emory University, 3563 Embry Circle, Chamblee GA 30341*

SUMMARY:

Recently significant attention has focused on potential ethical dilemmas in the delivery of mental health services in managed care and capitated systems. Ethical dialogue has centered primarily on the philosophical principles of autonomy, beneficence, informed consent, and society's larger interests in distributive justice and resource allocation. Although necessary and informative, these conversations may not offer the concrete, practical guidance sought in daily practice and routine decision-making by psychiatrists dealing with chronically ill patients in the HMO or managed care setting. Chronic mood and psychotic disorders, eating disorders, and other long-term illnesses requiring multimodal or multidisciplinary treatment require resources that exhaust allocated patient funds in capitated systems. Employing a case example of an actual eating-disordered patient, this presentation will discuss the practical bedside ethical decision-making a psychiatrist may face in the assessment and short- and long-range treatment planning of chronically ill patients in the managed care setting. Attention will also be given to the roles of the health care administrator, managed care officials and case managers, and the facilitation of teamwork among all involved professionals striving for high quality, comprehensive psychiatric care of individual patients within the broader managed care system.

No. 88C
NEW ETHICAL OBLIGATIONS FOR MANAGED CARE PRACTICE

Jodi L. Halpern, M.D., *Department of Psychiatry, UCLA, 760 Westwood Plaza, Los Angeles CA 90024*

SUMMARY:

Managed care organizations differ in their emphasis on quality care versus cost-containment, with differing impact on the psychiatrist's capacity to serve each patient's best interests. However, even in the best organizations, psychiatrists face conflicts of obligation. This is because the fundamental goals of managed care organizations are economic efficiency and the standardization of practice. Although these goals can conflict with optimizing individualized treatment, they do create new responsibilities and ethical obligations for managed care organizations that psychiatrists should be aware of. First, managed care organizations are expected to provide "appropriate" care for patients with varying levels of disease severity. Second, there is a responsibility to increase access to care for all members of the defined population, for example, by screening for depression, not just to treat those who seek care. Third, care is to be provided not only cost-effectively, but in the order of necessity, so that needier patients are not neglected because they are more expensive to treat. Despite their mission statements emphasizing these ethical ideals, managed care organizations do not necessarily follow these norms. By educating themselves about the ethical obligations of managed care, psychiatrists practicing under such policies can better equip themselves to maintain their professional ethics while transitioning into an era of population-based medical care.

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SYMPOSIUM 89—HARM REDUCTION AND ADDICTION: THE EUROPEAN EXPERIENCE
Joint Session with the Nederlandse Vereniging voor Psychiatrie

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should have a clear understanding of the harm reduction strategies toward drug addiction and the effectiveness of this approach in terms of survival, HIV/AIDS prevention and abstinence.

No. 89A
EFFECTS OF DECRIMINALIZATION OF CANNABIS IN THE NETHERLANDS: AN EPIDEMIOLOGICAL TEST OF THE VALIDITY OF THE PROHIBITIONIST POSITION

Wim Van den Brink, M.D., *Addiction Research, Amsterdam Institute, Jacob Obrechstraat 92/1071 KR, Amsterdam, Netherlands;* Dirk J. Korf, M.D.

SUMMARY:

Objective: The study aims to test the validity of the prohibitionist hypotheses regarding the effects of the decriminalization of cannabis in the Netherlands using epidemiological data collected in the Netherlands and other countries. According to the prohibitionist view, decriminalization of cannabis use will inevitably lead to an increase in the number of cannabis users and cannabis dependent individuals, and an increase in the number of heroin addicts. These heroine addicts are assumed to be recruited from the bigger population of cannabis users and will, therefore, resemble cannabis users in terms of sociodemographic and other background characteristics.

Methods: Multi cross-sectional epidemiological data on the number of cannabis users, the number of problematic cannabis users seeking treatment, and the estimated number of opiate addicts will be related to the historical development of the decriminalization of cannabis use in the Netherlands. In addition, epidemiological data from other European countries and the USA will be used as a cross-cultural comparison.

Results: The rise and spread of cannabis use occurred in the late 1960s and early 1970s, i.e., at the time that cannabis use was subject to criminalization. Cannabis use stabilized during the 1970s and early 1980s, i.e., at the time that cannabis use was subject to decriminalization. Since the late 1980s an increase in the use of cannabis is taking place, an increase that seems to parallel the increase in the number of coffee shops. European data and data from the USA fail to show a clear relationship between the national policy and prevalence of cannabis use. Continuation rates of cannabis use are rather low, and cannabis use rarely results in cannabis dependence as indicated by the small number of treatment-seeking cannabis users. The development of the prevalence of cannabis use is not related to the development of the number of opiate addicts in the Netherlands. This seems also to hold for other European countries and the USA. Finally, heroine users are quite different from cannabis users in sociodemographic and other background characteristics.

Conclusions: In the Netherlands and in other European countries and the USA there is no simple relationship between (de)criminalization of cannabis use and the prevalence of cannabis use and the number of heroine addicts. Furthermore, opiate addicts are quite different from cannabis users in terms of their ethnic and family background and in their socioeconomic status. Therefore, we conclude that there is no empirical support for a simple prohibitionist position.

No. 89B
AIDS PREVENTION AMONG INJECTING DRUG USERS: EVALUATION OF HARM REDUCTION

Erik J. Van Ameijden, Ph.D., *Public Health, Municipal Health Services, Nieuwe Achtergracht 100, Amsterdam NL 1018WT, The Netherlands*

SUMMARY:

The main type of drug user policies are medicalization, criminalization, and harm reduction. In Amsterdam, in the concept of harm reduction, several AIDS-prevention measures have been implemented, such as large-scale needle-exchange programs and methadone programs with a low threshold to participate. Evaluation of harm reduction in Amsterdam is mainly based on results of a cohort study with continuous recruitment of drug users (since 1985). Large reductions in injecting and sexual risk behaviors were observed, accompanied by a strong decline in the HIV incidence (from 10% to 3% per year) and a stable HIV prevalence of 30%. However, no evidence was found for specific interventions being (partly) responsible for the risk reductions. Moderate-to-strong evidence was only found for HIV testing and counseling. This weak evidence for effectiveness may be due to "community-wide" implementation of interventions through which on the individual level no relationship can be observed between interventions and outcomes. Therefore, it could only be concluded that the combination of measures has been effective. A literature review showed that other combinations of interventions, not necessarily based on harm reduction, have also been effective in slowing down an existing HIV epidemic. High needle availability is probably a critical factor. As epidemics may be prevented, interventions should start as early as possible.

No. 89C
INJECTING DRUG USE, HARM MINIMIZATION AND DECLINING HIV-1 PREVALENCE RATE IN LONDON

Gerry V. Stimson, Ph.D., *Department of Psychiatry, Center for Research, 200 Seagrave Road, London SW6 1RQ, United Kingdom;* Gillian M. Hunter, M.A., Tim Rhodes, M.Sc., Martin C. Donoghde, B.A., Colin Chalmers, M.Sc., John Parry, Ph.D.

SUMMARY:

In 1986, the London (and the rest of the UK) was faced with possible rapid spread of HIV infection among injecting drug users (IDUs). HIV prevention activities commencing in 1986-87 targeted vulnerable populations through syringe distribution, methadone treatment, and outreach. There were major changes in service practices, as ideas of harm minimization, accessibility, flexibility, and multiple and intermediate goals were developed.

Objective: To assesses policy development, service changes, and trends in HIV infection and risk behavior among IDUs in London.

Methods: HIV-1 and risk behavior measured in four surveys of IDUs in community-based and drug treatment settings (1990-93). Statistical comparisons across years were examined using mixed Binomial logistic and loglinear models. Risk behavior data from other studies, and analysis of London HIV prevention policies and programs from 1987 were examined. Association between epidemic trend, behavior change, and interventions was analyzed by documenting epidemiological, behavior, intervention, and policy indicators.

Results: Samples were typical of London injectors. HIV-1 prevalence rates declined from 12.8% in 1990, 9.8% in 1991, 7.0% in 1992, 6.9% in 1993. Statistical modeling suggests a decelerating decline, with no major confounders by subgroup or sampling bias. Major reductions in injecting risk behavior were documented post-1986, continued during first phases of study, and were maintained subsequently. Substantial injecting behavior change has followed implementation of risk reduction programs. There were no important changes in sexual behavior.

Conclusion: Behavioral and other hypotheses were examined as explanations for declining HIV-1 prevalence. The decline is attributed to changes in risk behavior following HIV prevention interventions. Comparative social analysis of epidemic trends is needed which links epidemiological, behavioral, intervention, and policy analysis. The London experience adds to the growing evidence of the significance of early interventions in encouraging behavior change and in limiting the spread of HIV infection.

No. 89D
SURVIVAL WITHIN LOW-THRESHOLD METHADONE PROGRAMS

Giel H.A. Van Brussel, M.D., *Mental Health, M.H.S. Amsterdam, PO Box 20244, Amsterdam 1000HE, The Netherlands;* Marcel C.A. Buster, M.S.

SUMMARY:

A differentiated, prevention oriented, "harm reduction" policy toward drug addiction has been implemented in Amsterdam for the past 15 years. The prevention of drug related harm concerns:

(1) Primary prevention; minimizing the onset of drug addiction among young people

(2) Secondary prevention; limiting the hazards of drug addiction

(3) Tertiary prevention; palliative care for those drug users not able to recover.

Data on the working of the Amsterdam integrated helping system will be presented. These data include results of a 10-year follow-up of a group of 2,000 drug users who participated in methadone services. This study focuses on overdose-mortality and other mortality among this group. This massive long-term observation enables us to evaluate the effectiveness and limitations of the Amsterdam low threshold methadone programs in regard to the life-threatening public health problem of drug addiction.

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3. Incidence of tuberculosis among drug addicts in Amsterdam methadone programmes. *European Journal of Public Health*; 5:253-258.

SYMPOSIUM 90—TREATMENT OUTCOMES IN THE MAJOR PSYCHIATRIC DISORDERS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to review the literature and evaluate the assessment of patients in naturalistic clinical settings in order to integrate outcome assessment into clinical practice and to judge the effectiveness of clinical services in community settings

No. 90A
LONGITUDINAL COURSE OF PANIC DISORDER

Mark H. Pollack, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC-815, Boston MA 02114;* Michael W. Otto, Ph.D., John W. Worthington, M.D., Jordan W. Smoller, M.D., Renee McLean, B.A., Jerrold F. Rosenbaum, M.D.

SUMMARY:

The longitudinal course of panic disorder is an issue of critical clinical and research importance. This information is important in understanding acute and long-term response to treatment, and the likelihood of sustained recovery or relapse during treatment and with treatment discontinuation. Information about the course of illness is also helpful in defining patients at risk for acute and long-term difficulties and examining the differential response of patient subtypes to therapeutic interventions.

In this presentation we will review follow-up studies of patients treated with pharmacologic and cognitive-behavioral interventions as well as longitudinal studies of patients treated naturalistically in the clinical setting. We will also present findings from our longitudinal study of panic disorder (N = 250) examining course of illness, response to pharmacologic and behavioral interventions, and predictors of outcome including the impact of childhood anxiety disorders on the long-term course of panic disorder in adulthood.

No. 90B
THE LONG-TERM COURSE OF DEPRESSIVE ILLNESS IN A NATURALISTIC CLINICAL SETTING

Wieslawa Tomaszewska, M.D., *Department of Psychiatry, NYU Medical School, 312 East 30th Street, #9A, New York NY 10016;* Eric D. Peselow, M.D., Ronald R. Fieve, M.D., Sunil D. Khushalani, M.D.

SUMMARY:

The utility of antidepressants in the long-term treatment of depression has been established in double-blind studies. One of the problems with the double-blind studies is their generalizability to clinical practice. For instance double-blind studies involving lithium show a 70% success rate over one to two years but naturalistic clinics studies have noted only a 40% response to lithium. Naturalistic studies regarding efficacy of antidepressants have been very scarce.

A total of 537 patients who were treated for depression and recovered—289 on tricyclics, 66 on MAOIs, 137 patients on SSRIs, and 45 patients on no medication—were followed from their seventh month of euthymic mood until one of three outcomes: termination well (remaining well until Oct. 1, 1994), dropout, and relapse. Patients were followed over a six-month to 12-year period (average follow-up time was 4.7 years). Probabilities of remaining free of a subsequent depressive episode for each drug class were assessed via a survival analysis. Overall 38% of the depressed sample had a known depressive episode despite receiving medication as compared with 84% on no treatment. The probability of remaining free of a depressive episode while on antidepressants was 86% at one year, 61% at two years, and 38% at five years. There were no differences between the three classes of antidepressants with respect to relapse rate.

In conclusion, in this naturalistic setting, long-term treatment with antidepressants, while more efficacious than no preventive treatment, still yields high rates of relapse. Where available, correlations between initial clinical symptoms, personality traits, and cognitive distortion and long-term course will be presented.

No. 90C
LONG-TERM OUTCOME IN BIPOLAR DISORDER

Michael J. Gitlin, M.D., *Department of Psychiatry, UCLA, 300 UCLA Medical Plaza, #2200, Los Angeles CA 90095;* Constance Hammen, Ph.D.

SUMMARY:

Manic-depressive illness was originally distinguished from schizophrenia by its better prognosis with discrete episodes, with typically complete remission to normal functioning between episodes. With the demonstration of mood stabilizer treatments beginning with lithium in the 1960s and 1970s, carbamazepine in the 1980s, and valproate in the 1990s, it was hoped that the long-term prognosis of manic-depressive illness (bipolar disorder) would show a marked improvement. Examining the relapse rates of the early controlled studies with lithium were supportive of the improved outcome with maintenance treatment. However, a series of larger scale naturalistic

studies have demonstrated a far more mixed prognostic picture with relapses common even with aggressive pharmacotherapy. This presentation will examine both the controlled and naturalistic studies, suggesting reasons why the results of the two sets of studies differ. Additionally, it will highlight some of the data from our own naturalistic study, which demonstrated a 73% relapse rate over five years in a cohort of bipolar I patients during continuous pharmacotherapy.

No. 90D
SCHIZOPHRENIA PREDICTORS OF LONG-TERM OUTCOME

Stephen I. Deutsch, M.D., *Department of Psychiatry, VA Medical Center, 50 Irving Street, NW, Washington DC 20422-0002;* Richard B. Rosse, M.D., Eric D. Peselow, M.D.

SUMMARY:

In the case of acute treatment for schizophrenia, the goals of treatment have been well delineated and emphasize reduction of key elements of psychosis (hallucinations, delusions, bizarre behavior, formal thought disorder). However, in the case of maintenance treatments therapeutic goals and treatment outcome have been less clearly delineated.

The purpose of this presentation is to evaluate and review the literature concerning important long-term issues in the management of the schizophrenic patient such as prevention of relapse and improvement in the quality of life (including a discussion of the management of negative symptoms). Pharmacologic treatment studies and issues involving constant or intermittent pharmacologic treatment will be discussed. Biological (prolactin, plasma HVA, methylphenidate, and amphetamine challenge) and clinical predictors of relapse will be presented. In addition, reviews of the literature regarding the efficacy of psychosocial treatments on relapse prevention and quality of life as well as the role of combined pharmacotherapy and psychosocial treatment for these parameters will be discussed.

Data from a sample of 100 patients who have attended a depot neuroleptic clinic over a 15-year period will be presented and clinical correlates associated with relapse as well as quality of life measures and consumer satisfaction of this mode of treatment will be presented.

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1. Pollack MH, Otto MW: Anxiety disorders: Longitudinal course and treatment. *Psychiatric Clinics of North America*, December 1995.
2. Kupfer DJ: Maintenance treatment in recurrent depression; Current and future directions. *British Journal of Psychiatry* 161:309-316, 1992.
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SYMPOSIUM 91—DIVERSITY IN PSYCHOSIS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant (1) should be able to accurately diagnose psychotic disorders in racial and ethnic minorities, and (2) should be able to use pharmacotherapy effectively, recognizing gender and ethnic issues.

No. 91A
TREATING PSYCHOSIS IN AFRICAN-AMERICANS

William B. Lawson, M.D., *Department of Psychiatry, Veterans Affairs Medical Cntr., 1482 West 10th Street (116A), Indianapolis IN 46202*

SUMMARY:

Psychotic disorders are often inappropriately treated among African Americans. Misdiagnosis is common. Schizophrenia is often over-diagnosed at the expense of manic-depressive illness and some anxiety disorders including obsessive-compulsive disorder and post-traumatic stress disorder. As a consequence antipsychotics are overused. Excessive dosing has been reported as well. Such an observation is interesting given recent data that African Americans may be at greater risk of abnormal involuntary movements. New antipsychotic agents offer the benefit of reduced side effects including lesser risk of abnormal involuntary movements. However, these agents tend to be more expensive and less available. These factors are especially important among African Americans with psychotic disorders because they are more likely to live with family and to get service in the public sector, which tends to have more restrictive formularies.

No. 91B
PSYCHOTROPIC RESPONSES IN ASIANS

Keh-Ming Lin, M.D., *Department of Psychiatry, Harbor-UCLA Medical Center REI, 1124 West Carson Street, Torrance CA 90002;* Russell Poland, Ph.D.

SUMMARY:

A large body of literature has indicated that Asian patients in general tend to respond to lower doses of neuroleptics as well as other psychotropics commonly used in the treatment of psychotic patients. At the same time, when treated with doses of psychotropics similar to those commonly prescribed for other ethnic groups, Asians appear to be significantly more likely to experience serious side effects. A series of studies have demonstrated pharmacokinetic, pharmacodynamic, as well as pharmacogenetic factors that may be responsible for such differences. In addition, sociocultural factors such as patients' culturally determined beliefs on the effect of medication, family involvement, compliance, and clinician-patient relationship, also powerfully influence patients' responses to medications, including those used in the treatment of psychotic patients. These factors as well as their clinical implications will be discussed in this presentation.

No. 91C
ANTIPSYCHOTIC TREATMENT OF ETHNIC MINORITIES

John M. Herrera, Ph.D., *Elmhurst Hospital, 79-01 Broadway, Elmhurst NY 11373*

SUMMARY:

A growing body of scientific evidence over the last two decades suggests that ethnic minorities may require lower dosages of antipsychotic medications for the treatment of schizophrenic symptoms. More recent studies have implicated the central role of genetic factors in the metabolism of these drugs as the biological basis for this differential response. This presentation will review three related studies that examine the use of typical and aytpical antipsychotic medications in Hispanic and Asian schizophrenics. Results will be discussed from studies with outpatient and inpatient samples, which replicate the finding that Hispanic and Asian schizophrenics are prescribed significantly less antipyschotic medication. In a third study with Hispanic and non-Hispanic subjects who entered into a

risperidone dosing trial, the results revealed a significant interaction effect for race, indicative of faster rate of symptom improvement on the part of Hispanic patients. The findings suggest that novel antipsychotic agents may be preferable for ethnic minorities, perhaps as a function of their relatively modest dopamine-D2 activity. The authors discuss these and related crosscultural findings and their implications for treatment of minority schizophrenics.

No. 91D
GENDER ISSUES IN THE DIAGNOSIS AND MANAGEMENT OF PSYCHOSIS

Freda C. Lewis-Hall, M.D., *Eli Lilly and Company, Lily Corporate Center DC2128, Indianapolis IN 46285*

SUMMARY:

Over the past decade, new research and clinical tools have led to major advances in the diagnosis and management of psychosis.

Although overall advances are substantial, advances in understanding the impact of gender on presentation, diagnosis, and management has been somewhat less substantial.

This presentation will provide a review of available information on the role of gender in this arena.

Epidemiologic, disease presentation, diagnostic dilemma, and treatment outcome data will be discussed.

No. 91E
MANIFESTATIONS OF PSYCHOSIS IN BLACKS

Michelle O. Clark, M.D., *Department of Psychiatry, UCSF/SF General Hospital, 1001 Potrero Ave., Room 7B-21, San Francisco CA 94110*

SUMMARY:

The manifestation of mental illness occurs when a person's thinking and/or behavior vary from that considered normative. Behavioral norms are determined within the context of an individual's cultural milieu. A key to the successful treatment of mental illness is to accurately assess the cause. In the process toward diagnosis in psychiatry the interpretations of the clinician determine outcome. It is therefore essential that a clinician be familliar with a patient's cultural norms when attempting to make a diagnosis.

The new world culture in the United States strengthened itself for centuries by fostering the concept of a melting pot of cultures. In this process individuals were rewarded for abandoning distinctive ancestral behaviors that set them apart from the majority culture. More recently our population is becoming increasingly diverse. Generations later people are reclaiming their cultural heritage. This reclaiming of roots is particularly challenging in the case of persons of African descent (blacks) due to the many myths and stereotypes surrounding their history and culture. The continued existence of racism impedes the overall development of this subculture in our country. It has a profound effect upon the manifestations of mental illness as evidenced by the over-representation of this subgroup in more severe diagnostic categories and more restrictive treatments.

This presentation will review the attitudes, knowledge, and skills required to achieve cultural competence in psychiatric treatment of black populations.

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3. Lin K, Finder E: Neuroleptic dosage for Asians. *Am J Psychiatry*, 140:490-491, 1983.
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SYMPOSIUM 92—ANTISOCIAL PERSONALITY DISORDER AND SUBSTANCE ABUSE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant will have a better understanding of the diagnosis and assessment of antisocial personality disorder and psychopathy in substance abusers, and a greater knowledge of the role of childhood trauma in the genesis of antisocial personality among substance abusers, as well as of the treatment response and outcome in antisocial substance abusers.

No. 92A
SUBSTANCE-INDUCED PERSONALITY DISORDERS

Bruce J. Rounsaville, M.D., *Department of Psychiatry, Yale University, 34 Park Street, New Haven CT 06519;* Roel Verheul, M.A., Wim Van den Brink, M.D., C. Hartgers

SUMMARY:

Distinguishing between personality disorder symptoms that are independent (I) vs. substance-related (SR) is a particular challenge for diagnosing comorbid Axis II disorders in substance abusers. DSM-IV guidelines currently recommend excluding Axis II symptoms that are accounted for by an Axis disorder, including a substance use disorder. In this study, Axis II diagnoses were made on a heterogeneous clinical sample of 370 patients entering treatment for substance use disorders.

We used a version of the Structured Clinical Interview for DSM-III-R (SCID-II), which was modified to determine, on an item-by-item basis, whether symptoms were attributed to subjects' substance use disorders (SR) or independent (I) of these disorders.

The majority (55.9%) of substance use disorder patients met criteria for at least one comorbid Axis II disorder, with Cluster B (45.7%) being particularly prominent, especially antisocial personality disorder (ASP) (27%) and borderline personality disorder BPD (18.4%). Notably, inclusion of SR symptoms led to a substantial number of newly diagnosed cases, especially for ASP (19.2%) and BPD (11.4%). Including SR symptoms improved the reliability of ASP and did not change the reliability of BPD diagnoses. Generally, patients with SR and one ASP and BPD diagnoses differed those without these diagnoses in a similar pattern.

Substantial numbers of substance abusers present with symptoms of Axis II disorders, which they attribute to their substance use disorder; however, these "substance-related" disorders, particularly ASP and BPD, demonstrate reliability and validity similar to that of "independent" disorders. Thus, exclusion of substance-related symptoms may lead to missed diagnoses of clinically significant syndromes.

No. 92B
ANTISOCIAL PERSONALITY DISORDER AND PSYCHOPATHY IN WOMEN COCAINE ABUSERS

Megan J. Rutherford, Ph.D., *Department of Psychiatry, University of Pennsylvania, 3900 Chestnut Street, Philadelphia PA 19104;* John S. Cacciola, Ph.D., Arthur I. Alterman, Ph.D.

SUMMARY:

This presentation examines the relationship of psychopathy to antisocial personality disorder (APD) according to five diagnostic systems. Psychopathy was assessed using the Revised Psychopathy Checklist (PCL-R; Hare, 1991). APD was diagnosed according to the Feighner Criteria, Research Diagnostic Criteria (RDC), DSM-III, DSM-III-R, and DSM-IV in 137 cocaine dependent women. Nineteen percent scored in the moderate to high range on the PCL-R. Rates of APD were 76% using Feighner Criteria, 61% for DSM-III, 31% for DSM-III-R, 26% for DSM-IV, and 11% for the RDC. With the exception of the RDC, over 75% of women satisfied adult APD criteria in all systems. Therefore, a primary reason for the differences in diagnostic rates appears to be the emphasis on and nature of the childhood APD criteria among the diagnostic systems. Of the 26 women in the moderate to high range on the PCL-R, all were diagnosed with APD according to DSM-III and Feighner Criteria, but only 15 were diagnosed according to DSM-III-R, 12 under DSM-IV, and 6 using RDC criteria. The emphasis placed on personality traits, childhood behaviors, and involvement of drug-related behaviors in each of the systems used to assess APD affects the degree of overlap found between APD and psychopathy.

No. 92C
TRAUMA AND ANTISOCIAL PERSONALITY IN DRUG ABUSERS

David P. Bernstein, Ph.D., *Department of Psychiatry, Mt. Sinai Hospital, 130 West Kingsbridge Road, Bronx NY 10468;* Leonard Handelsman, M.D., Laura Travaglini, M.A., Joseph Ruggiero, Ph.D., Paul Rinaldi, Ph.D.

SUMMARY:

Rationale: In this study, we examined the relationship of childhood trauma to antisocial personality in 62 heroin or cocaine dependent male patients.

Methods: Patients receiving inpatient drug detoxification were screened for antisocial features; selected patients completed a battery of structured interviews, including the Revised Psychopathy Checklist (PCL-R), Structured Interview for DSM-III-R Personality Disorders - Revised (SIDP-R), and the Childhood Trauma Interview (CTI).

Results: 48 patients (77%) met DSM-III-R criteria for antisocial personality disorder, while 16 (26%) met criteria for psychopathy (PCL-R score ≥ 25), a severe variant of antisocial personality. Frequency and severity of childhood physical abuse were highly predictive of psychopathic tendencies on the PCL-R ($r = .61$, $p < .001$, $r = .42$, $p < .01$, respectively, with the PCL-R total score). In contrast, other forms of maltreatment, such as sexual abuse, emotional abuse, and neglect were poorly correlated with psychopathy scores. Over 50% of psychopathic substance abusers reported physical abuse that occurred more than once per week and caused injuries, while none reported infrequent abuse. Psychopathic substance abusers were also more likely than nonpsychopaths to commit violent crimes ($p < .01$) and meet DSM-III-R criteria for PTSD ($p < .05$).

Discussion: These findings suggest that very frequent and severe physical abuse may play a role in the genesis of psychopathy. Implications for the prevention of both substance abuse and psychopathy will be discussed.

No. 92D
PREDICTING TREATMENT OUTCOME IN ANTISOCIAL ALCOHOL-DEPENDENT PATIENTS

Roel Verheul, M.A., *AIAR, Jacob Obrechtstraat 92, Amsterdam 1071 KR, The Netherlands;* Wim Van den Brink, M.D., Maarten W.J. Koeter, Ph.D., C. Hartgers

SUMMARY:

Although antisocial personality disorder (APD) is widely considered a robust predictor of poor treatment response and outcome, the available studies actually do not confirm this hypothesis. This inconsistency may be accounted for by two alternative explanations. First, the APD criteria set may identify a heterogeneous group of patients; within this group, other characteristics (e.g., psychopathic traits, absence of comorbid depression, ability to form an alliance with the therapist) distinguish those who respond well from those who respond poorly to treatment. Second, whether an effect on outcome is detected or not, strongly depends on the specific diagnostic criteria employed (e.g., in terms of time-frame requirements: lifetime vs. recent diagnosis). The aim in the current study is to examine the predictive value of APD in 432 male alcohol dependent patients. In addition, the two hypotheses mentioned above are tested using logistic regression analysis. Analyses will be controlled for pretreatment status. APD is assessed with the Composite International Diagnostic Interview (CIDI). Pre- and post-treatment status are measured by the European version of the Addiction Severity Index (EuropASI). The implications for APD assessment and diagnosis are discussed.

No. 92E
TREATMENT RESPONSE AMONG PERSONS WITH ANTISOCIAL PERSONALITY DISORDER

George E. Woody, M.D., *Drug Defense Treatment Ut, Philadelphia VAMC, 39th & Woodland Avenues, Philadelphia PA 19104;* Arthur I. Alterman, Ph.D., Megan J. Rutherford, Ph.D., John S. Cacciola, Ph.D., Thomas McLellan, Ph.D., Charles P. O'Brien, M.D.

SUMMARY:

A number of studies have shown that persons with antisocial personality disorder (APD) do not respond as well to substance abuse treatment as persons with no additional psychiatric disorder. This finding is sometimes interpreted to mean that APD is a uniquely negative prognostic indicator and that treating persons with this disorder is a waste of time. Data will be presented indicating that substance abuse treatment, particularly methadone maintenance, can have a substantial positive effect on persons with APD. Though most studies show that APD is associated with less response to treatment, and clinical experience indicates that their behavioral problems can make them very difficult to manage, they can benefit considerably from treatment even though they may not respond to the same degree as persons with no additional psychiatric disorder.

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with and without major depression, *Journal Nervous and Mental Disease*, in press, 1996.

SYMPOSIUM 93—THE PROFESSIONAL WOMAN: LIFE IN PERSPECTIVE
APA New York County District Branch's Committee on Women

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

This symposium will enable participants to become more conversant with conflicts and challenges in relationships of professional women. The identification of these issues in patients and colleagues will be readily discernable.

No. 93A
THE DATING GAME: ISSUES FOR SINGLE FEMALE PATIENT'S THERAPIST

Ann R. Turkel, M.D., *350 Central Park West, New York NY 10025-6547*

SUMMARY:

Many women approaching 30 enter treatment when they face the possibility that they may remain single, which may promote a sense of defectiveness and impaired self-esteem. These patients often choose women therapists to avoid a sexualized or potentially authoritarian transference, for the therapist's maternal attributes, and/or to furnish role models. The therapist's attitudes and values may influence the clinical formulation, choice of treatment modality, and even the focus of therapy.

While female patients may not be inclined to acknowledge the female clinician's authority, they may more readily expect and recognize their therapist's empathy. And even mild empathic responses may be translated by the patient into indications of nurturance. This can inhibit anger and foster too much dependency.

Countertransference issues may lead to over-indentification with patients and to therapists projecting their own experiences onto them. In addition, therapists may encourage a more intimate, more distant, or more egalitarian relationship than is helpful to the patient.

The therapeutic alliance also means examining the real relationship. A demand for the therapist to be more "real" may reflect negative transference. If the therapist shares more about herself, the gulf in the relationship may be increased by the disappointment over the misinterpretation.

No. 93B
GENDER ISSUES IN THE WORKPLACE

Carol A. Bernstein, M.D., *Department of Psychiatry, NY University Medical Center, 550 First Avenue, NB 20N11, New York NY 10016*

SUMMARY:

Much has been written about different ways in which men and women are perceived in the workplace. Deborah Tannen's book, *You Just Don't Understand,* has received widespread publicity. Some have attributed different perceptions and communication styles to biological differences in "wiring." Others believe that such differences are more environmentally driven and may represent subtle forms of discrimination and harassment. The author will discuss gender issues in the workplace with specific examples and will consider implications for the professional advancement of women in medicine as well as other fields. The psychological consequences of gender discrimination will also be explored.

No. 93C
CHALLENGES IN THREE GENERATIONS OF PROFESSIONAL WOMEN

Marianne Horney-Eckardt, M.D., *3066-A Via Serena South, Laguna Hills CA 92653*

SUMMARY:

The paper will briefly highlight dominant concerns (1) in the life of my mother Karen Horney, a pioneering professional woman, (2) in my life or the generation I belong to, and (3) in the lives of my daughters. While the issues are individually determined, they are also reflective of our respective generations.

Karen Horney was pioneering in her early decision to become a doctor, to enter barely discovered psychoanalysis, and in her protest against men's definition of women as weak, emotional, and intellectually limited.

My generation happily accepted the easy access to a professional career, but also accepted the fact that this privilege carried with it the responsibility for multiple roles. My generation was transitional consolidating gains made.

In my daughters' generation new fundamental cultural changes took place. Men became partners. New priorities arose on the professional front. Wives' and husbands' careers had equal priorities and new solutions had to be found.

No. 93D
THE PROFESSIONAL MOTHER: A CONTEMPORARY QUANDARY

Ildiko Mohacsy, M.D., *1065 Park Avenue, New York NY 10028*

SUMMARY:

The professional woman entering motherhood has to balance both her career and her children. As women gained increased control over reproductive decisions, their choices for personal fulfillment became more complex. The options women now enjoy, however, do not necessarily mean that they can "have it all." Guilt often accompanies a choice favoring either their career or their children. Biological fulfillment can be an integral part of a woman's life goals. In a society that places a low value on child rearing, it is difficult to meet both professional and parental demands. Many women work both as professionals and as mothers. The maternal instinct refers to the physical connection between mother and child. In our patriarchal society, men's suppression of their anima is encouraged and, with it, their maternal instinct. Because of this, mothering has been underrated by those in positions of power. Professional women have felt that they must choose between their career and their children. New solutions for coordinating parenthood with the demands of the workplace will emerge by recognizing the critical importance of child rearing and by improving the standing of motherhood in our culture.

No. 93E
HUSBANDS OF PROFESSIONAL WOMEN

Martin Symonds, M.D., *325 Clinton Avenue, Dobbs Ferry NY 10522*

SUMMARY:

As part of the continuing studies of dual career couples, which was started by my late wife Dr. Alexandra Symonds and myself after years of being involved with, both on a professional and personal level, dual career couples, this paper will focus on the husband of the professional woman.

In studying dual career marriages, the writer has observed the personality traits of the husbands of professional women that made it possible for them to contribute to the successful resolution of conflict in the areas of communication, intimacy, sharing, boundaries, power, and of dependency/independency, that occur in all marriages.

Some of these traits were, nurturing, noncompetitive enabling, self-sufficient, willing, and confortable to be in the background of the professional wife. They also possessed traits that allowed them to be able to have:

1. A cooperative, noncompetitive attitude and genuine pleasure in each other's accomplishments.
2. Mutual respect for each other's privacy, competency, rhythms, opinions, judgments, and decision making.
3. Nurturing of each other's idealized image.
4. Mutual active participation in decision making. Decision about vacations, friends, finances, etc., must be reached by consensus.
5. The capacity to listen to one another and give the other psychological room and space.

The paper will support and corroborate these observations by presenting clinical examples.

No. 93F
THE PROFESSIONAL WOMAN AS A DAUGHTER

Marian A. Ormont, M.D., *Department of Psychiatry, St. Lukes-Roosevelt, 230 Central Park West, #3K, New York NY 10024*

SUMMARY:

Over the last 40 years women have become increasingly able to establish themselves in society as professionals in many fields. The intricate, and invariably present, emotional and practical aspects of a daughter's relationship with her parents are made more complex by her assumption of a professional role. The combination of dynamic family issues, parental attitudes and expectations, a daughter's vision and professional identity, and prevailing sociocultural values creates a complex, multidimensional milieu. As daughters grow professionally, they may challenge the relatively static family structure. Parents often view the professional daughter in a different light than the nonprofessional daughter; she may be considered a success, an innovator, a failure, or a rebel.

The professional woman as a daughter is a multifacted topic, which can be viewed from many angles. It encompasses the relationship of a professional woman with her parents across the life cycle as well as the impact of culture, society, and morals on this relationship. Intergenerational differences in attitudes and expectations created by the women's movement of the 1960s affect parent-daughter relationships. The professional woman's relationship with her parents will be discussed within the framework of the women's movement of the 1960s and prevailing cultural, societal, and moral values.

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4. Chodorow, N: *The Reproduction of Mothering: Psychoanalysis and the Sociology of Gender*, University of California Press Berkeley, 1978.
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SYMPOSIUM 94—YOUTH SPORTS: CHARACTER BUILDING OR CHILD ABUSE?

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should (1) Have an understanding of how the youth experience interacts, positively and negatively, with child and adolescent psychological and physical development; and how professional athletes influence young athletes. (2) Understand the "achievement by proxy" and the female athlete triad concepts. (3) Conceptualize the role of the psychiatrist in promoting public awareness of the above and in educating the governing bodies of various youth sports so that the physical and psychological development and well-being of our children are given utmost priority.

No. 94A
THE HIGH COSTS OF SPORTS MANIA: ATHLETICS AND DEVELOPMENT

Barri K. Stryer, M.D., *Department of Psychiatry, UCLA, 1762 Westwood Boulevard, 440, Los Angeles CA 90024*

SUMMARY:

In the United States, 27 million children aged 6-18 are involved in an organized athletic program and another 20 million in less structured sports. These numbers continue to increase. The purpose of this talk is to provide an overview of the interaction between youth sport participation and psychological development. The benefits of youth sports, research on attrition, motivation, self-concept and stress, the potential negative sequelae of participation, and recommendations for the role of psychiatry in youth sports will be discussed. Sport participation may enhance psychological development, promote positive self-concept, and provide a myriad of important developmental experiences and skills. However, there is enormous risk during this vulnerable developmental period for a negative experience detrimental to self-concept and ultimate functioning. The majority of youngsters have enjoyable, relatively stress-free athletic experiences. For some, however, stress is significant, negating the positive effect such an experience can have on development and potentially leading to medical and psychological sequelae. Intensive sport participation may preclude other important developmental experiences. Performance anxiety and competitive stress have been related to negative parental and coach or teacher interactions, fear of failure, and amount of fun experienced. Competitive stress, after a certain point decreases performance, causes sleep disturbances, decreases enjoyment, increases injury rates, and contributes to anxiety and attrition. Excess stress has been seen to lead to dysthymia, depression, chronic fatigue, substance abuse eating disorders, burnout, malingering, conversion disorder, reflex sympathetic dystrophy, and adjustment disorder.

No. 94B
TRAINING/DEVELOPMENT MISMATCH

Daniel M. Begel, M.D., *316 N Milwaukee Street, #318, Milwaukee WI 53202-5803*

SUMMARY:

Although the behavioral problems of adolescent athletes may originate in earlier years, the families and coaches of troubled adolescent athletes are frequently surprised by the onset of difficulties. The capacity for concrete cognitive operations, along with the relative emotional quiescence that characterizes the latency years, renders athletes quite eager, prior to adolescence, to do whatever is asked of them by coaches and parents. The models of training and competition provided to these athletes, however, are often inappropriate for their age. Specialization, systematic training cycles, and excessive emotional value placed on winning are prematurely imposed and, often, enthusiastically accepted. Deprived of the opportunity for experimentation and spontaneous socialization that is an important part of athletic development, such athletes are poorly equipped to handle the new challenges of sports in adolescence.

Therapeutic work with adolescent athletes benefits from a willingness of the parents to understand their own needs for their child's athletic success. Psychoeducation with parents and coaches can provide specific alternatives that take into account the evolving capacities of young athletes.

No. 94C
LITTLE LEAGUE OR MAJOR LEAGUE: WHO CAN TELL AT TIMES?

Ronald L. Kamm, M.D., *257 Monmouth Road, #A-5, Oakhurst NJ 07755-1502*

SUMMARY:

The childhood experience of playing baseball, our national pastime, has changed greatly in the past 25 to 30 years. Where youngsters used to play in self-organized fashion on vacant lots and playgrounds, children today are "signed up" for Little League, thereby entering a very adult world of supervision, organization, and, in some cases, Machiavellian chicanery.

At it's best, the Little League experience can foster growth, confidence, and skill development in children who might have been excluded or ridiculed in sandlot days. Too often, however, the Little League "team"—with its uniforms, 12-week schedule, draft, formal practices, photos, and, sometimes standings—comes too closely to resemble a Major League team in the psyche of player, coach, and parent, all of whom then gravitate toward a "win at all costs" mentality.

Coaches, seeing the team as an extension of themselves, put winning before their two main tasks—teaching fundamentals to all of the players, and providing a fun experience.

Parents, living vicariously through their child's exploits, yell outrageous things from the stands, putting undue pressure on their and other children, and creating stress, which often carries over into the home.

Suggestions are given in this presentation for a new approach to the Little League experience, stressing primary prevention through education of parents, coaches, and players. The subjects of girls' softball and co-ed baseball are also touched on, as is the sticky situation that exists when a parent decides to coach his or her child's team.

No. 94D
SYSTEMIC ABUSE IN ELITE WOMEN'S GYMNASTICS: AN EXAMPLE OF EXTREME "ACHIEVEMENT BY PROXY" BEHAVIOR

Ian R. Tofler, M.B., *Department of Psychiatry, Children's Hospital, 200 Henry Clay Avenue, New Orleans LA 70118;* Barri K. Stryer, M.D., Lisa R. Herman, M.S.

SUMMARY:

Elite youth sport provides an excellent template for evaluating the current practices and trends upon which virtually all competitive youth sports are based. The authors examine one elite sport, women's gymnastics, and identify the major medical and psychiatric sequelae of intensive training. Recent attempts from within the sport to monitor itself in response to negative publicity are discussed. The difficulties experienced within women's gymnastics, in extreme cases, can be conceptualized as a variant of child abuse. The authors describe the behavioral continuum that may lead to "achievement by proxy" abuse: exploitation of a child, with that child's willing collusion, occurs to gratify the perpetrating adult and adult system's ambitions for achievement via vicarious success and collateral benefits. To address these concerns, recommendations are suggested that could be used as a model for supervision at all levels of competitive youth sport. The goal of these recommendations is to provide a balance between the excitement and benefits of competition, while protecting the physical and mental integrity of our youth. These strategies require the involvement of internal and independent regulatory bodies. Education and primary prevention, in addition to the promotion of mental, physical, and social development, enable talented youngsters at all competitive levels to be supported rather than crippled by their sport as they enter adulthood.

No. 94E
THE PRO ATHLETE AS ROLE MODEL

Ira D. Glick, M.D., *Department of Psychiatry, Stanford University, 401 Quarry #2122, Stanford, CA 94305*

SUMMARY:

Introduction: In most primitive as well as modern cultures, the athlete is viewed as a positive role model for emotional development in children. How did this notion evolve? Is it based on any data? Is it true?

Method: First I present a synopsis of the history and meaning to the culture of sports. Next using basketball as an example, I detail the "psychology" of that sport for the individual, the family and the community in which it exists. Lastly I summarize the literature examining the relationahip of emotional maturity and athletic achievement.

Results: Evolving from "warrior" to "athlete" as a representative of the culture, the notion that superior athletic achievement is synonymous with high emotional maturity has deep historical roots and has increasingly pervaded our culture. Although some professional players achieve both, the limited data available fails to support the hypothesis that they are significantly correlated, i.e. athletes had similar emotional developmental levels as non-athletes. Case examples are presented.

Conclusion: Good athletes can be positive role models for the concept that hard-work, desire and dedication equal achievement, but in general they are no better than non-athletes as examples of mature development for children to emulate.

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SYMPOSIUM 95—HUMAN VIOLENCE: BIOPSYCHOSOCIAL PERSPECTIVES
APA Corresponding Task Force on National and International Terrorism and Violence

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

Participants will learn new data from neurobiology, sociobiology, developmental psychology, social sciences, and psychiatry that help us to understand and better modulate sources of human violence, as seen in antisocial personality, child abuse, disordered social conditions, dominance struggles, and paranoid process.

No. 95A
THE SOCIOBIOLOGY OF HUMAN VIOLENCE

John O. Beahrs, M.D., *Department of Psychiatry, Oregon Health Sciences Univ, PO Box 1036, Portland OR 97207*

SUMMARY:

Increasingly important in psychiatry is the treatment of violent offenders and their victims, as well as the prevention of violence. This paper reviews four areas where sociobiology contributes to understanding sources of violence: i.e., alternative reproductive strategies, parent-child conflict, competition for status, and the function of enemies. Contributing to antisocial behavior is an alternative reproductive strategy for disadvantaged organisms. Sociobiology also predicts significant degrees of parent-child conflict. Foster parenting weakens the natural constraint of shared genetic interest, resulting in increased likelihood of child abuse. Demoralization and low interpersonal status favor the use of potentially violent high-risk strategies in dominance struggles. Finally, cooperation in the face of conflicting interests is enhanced by common enemies, increasing the potentials for violent conflict. Discussion will explore points of impact at which psychiatrists, individually and collectively, can modulate these processes toward the containment of human violence.

No. 95B
THE NEUROBIOLOGY OF AGGRESSION

Michael McGuire, M.D., *Department of Psychiatry, Neuropsychiatric Institute, 760 Westwood Plaza, Los Angeles CA 90095*

SUMMARY:

Findings from studies predominantly of male vervet monkeys (*Cercopithecus aethiops sabaeus*) point to the following aggression-influencing factors: age, sex, status, context, CNS serotonin and norepinephrine activity, and circadian rhythms. The frequency of aggression increases dramatically toward the end of adolescence and levels off throughout adulthood, and it is greater in age- and status-matched adolescent and adult males than females. Low status males engage in aggression more frequently than high-status males. Aggression among adult males is least frequent in group contexts, most frequent in two-male contexts. A reduction of CNS serotonin or an increase in CNS norepinephrine dramatically increases the frequency of aggression; serotonin-induced aggression is 'purposeful' while norepinephrine-induced aggression is not. Aggression is more frequent during mid-morning and mid-afternoon, times in which animals are most actively socializing. Original data are presented on each of the preceding relationships. The neuroanatomy of aggression is not reviewed. Previous studies of vervet monkeys are extrapolated to humans. It is argued that studies of aggression in humans with and without disorders need to address the influences of age, sex, status, context, CNS neurotransmitter states, and circadian variables.

No. 95C
DEVELOPMENTAL ISSUES IN ANTISOCIAL VIOLENCE

Thomas J. Dishion, Ph.D., *Department of Psychology, Oregon Social Learning Center, 207 East 5th Street, #202, Eugene OR 97401*

SUMMARY:

Conduct disordered behavior is shaped in early development when temperamentally coercive children with ineffective parental limit setting become excessively aggressive. This leads to peer rejection soon after school entry, consolidating the disorder. Not all of these children will eventually become violent, nor do they lack friends altogether. Further shaping occurs during adolescence. This paper examines to what extent male adolescent friendships are associated with violent behavior patterns in early adulthood. A total of 206 boys were observed discussing coping strategies with close friends at ages 13-14, 15-16, and 17-18. Despite transience of specific friendships, there was considerable continuity in the boys' relationship processes, especially in respect to their discussion topics. Positive reactions to rule-breaking topics were associated with subsequent violent antisocial behavior. Using both criminal records and self-reports, and controlling for the boys' pre-existing antisocial behavior and their families' discipline practices, further analyses test the extent to which specific violent content material is associated with subsequent violence.

No. 95D
THE DYNAMICS OF VIOLENCE

L. Gordon Kirschner, M.D., *3421 Garrison Street, NW, Washington DC 20008*

SUMMARY:

Violence occurs when a system has been driven to the extremes, that is, when rigid, simple, narrow possibilities are all that remain, and the wide range of a fluid, flexible, graded repertoire has been foreclosed. Violence so defined includes physical, psychological, political, military, intended, careless, sadistic, and indifferent destruction. The subjective experience of violence manifests this same nature when described by people who have been violent. Such is found in personal memoirs and is observed in our patients. Crowding, poverty, and social disorganization contribute to violence by the constriction of possibility. Experimental neurobiology of violence reflects this same narrowing in range of potential reactions shown, for example, in studies of animals' vasopressin and serotonin systems, where stress that produces violent behavior also compromises the range of brain systems. Study of nonlinear, dynamic systems reveals patterns in self-organized criticality in which catastrophic events occur. Application of this principle to human development and personality will help to define conditions that lead to violent behavior.

No. 95E
THE ROOTS OF PARANOIA

Jerrold M. Post, M.D., *Political Psychology, George Washington University, 2013 G Street, NW, Ste 202A, Washington DC 20052*

SUMMARY:

In considering the biological and psychological roots of violence, it is important to consider what determines the target of violence. The identification of the enemy, the object of violent attack, has both biological and psychological roots. This paper considers the roots of paranoia from these twin perspectives. We are "hard wired" to fear the enemy. Evolutionary biology suggests it is adaptive to be suspicious of the other, to conceal intentions, to penetrate simulation of amity. Yet at the same time there are adaptive advantages to cooperation. From the perspective of developmental psychology, "stranger anxiety" is found at eight months. Distinguishing between the "me" and the "not me" is critical to the process of identity formation. Identification with familiar objects is the foundation of nationalism; fear of unfamiliar objects is the foundation of the concept of the enemy. Especially at times of social distress, there is a readiness to project inner rage at suitable targets of externalization, enemies who have been identified by political demagogues. These identified enemies then become legitimated targets of violent attack.

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5. Post J, Robbins R: *Political Paranoia: The Psychopolitics of Hatred*. Yale University Press, 1997.

SYMPOSIUM 96—CURRENT CONTROVERSIES IN CHILD CUSTODY: WHAT WE DO AND DON'T KNOW

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the end of this presentation, the participant should be aware of the research data (and its limitations) concerning controversial issues in custody determinations.

No. 96A
ATTACHMENT LOSS AND RESTITUTION IN MAN

Justine D. Call, M.D., *Department of Psychiatry, UC Irvine, 1958 Galaxy Drive, Newport Beach CA 92660*

SUMMARY:

Studies of attachment will be reviewed beginning with Darwin (1872) and including John Bowlby's work (1944-1988) on attachment and loss in infancy; Bowlby's (1953) description of the infant's separation response of protest, withdrawal, and avoidance; and Robertson's (1953) and Heinecke's (1966) study and follow-up of the infant's response to brief separations from a few days to two weeks. The basic motivation for mother-infant attachment as found in ecological, psychoanalytic, and learning theory together with the development and inter-relationship between attachment and the language of affects (Call 1995) in infancy will be reviewed. The ontogenesis of the attachment process and short- and long-term consequences to loss will be described.

In addition, Mary Ainsworth's semi-structured separation-reunion studies as observed in American, African, and Japanese infants resulting in secure, avoidant, anxious, other, and mixed types at one year of age will be presented. Also, Mary Main's follow-up studies of American infants so classified and then seen again at five years, eight years, and during adolescence will be presented. Results of the studies of the mothers correlated with their infants by type will be evaluated utilizing the adult attachment interview (AAI).

Correlates of brain development and relevance for adoption policy practice will be cited.

No. 96B
JOINT CUSTODY AND SOLE CUSTODY: CLINICAL, LEGAL AND GENDER ISSUES

Wade C. Myers, M.D., *Department of Psychiatry, University of Florida, PO Box 100256/JHMHC, Gainesville FL 32610-0256*

SUMMARY:

This paper presentation will focus on pertinent clinical, legal, and gender issues pertaining to joint custody and sole custody. Historically, custody disputes were often settled by awarding custody to one parent. Over the past few decades there has been a shift in judicial emphasis, as well as legislative changes, so that many states now advocate joint custody over sole custody, unless there are compelling reasons to do otherwise. For example, Florida mandates shared parental responsibility unless there is a finding that it is not in the best interests of the child.

There is a growing body of research on child custody that can be helpful in making recommendations to the courts, as long as it is clinically supported. For instance, chronic high levels of hostility between parents following divorce bode poorly for joint custody. There is some evidence that boys may do better in father custody families, while girls may do better in mother custody families. Frequent visitation is best when interparental conflict is low.

In summary, there are no generalizations that can be applied to custody evaluations. Each divorcing family going through a custody dispute must be looked at individually to determine what will be the best arrangement for the children.

No. 96C
REVISITING THE TRANSRACIAL ADOPTION CONTROVERSY

Yvonne B. Ferguson, M.D., *Department of Psychiatry, University of SF-Fresno, 1212 West Main Street, Visalia CA 93291*

SUMMARY:

Although same race adoptive placement is preferred, all other variables being equal, detrimental psychological scarring can occur if extant transracially placed children are removed from their homes after bonding has occurred. Nor should African-American children be allowed to languish indefinitely in foster homes while the perfect family is sought.

The National Association of Black Social Workers believes that only African-American parents can teach African-American children how to cope with racism. In 1990 a California law took effect that requires adoption agencies to spend 90 days trying to match children ethnically before allowing transcultural placement. Eighty-five percent of African-American families who apply for adoption through government agencies are turned down, yet approximately 40% to 50% of all foster children are African American. Whether concerned agencies are making good faith efforts to comply with the spirit of the law will be examined.

Recommendations for children already placed transracially include family support groups such as Interracial Pride in Northern Califor-

nia. Additionally, transracially adoptive parents can live in mixed neighborhoods in order to provide their children with same-race role models and mentors. If parents plan to adopt more than one child, the child should be from the same racial group. This provides sibship support for the adopted children.

No. 96D
GAY AND LESBIAN PARENTING

Margery S. Sved, M.D., *Adult Psychiatry, Dorothy Dix Hospital, South Boylan Avenue, Raleigh NC 27603-2176;* Debbie R. Carter, M.D.

SUMMARY:

Custody cases involving gay male and lesbian parents and their children are some of the most complex and challenging judicial determinations in which mental health professionals participate. The use of sexual orientation in custody hearings has often been based on prejudice rather than scientific evidence or the best interest of the child. Knowledge of the common negative and incorrect assumptions about lesbian and gay male parenting is essential for the professionals involved in such custody cases. This paper will review the current research and literature about the development of children of lesbian and gay parents, about issues for gay men and lesbians who are parents, and about custody issues for gay men and lesbians. Areas of further family research needed to assist mental health professionals will also be outlined.

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SYMPOSIUM 97—GAMBLING: BIOLOGICAL/GENETIC, TREATMENT, GOVERNMENT AND GAMING CONCERNS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to diagnose pathological and problem gamblers; recognize associated and complicating factors; be familiar with recent genetic and neurobiological findings; understand the role of medication and behavioral treatments; and appreciate social and political factors that contribute to this problem.

No. 97A
GAMBLING: OVERVIEW AND NEW PHARMACOLOGICAL TREATMENTS

Eric Hollander, M.D., *Department of Psychiatry, Mt. Sinai Medical Center, 1 Gustave Levy Place, New York NY 10029;* Concetta M. Decaria, Ph.D., Cheryl M. Wong, M.D., Jee Kwon, B.A., Lorraine Simon, M.A.

SUMMARY:

Recent surveys have suggested a substantial increase in the prevalence of pathological gambling (PG), from 4.6% to 7.3% in New York State over the past 10 years. Other studies suggest a direct correlation between increased access to legalized forms of gambling and the number of Gamblers Anonymous groups in any community. In addition to impulsive and addictive features of pathological gambling, there is a prominent compulsive core, along with difficulty inhibiting the repetitive nature of the gambling behavior. Given these phenomenological similarities between PG and OCD, we carried out two controlled trials with "antiobsessional" serotonin reuptake inhibitors (SRIs). An initial pilot study of clomipramine (CMI) and placebo demonstrated greater decrease in gambling behavior in five PG patients with CMI. Next, ten PG patients completed a blind, crossover trial of the SSRI fluvoxamine (8 weeks) and placebo (8 weeks). Patients were on average 42 years of age, had a 21-year gambling duration, all had positive family history of gambling, and half lost >$10,000 in a single day. Seven out of 10 (70%) were noted to be endpoint fluvoxamine treatment responders, judged by both 25% decrease in PG-YBOCS score, and PG-CGI improvement of much/very much improved. Mean fluvoxamine dose for responders was 210 mg/day, and 2/3 of nonresponders had comorbid cyclothymia. PG is becoming an ever greater public health concern, and new pharmacological treatments with SSRIs appear promising.

No. 97B
THE GENETICS OF PATHOLOGICAL GAMBLING

David Comings, M.D., *Medical Genetics, City of Hope, 1500 East Duarte Road, Duarte CA 91010*

SUMMARY:

Pathological gambling is an impulse disorder that has many similarities to alcoholism and substance abuse (SA). These include an aroused euphoric state, feeling a high, craving more action, and withdrawal symptoms. Because of this, we postulated that a genetic defect in the dopaminergic reward pathway might be a risk factor. Prior studies have suggested that the frequency of the Taq A1 allele of the dopamine D2 receptor gene is increased in some severe alcoholism, polysubstance abuse, nicotine dependence, post-traumatic stress disorder, ADHD, Tourette syndrome (TS), and obesity, indicating this variant is common to a spectrum of impulsive, compulsive, addictive behaviors. We examined the DRD2 genotype of 171 Caucasian pathological gamblers (PG). Of these, 50.9% carried the D2A1 allele vs. 25.9% of 714 non-Hispanic controls screened to exclude drug and alcohol abuse ($p < .00000001$, odds ratio equals 2.96). Of those in the upper 50% of severity, 63.8% carried the D2A1 allele compared to 40.9% of those in the lower 50% of severity. Substance abuse was an additive factor but did not explain the results in that 44.1% of PG free of SA carried the A1 allele, compared to 60.5% of those with comorbid SA. Thus, there was a progressive increase in the A1 allele from 25.9% for controls, 44.1% for PG without SA, to 60.6% for those with SA. We also examined the possible compounding role of depression and religion and neither was a factor in these results. The dopamine D1 receptor gene was also examined. There was a significant increase in homozygosity for the 11 or 22 alleles of the DdeI polymorphism in PG compared to controls. A similar increase was noted in individuals with other compulsive behaviors including nicotine dependence and TS. These results are consistent with the multifactorial and polygenic origin of pathological gambling and suggest that dopamine DRD1 and DRD2 are two of the genes that contribute to the risk. These results are also consistant with the concept of a genetic reward deficiency syndrome involved in a spectrum of addictive behaviors.

No. 97C
NEUROBIOLOGY OF PATHOLOGICAL GAMBLING

Concetta DeCaria, Ph.D., *Department of Psychiatry, Mt. Sinai Medical Center, 1 Gustave Levy Place, New York NY 10029;* Eric Hol-

lander, M.D., Rena M. Nora, M.D., Daniel Stein, M.B., Daphne Simeon, M.D., Lisa J. Cohen, Ph.D., Benito H. Tan, M.D.

SUMMARY:

Pathological gambling (PG), an impulse control disorder, is a common, disabling illness with substantial personal, social, and occupational impairment. There is considerable evidence of serotonergic dysfunction in impulsive-aggressive disorders, and likewise, in PG, serotonergic dysregulation has been implicated. Noradrenergic systems may modulate serotonergic effects on aggressive behavior toward self or others. Biological challenges with oral m-chlorophenylpiperazine (m-CPP), a partial serotonin receptor agonist, and oral clonidine, an alpha-2 adrenergic receptor agonist, were conducted to assess serotonergic and noradrenergic receptor sensitivity in 10 male PG patients and 10 matched healthy controls under randomized, placebo-controlled, double-blind conditions. Prolactin response to m-CPP was significantly increased in PG patients relative to healthy controls. Further, there were significantly increased ratings of "high" in PG patients, similar to that which is experienced by pathological gamblers while gambling. These findings are comparable to findings in other impulsive disorders (i.e., borderline personality disorder, trichotillomania, substance abuse). There was also an augmented growth hormone response to clonidine in PG. Implications of serotonergic and noradrenergic receptor hypersensitivity in PG and impulsivity are discussed. Additionally, neuropsychological assessment and neurological soft sign exams were administered, demonstrating visuospatial impairment in PG.

No. 97D
BIOBEHAVIORAL TREATMENT FOR PATHOLOGICAL GAMBLERS

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SUMMARY:

Some 1.5% of the general adult population are estimated to be pathological gamblers in need of professional therapy. Frequently, high comorbidity with other Axis I and II disorders as well as severe interpersonal and financial problems are present. In psychiatric settings, specific treatment is rarely available. Treatment research has remained limited.

This paper will first outline the essential differences between the still predominant "addiction" model and a multimodal model of pathological gambling derived from functional psychopathology and learning theory (avoidance of "negative state"). The behavioral model will be compared with most recent results from brain imaging studies in OCD, neurological studies (including results with a "gambling test") in patients with frontal lobe lesions, cognitive models of "inevitable illusions," and animal studies on stereotyped behaviors.

Treatment consequences for and results of behavior therapy with such an approach, as well as results with pharmacotherapy, will be summarized. Psychiatry, by incorporating behavior therapy and specific pharmacotherapy, could substantially improve help for this Zeitgeist-related disorder. A preliminary indication-model will be presented, outlining how and when to use behavior therapy, medication, or "addiction" therapy, singly or in combination.

No. 97E
GAMING INDUSTRY CONCERNS AND GAMBLING

Alfred Cade, *Caesars Atlantic City, 400 Leenie Lane, Linwood NJ 08221*

SUMMARY:

Casino operators have long been concerned about the problems associated with the important social issue generally called problem gambling. Although little known by the general public, major casino companies have developed some initiatives to address this problem. The American Gaming Association is currently leading several outstanding new innovative programs that should be of interest to the attendees of this symposium. This presentation will chronicle those initiatives and highlight how two associations, the American Gaming Association and the American Psychiatric Association, can assist each other in better understanding and addressing this important matter. Specifically, bold research initiatives are being proposed for appropriate institutions to provide the valuable, reliable data needed by the industry and the government to design the programs required for proper education and treatment.

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SYMPOSIUM 98—CURRENT ISSUES IN PSYCHIATRY AND RELIGION

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, participants should be able to discuss a number of current issues at the interface of psychiatry and religion. Participants should be aware of converging themes of various schools of psychiatry and psychotherapy, major world religions, and implications for psychiatric practice and education.

No. 98A
PSYCHIATRY AND MAJOR WORLD RELIGIONS

J. David Kinzie, M.D., *Department Of Psychiatry, University of Oregon Med Ctr, 3181 SW Sam Jackson Park Road, Portland OR 97201*

SUMMARY:

The historical relationships of the major religions to mental illness and treatment of the mentally ill are reviewed in this section of the symposium. Tension between supernatural explanations and objective scientific descriptions of behavior have been present in most religions over time. Followers of Hinduism, Buddhism, Confucianism, Taoism, Judaism, Christianity, and Islam have at various times attributed mental illness to supernatural or evil forces. But, some religions also have been important forces in the treatment of mental illness. Buddhism promoted hospitals in China, and through Zen and Morita therapy in Japan continued family involvement with the mentally ill was promoted. Judaism traditionally has promoted service to others and was a primary religion that interfaced with the early psychoanalytic movement. Although Christianity originally taught that the mentally ill were under the influence of the devil, in the 19th century it humanized hospitals for the mentally ill. Islam kept alive a scientifically oriented medicine and psychiatry during Medieval European times.

Contemporary issues at the interface of psychiatry and organized religion also will be discussed, such as the respective roles of mental health professionals and clergy in working with the mentally ill, and also the rise of fundamentalism in some major religions.

No. 98B
RELIGIOUS MOVEMENTS: INFLUENCE ON PSYCHOTHERAPY

Joseph J. Westermeyer, M.D., *Department of Psychiatry, Minneapolis VAMC, 1 Veteran's Drive (116A), Minneapolis MN 55417;* David R. Johnson, M.D.

SUMMARY:

Principles of psychotherapy hark back to animistic religion, probably long predating the organized monotheistic/polytheistic religions of historical times. From the beginning of history, even the polytheistic religion of the Greco-Roman era provided theories for mental health, mental-emotional maladies, and the amelioration or cure of such maladies. Buddhist sects have longed focused on means for individuals to seek a "middle way" through religious truths, meditation, and practice, thereby preventing mental and spiritual deterioration. Islamic and Christian thinkers and healers have focused more heavily on healing practices and the care of the ill, including the mentally ill.

Out of these diverse origins have come several treatment and recovery orientations that owe their origins to religious philosophies and practices. These include moral treatment, several self-help movements, Morita therapy, Linehan's cognitive-behavioral therapy, existential psychotherapy, so-called Christian psychiatry, and the use of hallucinogens in psychotherapy. In addition, psychiatric understanding of animistic views of the world has influenced the application of modern psychotherapies as applied to the care of animistic patients. Each of these psychotherapeutic and recovery approaches will be reviewed in light of their religious influences.

No. 98C
MORAL AND SPIRITUAL ISSUES FOLLOWING TRAUMATIZATION

Landy F. Sparr, M.D., *Department of Psychiatry, Oregon Health Sciences Univ, PO Box 1034/VA Med Ctr, 116A, Portland OR 97207;* John F. Fergueson, M.Div.

SUMMARY:

The trauma literature has frequently included the citing of spiritual/religious issues as an important aspect of understanding psychological responses to trauma. Most mental health workers would acknowledge that those who are truly traumatized undergo a deep moral crisis that may be the first step in a life-long struggle to reconstitute values, beliefs, and a sense of the meaning of life. Indeed, it is some victims' first encounter with evil. They may realize that they have committed, or been involved in, acts with real and terrible consequences that have shattered their sense of an understandable reality. Three assumptions may be destroyed: (1) the belief in personal invulnerability, (2) the perception of the world as comprehensible, and (3) the view of the self in a positive light. Once basic assumptions are challenged, there is a universal need to make sense of what has happened. While these issues have often been indicated as major determinants in both the development of, and recovery from, PTSD, their practical application may be obscure. In spiritual terms, the experience of something more powerful than oneself is transcendent because the self cannot defend against it and because individuals may have had their most powerful, ecstatic experience during traumatization. While ecstasy is usually thought of as positive, it can also have an effect that is at the same time energizing and disintegrative and pulls individuals to reenact, either directly or symbolically, their trauma. Trauma survivors must confront these questions in direct ways. Abstract ideas and metaphysical philosophies will generally be inadequate to reduce suffering. To be helpful, spiritual insight must be intimately personal and not only acknowledge human imperfection but also provide relief from despair and hopelessness. This presentation will look at trauma in its spiritual context and examine the profound dynamics that often fixate a person's life in the traumatic experience. Awareness of this reality can open up new avenues for healing and restoration.

No. 98D
USE OF RELIGION BY MEDICAL PATIENTS TO COPE

Harold Koenig, M.D., *Duke University Med Ctr, Box 3400, Durham NC 27710;* Kenneth Pargament, Ph.D.

SUMMARY:

Objective: To examine the prevalence and patterns of religious coping behaviors in a sample of hospitalized medically ill patients, and explore their associations with health outcomes.

Methods: Subjects were patients age 55 or over hospitalized on the medical services of Duke Hospital or the Durham VA Hospital. The RCOPE, an instrument that examines on a 0-3 scale the extent to which patients cope using 60 different religious behaviors/cognitions, was administered to consecutively admitted patients. Health outcomes included depressive symptoms, cognitive status, functional status, and stress-related growth, each assessed using standard validated measures.

Results: Three-hundred patients ages 55 to 96 (mean age 68) completed the RCOPE questionnaire. The sample was 47% women, 36% African American, and 51% had at least a high school education. The most common medical diagnoses were heart diseases (41%), infection (12%), respiratory disease (11%), and cancer (9%). Cognitive impairment was common (27%), as was depression (52%) and functional impairment (two-thirds of the sample required help with at least five activities of daily living). Despite functional impairment, 48% attended church weekly or more often, 82% prayed or read the Bible daily or more often, and 86% indicated that religion was "very important" in their lives. Different types of religious coping behaviors and cognitions were both positively and negatively related to health outcomes.

Conclusions: Religious coping behaviors are common in health care settings, and depending on the type of religious coping involved, may be either negatively or positively related to health outcomes.

No. 98E
RELIGIOUS AND SPIRITUAL ISSUES IN MEDICAL EDUCATION

Francis G. Lu, M.D., *Department of Psychiatry, University of CA at SF, 1001 Potrero Avenue, San Francisco CA 94131;* David B. Larson, M.D.

SUMMARY:

Like the fields themselves, psychiatric and medical school education have traditionally either ignored or pathologized patients' religious or spiritual experiences. At the 1992 American Psychiatric Association Annual Meeting, Scott Peck, M.D., asserted that psychiatry's continuing neglect in this area has led to "occasional, devastating misdiagnosis; not infrequent mistreatment; an increasingly poor reputation; inadequate research and theory; and a limitation of psychiatrists' own personal development."

This presentation will report on new developments in psychiatric and medical education on religious and spiritual issues. In response

to new ACGME essentials for psychiatric residency programs to include religious and spiritual issues, the National Institute for Healthcare Research in 1996 published a monograph entitled "Model Curriculum for Psychiatric Residency Programs: Religious and Spiritual Issues in Clinical Practice." It seeks to integrate modules on these issues into existing didactic and clerkship experiences. Secondly, this presentation will report on the April 1997 conference "Advancing the Incorporation of Spiritual Components in Medical School Curriculums and Residency Training Programs," which brought together educators and educational organizations in psychiatry and primary care to review current curriculums and suggest new directions based on the latest empirical research.

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SYMPOSIUM 99—SCHIZOPHRENIA: PUTTING RESEARCH INTO PRACTICE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to discuss the available research findings on the efficacy of pharmacotherapies, family interventions, and assertive community treatment for schizophrenia, as well as barriers to best practices in these areas, and possible solutions.

No. 99A
THE SCHIZOPHRENIA PATIENT OUTCOMES RESEARCH TEAM: AN OVERVIEW

Anthony F. Lehman, M.D., *Department of Psychiatry, University of Maryland, 645 West Redwood Street, Baltimore MD 21201*

SUMMARY:

Considerable research efforts over the past few decades on the nature and treatment of schizophrenia have yielded important advances to improve the outcomes of this disorder. Recent action plans, including the Decade of the Brain, the NIMH National Plan on Schizophrenia Research, and the NIMH's report, "Caring for People with Severe Mental Disorders: A National Plan of Research to Improve Services," promise major new advances over the next several years. As research advances, it is critical to ensure that patients in everyday practice receive the most effective treatments being developed. The Schizophrenia Patient Outcomes Research Team (PORT) is a five-year project that is developing treatment recommendations based upon a comprehensive review of the scientific literature and examination of current patterns of care in usual practice and their relationship to patient well-being and outcomes. The PORT has developed more than 40 specific recommendations about "best practices" covering a broad range of interventions including pharmacotherapies, psychosocial interventions, and service system models. This presentation will provide an overview of the methods used to develop these recommendations as well as provide specific examples of the recommendations and their implications.

No. 99B
PATIENT OUTCOMES RESEARCH TEAM: PHARMACOLOGICAL TREATMENT RECOMMENDATIONS

Robert W. Buchanan, M.D., *Department of Psychiatry, Maryland Psychiatric Research, PO Box 21247, Baltimore MD 21228-5567;* Julie Zito, Ph.D., Alan Lyles, Ph.D., Anthony F. Lehman, M.D.

SUMMARY:

The modern era of the pharmacological treatment of schizophrenia began in 1952 with the discovery that chlorpromazine possessed antipsychotic properties. The development of hundreds of pharmacological agents for the treatment of schizophrenia then followed. The Patient Outcomes Research Team (PORT) for Schizophrenia project has conducted an extensive review of the studies investigating the use of these agents. Specific areas reviewed include: 1) the efficacy of conventional antipsychotics in the treatment of acute episodes and maintenance treatment; 2) the efficacy of atypical antipsychotics, including clozapine and risperidone; and 3) the efficacy of adjunctive pharmacotherapies, i.e., benzodiazepines, antiepileptics, antidepressants, and lithium. Outcome measures of efficacy include positive and negative symptoms, social and occupational functioning, and quality-of-life measures. These reviews form the basis of the PORT recommendations for the pharmacological treatment of schizophrenia.

In this presentation, we will present the PORT recommendations for the use of conventional and atypical antipsychotics and adjunctive agents for the treatment of schizophrenia. In addition, we will present data on the relationship of PORT treatment recommendations to actual clinical practice, and patient and provider characteristics predictive of compliance with the recommendations.

No. 99C
RECOMMENDATIONS FOR FAMILY INTERVENTIONS IN SCHIZOPHRENIA

Lisa B. Dixon, M.D., *Department of Psychiatry, University of Maryland, 645 West Redwood Street, Baltimore MD 21201;* Alan Lyles, Ph.D., Jack Scott, Sc.D., Ann Skinner, M.S.W., Maureen Fahey, M.L.A.

SUMMARY:

A literature review of controlled research provides the basis for the following schizophrenia treatment recommendation on family interventions: Patients who have ongoing contact with their families should be offered a family psychosocial intervention that provides a combination of education about the illness, family support, crisis intervention, and problem-solving skills training. Analyses of primary and secondary data reveal probable poor compliance with this recommendation in clinical practice. *Less than one percent* of persons with schizophrenia on Medicare received a schizophrenia service billed as family therapy. Younger persons were more likely to receive this service. Of persons with schizophrenia in Georgia who have Medicaid (N = 9934), 7.4% received a schizophrenia service billed as family therapy. Younger, Caucasian, and male patients were more likely to receive a family service. A sample of directly interviewed, treated schizophrenia patients in Georgia and Ohio (N = 719) revealed that only 30% of their families had received information about mental illness. Patients who were younger, had more education, and lived in the community rather than the hospital were more likely to report receiving family education. Dissemination efforts suggested that the

most important obstacles to implementation perceived by a group of Ohio providers was uncertainty about agency and intervention funding.

No. 99D
SCHIZOPHRENIA PATIENT OUTCOMES RESEARCH TEAM: PUTTING RESEARCH INTO PRACTICE

Jack Scott, Sc.D., *Department of Psychiatry, University of Maryland, 645 West Redwood Street, Baltimore MD 21201;* Lisa B. Dixon, M.D., Anthony F. Lehman, M.D.

SUMMARY:

This presentation will summarize evidence for the impact of assertive community treatment (ACT) and other models of case management on several types of clinical outcomes for the treatment of schizophrenia. ACT and other forms of intensive case management have been shown to reduce psychiatric hospitalization for patients at heightened risk for frequent readmissions and to increase the use of various community-based services. ACT programs can also reduce psychiatric symptomatology, promote residential stability, and improve social functioning. PORT treatment recommendations concerning ACT and intensive case-management programs are discussed. Data are presented from the PORT field survey (n = 719) conducted in two states (Georgia and Ohio). These data compare intensive case management services with generalist case management models in terms of four issues: access to services types of assistance provided predictors of service utilization and satisfaction with services. Clinical implications of these data for the care of persons with schizophrenia are discussed.

No. 99E
DISSEMINATING TREATMENT RECOMMENDATIONS

Howard H. Goldman, M.D., *Department of Psychiatry, University of Maryland, 645 West Redwood Street, Baltimore MD 21201;* Elizabeth A. McGlynn, Ph.D.

SUMMARY:

This presentation will focus on the dissemination of the project's treatment recommendations. The five communities involved in the Schizophrenia PORT data collection were also selected to participate in the plan to disseminate the recommendations, permitting the PORT to track the impact of the effort. In March and April 1996, providers, patients, and their families in each of the communities were exposed to a one-day continuing education program on a selection of treatment recommendations focusing on psychopharmacology, family interventions, assertive community treatment, and inpatient care. In addition, pairs of the communities were involved in supplementary dissemination strategies: for example, "academic detailing" was used to amplify the dissemination of the psychopharmacologic recommendations during the autumn of 1996, and training in specific techniques of family supportive interventions were begun in June 1996. The feasibility of these strategies will be assessed, and their impact will be evaluated, examining patterns of practice abstracted from clinical records.

REFERENCES:

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SYMPOSIUM 100—SOMATIZATION, PSYCHOLOGY, AND CULTURE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

To improve understanding of the medical, psychological, sociocultural, and gender-specific aspects of somatizing and medically unexplained conditions. Participants should understand the impact of cultural attitudes toward bodily appearance and bodily functions and the role of caregivers and treatment settings in the alleviation of distress associated with somatization or medically unexplained conditions.

No. 100A
AN INTEGRATIVE MODEL OF SOMATIZATION

Laurence J. Kirmayer, M.D., *Inst of Comm & Family Psych, 4333 Cote Ste-Catherine Road, Montreal PQ H3T 1E4, Canada;* Gary M. Rodin, M.D.

SUMMARY:

This presentation will present an integrative cognitive and sociocultural model of somatization. Cognitive psychological models emphasize the role of feedback loops involving bodily focused attention, symptom interpretation, and coping behavior in amplifying somatic distress and giving it priority over coexisting emotional distress or social problems. However, these models do not explain the social meaning of somatic symptoms to patients or practitioners. Ethnographic research demonstrates the social and cultural embedding of somatic distress and identifies several ways in which somatic symptoms are given meaning: (1) as indices of underlying disease or physiological disturbance, occurring as one manifestation of abnormalities in structure or process; (2) as indices of underlying psychopathology; (3) as metaphors for other domains of experience; (4) as culturally patterned idioms of distress used to communicate about a range of social predicaments; and (5) as strategic moves in local systems of power, which serve to position the afflicted individual. These meanings are not intrinsic to somatic symptoms but arise from how they are used by patients, their families, and clinicians. Implications of this cultural perspective for clinical approaches to somatizing patients will be presented.

No. 100B
SOMATIZATION AND GENDER

Janet M. de Groot, M.D., *The Toronto Hospital, Western Division, Dept. of Psychiatry, Toronto ON M5T-258, Canada*

SUMMARY:

Evidence suggests that women tend to somatize more than men. Some somatizing disorders, particularly anorexia nervosa and bulimia nervosa, occur predominantly in women. The greater frequency of somatization in women may be due to factors such as the increased cultural acceptance of physical complaints and help-seeking behavior in women and their greater awareness of bodily experience and physical appearance. Somatic distress needs to be considered in terms of its experiential, relational, and social context. In other cases, it

reflects a communication of distress in a fashion that is perceived as less stigmatized. Somatic preoccupation reflects a relative deficit in the development of a psychological sense of self and/or impairment in the capacity to be aware of emotional experience. The developmental and relational basis of some somatizing conditions in women will be described and recommendations for treatment will be offered.

No. 100C
EXERCISE COMPULSION AND BODILY PREOCCUPATION

Caroline Davis, Ph.D., *Department of Psychology, The Toronto Hospital, 200 Elizabeth Str, Toronto ON M5G 2C4, Canada*

SUMMARY:

It has been argued that Western culture has become a "culture of narcissism," demonstrated in the increasing emphasis on exercise and dieting for women to achieve a low body weight. Paradoxically, the current ultraslender ideal of female attractiveness has peaked when the fast-food industry is expanding, the proportion of physically active North Americans is declining, and adult obesity rates have reached 30%. Marketing of bodily perfection by the popular media is accepted by much of our society. The high prevalence of eating-related disorders in young women may arise from the conflict between culture and biology. Animal experimentation has demonstrated that strenuous physical activity and caloric restriction potentiate severe weight loss. These two behaviors foster neurochemical changes that mimic those found in obsessive-compulsive disorder. Behavioral and psychological variables in eating-disordered patients parallel those in animals with exercise-induced weight-loss syndrome. These results can be interpreted with a psychobiological model that implicates high-level exercise in the etiology, progression, and maintenance of some eating disorders.

No. 100D
ENVIRONMENTAL HYPERSENSITIVITY

Diane Meschino, M.D., *Department of Psychiatry, The Toronto Hospital, 200 Elizabeth Str, Toronto ON M5G 2C4, Canada*

SUMMARY:

Environmental hypersensitivity (EH) is a chronic condition in which sufferers report multiple symptoms following exposure to low levels of multiple unrelated chemicals. There are varied and conflicting explanations regarding its etiology, nature, and appropriate treatment. For some sufferers, the diagnosis of EH provides organization and legitimization of their symptoms and hope for treatment. However, psychiatric and psychological studies are often perceived by sufferers to be dismissive of the medical aspects of their condition or to invalidate their experience. There are dangers of stigmatization resulting from psychological or psychiatric research. Economic, medical, psychological, and social consequences follow from the diagnostic labeling and etiologic hypotheses. In addition, investigators may fear expressing views that cause them to be attacked by patients or advocates for such conditions. However, systematic research on the experience of patients with EH has been welcomed by sufferers, advocates, and investigators. The Explanatory Model Interview Catalogue (EMIC) is a new qualitative measure that may be used to study this condition. This mode of inquiry may provide information that will foster more therapeutic relationships between patients and health care providers and diminish unnecessary health care utilization.

No. 100E
THE BRAIN, PSYCHIATRY, AND CHRONIC FATIGUE SYNDROME

Susan E. Abbey, M.D., *Department of Psychiatry, Toronto Hospital, 200 Elizabeth Street, Toronto ON M5G 2C4, Canada*

SUMMARY:

Chronic fatigue syndrome (CFS) remains a poorly understood condition that is likely heterogeneous in etiology and outcome. A subset of CFS patients meet criteria for a somatoform disorder. Popular culture appears to play a strong role in molding the experience of CFS sufferers, their preference for various forms of treatment, and the acceptance of CFS in the general and medical community as a legitimate medical diagnosis. The status of the "brain," psychiatry, and the diagnosis of somatoform disorders in CFS discourse and CFS self-help and advocacy community will be reviewed based on a qualitative analysis of the popular literature. Early CFS-related writings focused on muscles and microbes and rejected psychiatric findings. Neuropsychological abnormalities were the focus of the next stage, parallel with widespread interest in AIDS-related dementia in the medical community. Recently, psychiatric findings have gained acceptance, as manifestations of limbic system dysregulation and central nervous system involvement have become evident. The implications of these findings for understanding the role of culture in modulating individual and social response to somatoform disorders will be discussed.

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SYMPOSIUM 101—REVISITING TRAUMA, PTSD, AND DISSOCIATION

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, participants should learn the various definitions of dissociation, variations in the way dissociation and PTSD symptoms are measured, and findings regarding relationships between dissociation and PTSD across trauma types and populations.

No. 101A
THE VARIETY OF DISSOCIATIVE EXPERIENCES

Bessel A. van der Kolk, M.D., *HRI Trauma Center, 227 Babcock Street, Brookline MA 02146*

SUMMARY:

In recent years, psychiatry has rediscovered that dissociative processes play a critical role in the development of trauma-related psychological problems. While it is agreed that the term "dissociation" refers to a compartmentalization of experience, it has come to refer to a spectrum of clinical phenomena. This presentation will examine the various uses of the word "dissociation," how these different phenomena can be measured, and how they are interrelated. Primary dissociation: In this phenomenon, sensory and emotional elements of the event are not integrated onto personal memory and identity; it is best measured with the Traumatic Memory Inventory (TMI). This is characteristic of PTSD, in which patients re-experience dissociated traumatic memories in the form of nightmares and flashbacks. Another phenomenon is secondary dissociation, in which an individual is unable to integrate the incoming sensory input related to an experience and often reports mentally leaving his or her body at the moment of the trauma and observing what happens from a distance. This phenomenon can be best measured with the Peritraumatic Dissociation Experience Questionnaire (PDEQ) or the Stanford Acute Stress Reaction Questionnaire.

The phenomenon of tertiary dissociation refers to the ongoing use of dissociation in day-to-day experience, including having distinct ego-states that contain the traumatic experience. Examples are the multiple dissociated identity fragments in dissociative identity disorder (DID). The utilization of ongoing dissociative responses on a day-to-day basis is best measured by the Dissociative Experiences Questionnaire (DES) and the encapsulation of traumatic experiences in separate states of consciousness by the Dissociative Disorders Interview Scale (DDIS) or the SCID-D.

We will present two data sets in which the interrelationship between these various dissociative phenomena is examined: 1) child abuse and traffic accident victims with PTSD and 2) people who woke up during surgical anaesthesia.

No. 101B
DISSOCIATION IN HOLOCAUST SURVIVORS WITH PTSD

Rachel Yehuda, Ph.D., *Department of Psychiatry, Mt. Sinai School of Medicine, 130 West Kingsbridge Road, Bronx NY 10468*

SUMMARY:

In this presentation, data about dissociation and dissociative symptoms in Holocaust survivors will be presented. Approximately 100 elderly Holocaust survivors recruited from the community with and without PTSD and a comparison group were studied. Dissociation was evaluated with the Dissociative Experiences Scale (DES). We also assessed past cumulative trauma and recent stress as well as PTSD symptoms. Holocaust survivors with PTSD showed significantly higher levels of current dissociative experiences compared with the other two groups. However, the extent of dissociation was substantially less than that observed in other trauma survivors with PTSD. DES scores were significantly associated with PTSD symptom severity and were significantly correlated with age at the time of the trauma (i.e., younger age at the time of the Holocaust was associated with higher DES scores). However, the relationship between DES scores and trauma exposure was not significant.

Conclusions: Possible explanations for the generally lower DES scores in our sample include: the current age of the survivors, the length of time since the traumatic event, and possible unique features of the Holocaust survivor population. Although dissociation does seem to be present in a particular subgroup of individuals who were children during the Holocaust, the findings call into question the current notion that PTSD and dissociative experiences represent the same phenomenon. The findings suggest that the relationships among dissociation, trauma, and PTSD can be further clarified by longitudinal studies of trauma survivors.

No. 101C
DISSOCIATION AND PTSD SYMPTOMS ACROSS TRAUMA TYPES

Eve B. Carlson, Ph.D., *806 Racine Street, Delavan WI 53115*

SUMMARY:

Trauma researchers have found strong relationships between dissociation and posttraumatic stress disorder (PTSD) symptoms, indicating that these may be covarying or parallel responses to traumatic experiences. In a study of psychiatric inpatients, we examined whether the strength of this relationship varied between patients who had only traumatic childhood abuse experiences and patients who had only adult traumatic experiences. Using a standard structured interview for PTSD that inquires about symptoms relating to an index trauma, we found strong relationships between PTSD and dissociation for patients who had only traumatic childhood abuse ($r = .71$, $p < .00001$), but not for patients who had only adult traumatic experiences ($r = .28$ n.s.). Interestingly, when PTSD symptoms were measured using a scale that did not key symptoms to an index trauma, we found strong relationships between PTSD and dissociation both for patients who had only traumatic childhood abuse ($r = .75$, $p < .00001$) and for patients who had only adult traumatic experiences ($r = .70$, $p < .00001$). These results seem to support the notion of a strong relationship between dissociation and PTSD symptoms and raise the possibility that the way we collect information about PTSD symptoms may influence the findings about relationships between PTSD symptoms and other experiential and symptom variables.

No. 101D
TRAUMA AND DISSOCIATION IN THE GENERAL POPULATION

John N. Briere, Ph.D., *Department of Psychiatry, USC School of Medicine, 1937 Hospital Place, Los Angeles CA 90033;* Diana Elliott, Ph.D.

SUMMARY:

The role of trauma in the development of dissociative symptoms was examined in a representative sample of 834 individuals from the general population. Subjects were administered the Trauma Symptom Inventory (TSI; Briere, 1995) and the Traumatic Experiences Survey (TES; Elliott, 1992), from which data on the TSI Dissociation scale and specific traumatic events from the TES were analyzed. Simultaneous multiple regression analysis indicated that dissociative symptoms are associated with a variety of childhood and adult traumatic experiences, but not sociodemographic variables (age, sex, race, income, and marital status) once trauma exposure is taken into account ($R = .43$, $F(18,807) = 10.44$, $p < .00001$). Further, sexual traumas (both child and adult) are more associated with dissociative symptoms than childhood or adult physical traumas, and interpersonal traumas are strong predictors of dissociation, whereas non-interpersonal stressors (e.g., disasters, serious auto accidents) are not associated with dissociative symptoms. Stepwise multiple regression analysis, using a minimum p-to-enter of .005, indicated that the four most powerful predictors of dissociation were (in order of predictive magnitude) childhood sexual abuse, adult sexual assault (including rape), adult physical assault, and childhood physical abuse.

No. 101E
DISSOCIATION TRAUMA AND DSM-IV ACUTE STRESS DISORDER

David Spiegel, M.D., *Department of Psychiatry, Stanford Medical School, 401 Quarry Road, Room 2325, Stanford CA 94305-5544;*

Cheryl Koopman, Ph.D., Catherine Classen, Ph.D., Andrew Freikel, M.D.

SUMMARY:

We have collected data in three distinct studies examining symptom prevalence, sensitivity to trauma exposure, and concurrent and predictive comorbidity of acute stress disorder in three normal populations:

1) *Earthquake:* a study of persons who experienced the Loma Prieta earthquake in October 1989 (101 immediately after the earthquake and 98 four months later);

2) *Execution:* a study of 82% (15/18) of the media witnesses to the execution of Robert Harris, the first person to be executed in California in over two decades; and

3) *Firestorm:* a study of 187 persons assessed within the first months after the Oakland/Berkeley firestorm of October 1991, with 82% completing a second assessment seven months later.

The major implications of these studies are:

A. *High prevalence after trauma.* In all three studies, respondents report high levels of dissociative, anxiety, and other symptoms (e.g., despair, anger) immediately after a traumatic event. These findings are consistent with studies of combat stress response (Solomon), the North Sea Oil Rig disaster (Holden), the Ash Wednesday bush fires (MacFarlane), and the Hyatt Regency skywalk collapse (Wilkinson).

B. *Symptoms are associated with the degree of trauma.*

C. *Symptoms co-occur and can be reliably measured.* These symptoms can be reliably assessed, with the measures showing moderate to high Chronbach's alphas on the scales assessing dissociative (alpha = .90, $p < .001$), anxiety (alpha = .91, $p < .001$), and other symptoms (alpha = .81, $p < .001$).

D. *State rather than trait.* In the earthquake and firestorm studies, significantly fewer persons reported these symptoms four months after the event than in its immediate aftermath.

E. *Concurrent validity: Associations with other measures of distress in response to trauma as well as with dysfunctional behavior in the immediate aftermath of trauma.* Dissociative symptoms experienced immediately after the firestorm were highly correlated with overall scores on the Impact of Event Scale (Horowitz, Wilner & Alvarez, 1979) ($r = .71$, $p < .001$), and with both the avoidance ($r = .63$, $p < .001$) and intrusion subscales ($r = .62$, $p < .001$).

F. *Prediction of later distress, including posttraumatic stress symptoms and anxiety.* This pattern of dissociative and anxiety symptoms experienced in the immediate aftermath of a traumatic event (i.e., the Oakland/Berkeley firestorm) predicts the occurrence of later disorders. In the firestorm data, dissociative, anxiety, and other symptoms assessed immediately after the firestorm are highly associated with PTSD symptoms assessed on the Civilian Mississippi Scale (Keane et al., 1987) and on the Impact of Event Scale seven months later. Four dissociative symptoms alone predict later PTSD with 94% sensitivity and 78% specificity.

No. 101F
PROSPECTIVE STUDIES OF PERITRAUMATIC DISSOCIATION IN TRAUMA SURVIVORS

Arieh Y. Shalev, M.D., *Department of Psychiatry, Hadassah University, PO Box 12000, Jerusalem 91120, Israel;* Tuvia Peri, Dalia Brandes, Tall Sahar, Scott P. Orr, Ph.D., Roger K. Pitman, M.D.

SUMMARY:

Dissociative symptoms have been described in survivors of child abuse, traumatized refugees, and combat veterans. Retrospective studies suggest that dissociation may be a specific predictor of PTSD. Two prospective studies of civilian trauma survivors have assessed the specificity, sensitivity, and positive predictive value (PPV) of experiencing dissociation during trauma (peritraumatic dissociation) in predicting PTSD. In the first study (n = 51, 25% PTSD six months after trauma) dissociation was the best predictor of PTSD, explaining 29% of the variance in PTSD symptoms. Peritraumatic dissociation predicted PTSD symptom intensity regardless of the occurrence of PTSD, and its effect was not mediated by early anxiety, intrusion, avoidance, or depression. In the second study (n = 235, 17% PTSD four months after trauma) peritraumatic dissociation was better than other measures of early symptoms in predicting PTSD in that it better predicted the disorder, while other measures were better at predicting recovery. Dissociation may represent psychological and biological sequelae of early traumatization, related to the physiology of glucocorticoid and mineralocorticoid receptors in the hippocampus and its effect on spatial recognition and memory organization.

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SYMPOSIUM 102—DIAGNOSIS AND TREATMENT OF VARIOUS DEPRESSIVE SUBTYPES

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to understand the diagnostic, treatment, and prognostic implications of five different depressive syndromes (childhood depression, atypical depression, melancholic depression, bipolar depression, and depression associated with a general medical condition), to help clinicians better manage and treat their patients.

No. 102A
PHARMACOTHERAPY OF CHILD AND ADOLESCENT DEPRESSION

Barbara G. Geller, M.D., *Department of Psychiatry, Washington University, 4940 Childrens Place, St. Louis MO 63110-1002*

SUMMARY:

Unlike the wealth of studies of antidepressant agents for depressive disorders occurring during the adult years, there is a paucity of data for similar studies conducted on the pediatric age group. A review of the largely negative studies of tricyclic antidepressants and of the more recent positive study of fluoxetine will be provided. In addition, a study of lithium for bipolar depression in children will be presented. Speculation on reasons for poor response will include subgroup typing, severity of illness, and duration of episode. High potential for switch to bipolarity among depressed children will be reviewed.

The relationship between increased familial loading for affective disorder in early-onset depression and outcome of drug therapy will also be presented. Clinical applications and directions for future investigation will be included.

No. 102B
ATYPICAL DEPRESSION: IS IT A VALID CLINICAL ENTITY?

Jonathan W. Stewart, M.D., *Department of Psychiatry, NYS Psychiatric Institute, 722 West 168th Street, New York NY 10032;* Frederic M. Quitkin, M.D., Patrick J. McGrath, M.D., Judith G. Rabkin, Ph.D.

SUMMARY:

Patients with atypical depression are characterized as having a depressed mood that is reactive to the environment plus two of the following four additional symptoms: hypersomnia, hyperphagia, intense lethargy, and rejection sensitivity. Patients with this syndrome are responsive to MAOI's but not tricyclic antidepressants.

The above hypothesis was confirmed in a series of studies by our group and others. We have studied 401 depressed outpatients randomly assigned to receive phenelzine (60-90mg/day), imipramine (200-300mg/day), or placebo for six weeks. Patients with mood reactivity but none of the above four associated symptoms responded equally well to both phenelzine and imipramine. Data and discussion concerning the role of SSRI's in atypical depression will be presented.

Additional data attempting to confirm the validity of atypical depression have noted differences between patients with atypical depression and nonatypical depression, including earlier age of onset, more chronic course of illness, fewer biologic abnormalities, and fewer family members with severe depression, but more relatives with chronic depression.

No. 102C
MELANCHOLIC DEPRESSION: DIAGNOSIS, TREATMENT, AND LONG-TERM COURSE

Eric D. Peselow, M.D., *Department of Psychiatry, NYU School of Medicine, 32 Bassett Avenue, Brooklyn NY 11234;* Ronald R. Fieve, M.D.

SUMMARY:

Despite a lack of evidence, it has been assumed that the subclassification of melancholic depression has been a useful guide in the management of the depressed patient. Melancholia has been correlated with treatment response as well as a wide variety of demographic, psychosocial, and biological variables. However, there has been little work done on validating the concept of melancholic depression. There have been few studies differentiating biological, clinical, and outcome variables unique to melancholia.

Our group has evaluated more than 500 individuals who were classified as either having melancholic or nonmelancholic depression (approximate N of 250 in each group). Demographic data as well as clinical symptom profile, cognitive profile, life event, and personality trait data were obtained on this sample. Short- (six week) and long-term outcome data (up to one year) were obtained for melancholic and nonmelancholic patients who were treated in double-blind trials and for those who were treated naturalistically in a clinical setting.

Overall, the results seem to indicate that the melancholic depressed patient was more severely ill (as measured by depression rating scales such as the Hamilton and Beck), had fewer life events, had fewer cluster B but more cluster A traits, and had less interpersonal dependency than nonmelancholic depressed patients. Overall, melancholic patients showed a greater drug/placebo differentiation than nonmelancholic patients and had a slightly better one-year outcome than nonmelancholic patients.

No. 102D
DIAGNOSIS AND TREATMENT OF BIPOLAR DEPRESSION

Gary S. Sachs, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC-815, Boston MA 02114*

SUMMARY:

Like depressed unipolar patients, depressed bipolar patients frequently present with disabling symptoms and a high risk for suicide. Despite similar phenomenology, unipolar and bipolar depression differ in course and response to treatment. Although the DSM-IV criteria for the episodes are the same, unipolar depression and bipolar depression are recognized as different illnesses.

The few available studies of bipolar depression suggest that therapies effective for unipolar depression are likely to be effective for bipolar depression. All antidepressant therapies carry the risk of inducing mania or accelerating cycling, but therapeutic agents appear to differ in their efficacy and propensity to induce mania. The most effective treatments reported are ECT and tranylcypromine. The only study of bipolar depression in which all patients received concurrent mood stabilizer therapy compared double-blind treatment with bupropion versus desipramine. This study found equal antidepressant efficacy, but a significantly higher switch rate into mania/hypomania for desipramine-treated patients. Patients with bipolar depression may respond to therapies that are ineffective for unipolar depression. Lithium is the best studied, but other mood-stabilizing agents (carbamazepine and valproate) may also be effective for bipolar depression. Guidelines are offered to manage risk of bad outcome for treatment of bipolar depression.

No. 102E
TREATMENT OF DEPRESSED HIV-POSITIVE PATIENTS

John C. Markowitz, M.D., *Department of Psychiatry, Cornell University Medical Col, 445 East 68th Street, Ste 3N, New York NY 10021;* Gerald L. Klerman, M.D., Kathleen F. Clougherty, M.S.W., Lisa A. Spielman, Ph.D., Baruch Fishman, Ph.D., Samuel W. Perry III, M.D.

SUMMARY:

Treatment of psychiatric disorders in the medically ill is an area of growing interest, but to date there have been few careful studies. Available research suggests that antidepressant medication is efficacious for depressed medically ill patients, with slightly lower rates than in medically healthy patients. Clinical trials have demonstrated the efficacy of antidepressant medication for depressed HIV-positive patients.

Focal psychotherapies may also have efficacy. This presentation describes the only data to date on individual psychotherapy of depressed HIV-positive patients.

Methods: Depressed subjects (n = 101) were randomized to 16 weeks of treatment with interpersonal psychotherapy (IPT), cognitive behavioral therapy (CBT), supportive psychotherapy (SP), or SP with imipramine (SWI). Therapists were trained to competence, followed treatment manuals, and were monitored for adherence.

Results: Depression scores improved across treatments. In analyses using ANCOVAs of Hamilton Depression Rating Scale and Beck Depression Inventory scores, IPT and SWI generally appeared significantly more efficacious than CBT or SP.

Conclusion: Medically ill patients are more alike than different from those who are medically healthy in their response to antidepressant treatments.

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SYMPOSIUM 103—RECENT ADVANCES IN DISORDERS OF EATING AND WEIGHT

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

This symposium will provide a detailed review of recent advances understanding the etiology and treatment of eating and weight regulation disorders.

No. 103A
ROLE OF SEROTONIN IN DISORDERS OF EATING AND WEIGHT

David C. Jimerson, M.D., *Department of Psychiatry, Beth Israel Hospital, 330 Brookline Avenue, Boston MA 02215-5491;* Eran D. Metzger, M.D., Barbara E. Wolfe, Ph.D.

SUMMARY:

Recent investigations suggest that alterations in the regulation of central nervous system (CNS) serotonergic pathways may play a role in the pathophysiology of eating disorders. CNS serotonin contributes to postingestive satiety, with decrements in serotonin leading to increased meal size and weight gain. Thus, efficacy of fenfluramine as an adjunct in weight loss treatment for obesity is thought to reflect serotonin agonist effects. Additionally, dysregulation in CNS serotonin may contribute to depressed mood, obsessive-compulsive characteristics, and/or impulsive behavioral patterns in patients with eating disorders. This presentation summarizes recent findings, particularly from neuroendocrine challenge studies, showing decreased serotonergic responses in patients with moderate to severe bulimia nervosa or anorexia nervosa. Preliminary results from patients studied following clinical improvement indicate that at least some of these neurobiologic alterations may be state-related. Controlled trials have shown decreased symptom severity in patients with bulimia nervosa treated with serotonin-active antidepressant medication. These results highlight the need for additional studies of serotonin regulation in bulimia nervosa, anorexia nervosa and binge eating disorder, and the value of additional clinical trials of selective serotonergic medications in the treatment of patients with eating disorders.

No. 103B
THE TREATMENT OF BULIMIA NERVOSA

B. Timothy Walsh, M.D., *Clin. Psychopharmacology, NY State Psychiatric Institute, 722 West 168th Street, Unit 98, New York NY 10032-2603*

SUMMARY:

There have been major advances in the last decade in the treatment of bulimia nervosa. More than 15 double-blind, placebo-controlled trials have established that a variety of antidepressant medications are useful in this syndrome. Surprisingly, there appears to be no relationship between the pretreatment level of mood disturbance and the response to antidepressant medication. While most of the agents examined appear to have similar efficacy, the SSRI fluoxetine may have a relative advantage because of a comparatively low incidence of side effects. Nonpharmacologic therapies, especially cognitive behavioral therapy (CBT), have also been demonstrated to be effective in the treatment of bulimia nervosa. More recent research has examined whether CBT is superior to other focused psychotherapies, such as interpersonal therapy (IPT), and whether it is useful to combine medication and psychotherapy. Challenging problems in this field include identifying which patients are most likely to respond to which therapies, and developing interventions for the substantial number of patients who fail to respond adequately to either antidepressant medication or a focused psychotherapy.

No. 103C
CURRENT STATUS OF BINGE EATING DISORDER

Michael J. Devlin, M.D., *Clin. Psychopharmacology, NY State Psychiatric Institute, 722 W 168th Street, Unit 116, New York NY 10032-2603*

SUMMARY:

The five years since binge eating disorder (BED) was first described as a syndrome have yielded a rapidly increasing body of information concerning the characteristics of affected individuals, their eating behavior, and their response to various forms of treatment. One approach to the study of this disorder has been to use our knowledge of bulimia nervosa (BN) to generate hypotheses concerning BED. The systematic testing of these hypotheses has yielded an intriguing pattern of similarities and differences between the two disorders of binge eating. Although most patients presenting with BED are obese and those with BN are most often of normal weight, community studies suggest that: (1) a substantial proportion of individuals with BED are of normal weight; and (2) a tendency toward obesity is a risk factor for BN. While both BED and BN are characterized by binge eating and frequent dieting, patients with BN almost invariably begin dieting before binge eating, while patients with BED often binge before dieting. Laboratory studies of binge eating demonstrate that binges in BED patients are similar but not identical to binges seen in BN. Treatment studies indicate that psychotherapeutic techniques used in the treatment of BN may also be useful for BED but must be modified to take into account the differing eating patterns of the two groups. Medication studies suggest that the response patterns of the two groups are similar but that differences may emerge as further studies are carried out. Further studies are needed to clarify the features and pathophysiology of BED and its relationship to other disorders of eating and weight.

No. 103D
PSYCHOLOGICAL TREATMENT OF BINGE EATING AND OBESITY

Marsha D. Marcus, Ph.D., *Department of Psychiatry, Univ of Pittsburgh Sch of Med, WPIC, 3811 O'Hara Street, Pittsburgh PA 15213*

SUMMARY:

Although advances in molecular biology and genetics undoubtedly will revolutionize our understanding of obesity and its treatment, they will not be likely to explain marked increases in obesity over the last 12 years. Increases in the prevalence of obesity are probably due to lifestyle factors (decreases in activity, availability of energy-dense highly palatable foods). Thus, more effective interventions to promote lifestyle changes and deal with distressing psychological correlates of obesity are clearly needed.

Binge eating disorder (BED), a syndrome of regular and persistent binge eating that is not accompanied by inappropriate compensatory behaviors such as self-induced vomiting, affects as many as 30% of individuals who seek obesity treatment. Recent work on the treatment of BED will be reviewed to demonstrate how eating disorders research may inform efforts to treat obesity. Strategies used to treat binge eating that may be useful in the treatment of obesity include cognitive techniques that focus on the modification of maladaptive attitudes and beliefs relating to shape and weight, behavioral strategies to promote moderation and self-acceptance, self-soothing and mood-management skills, and amelioration of interpersonal problems that maintain maladaptive eating patterns.

No. 103E
PHARMACOLOGICAL TREATMENT OF BINGE EATING DISORDER

Albert J Stunkard, M.D., *University of Pennsylvania, 3600 Market Street, Room 734, Philadelphia PA 19104-2611;* Robert I. Berkowitz, M.D.

SUMMARY:

There is a need for a radical revision of policy on the treatment of binge eating disorder. Recent studies suggest a very high (70%) rate of placebo response in patients with this disorder. Clearly, therapeutic efficacy can be ascribed only from placebo-controlled trials. None of the trials of cognitive behavioral therapy met this criterion; all used only waiting-list controls. Despite the need for pharmacologic treatment of binge eating disorder, only five studies have evaluated this modality and only two have demonstrated efficacy. McCann and Agras reported that desipramine produced a significant reduction in binge frequency, while Stunkard, et al. found that the appetite suppressant d-fenfluramine was similarly effective. This latter effect was achieved with no reduction in body weight, suggesting that this serotonergic agent may have two distinct actions. There is a pressing need for further studies of pharmacologic treatment of binge eating disorder.

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SYMPOSIUM 104—THE INTERFACE OF PSYCHODYNAMIC AND COGNITIVE-BEHAVIOR PSYCHOTHERAPIES: IMPLICATIONS FOR TREATMENT AND TRAINING
APA Commission on Psychotherapy

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation the participants should understand the theoretical similarities and differences between psychoanalytic and learning theory as these relate to personality development and treatment. They will be able to make clinical and educational decisions based on an informed integration of the two treatment modalities.

No. 104A
A PSYCHOANALYST LOOKS AT COGNITIVE BEHAVIOR

Arnold I. Goldberg, M.D., *Institute for Psychoanalysis, 122 S. Michigan Ave. Ste 1305B, Chicago IL 60601-7401*

SUMMARY:

Understanding the nature of the ongoing relationship with the therapist is the clue to tying together all supposed divergent forms of psychotherapy. The unconscious derivatives of all treatments must be comprehended for a unified theory of treatment.

No. 104B
A LEARNING THEORY APPROACH TO EATING DISORDERS

Katherine A. Halmi, M.D., *Department of Psychiatry, Cornell Medical College, 21 Bloomingdale Road, White Plains NY 10605-1504*

SUMMARY:

Cognitive-behavioral treatment (CBT) of anorexia nervosa (AN) is based on learning theory and includes two core assumptions. First, AN develops as a way of coping with aversive experiences often associated with developmental transitions and distressing life events. The fears and tensions relieved by anorectic behavior reflect deficient coping abilities in areas of developmental transitions and expectations, fears of maturity and autonomy, feelings of ineffectiveness, poor self-esteem, and disturbed relationships with family members or friends. Preoccupation with food and weight is so consuming that the anorectic is distracted from other distresses. The anorectic "solution" becomes highly reinforcing.

The second assumption is that food restriction and rituals of food avoidance become entrenched habits independent of the events that provoked them.

The primary aim of treatment is to achieve normal eating patterns and a normal weight. Behavioral methods are used to increase food intake, and CBT methods are used to reduce anxiety and change distorted cognitions. New problem-solving skills are developed. The CBT rationale for treating bulimia will also be presented.

No. 104C
THE COGNITIVE THERAPY APPROACH TO PSYCHODYNAMICS

Michael E. Thase, M.D., *Department of Psychiatry, Western Psychiatric Institute, 3811 O'Hara Street, Pittsburgh PA 15210*

SUMMARY:

Cognitive-behavioral therapy is often unjustly criticized as having a "surface" orientation and avoiding important "deeper" conflicts, as well as minimizing transference issues. In this presentation, videotape and/or role-play vignettes are used to illustrate the potential "depth" of cognitive behavioral therapy regarding identification of core beliefs or schema and incorporating the patient's thoughts, feelings, and nonverbal behaviors about the therapeutic relationship within the cognitive model.

No. 104D
PSYCHODYNAMIC PSYCHOTHERAPY: AN INTEGRATIVE PROCESS

Sherwyn M. Woods, M.D., *Department of Psychiatry, University of Southern CA, 5284 Los Diegos Way, Los Angeles CA 90027-1016*

SUMMARY:

Theoretical purity rarely has much of a place in effective psychotherapy. Rather, flexibility in conceptualization and technique is often both desirable and essential. Appropriate flexibility is not synonymous with either wildness or sloppiness, but rather with the capacity to view the patient and the treatment from multiple vantage points: biologic, psychodynamic, behavioral, cognitive, cultural, etc. The patient at any moment in time is the aggregate of multiple lines of developmental influence, each exerting its own particular influence, while simultaneously influencing the others. The usefulness of this model is particularly well illustrated by the integration of psychodynamic and cognitive-behavioral theories in understanding human psychological suffering and our attempts to alleviate it and initiate the process of change.

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SYMPOSIUM 105—TRANSFORMING TRAINING: THE CHALLENGE OF THE FUTURE
Joint Session with the American Association of Directors of Psychiatric Residency Training and APA Committee on Consultation-Liaison Psychiatry and Primary Care Education

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to identify areas of psychiatric education that need to be addressed to better prepare psychiatric residents for future practice.

No. 105A
THE PSYCHIATRIST'S ROLE IN FAMILY PRACTICE

Frank V. deGruy, M.D., *University of S Alabama, 15041 Springhill Avenue, Mobile AL 36604*

SUMMARY:

A great deal of mental health care is rendered in the primary care setting by primary care clinicians, and always will be, despite the inherent difficulties and disincentives. The literature documenting the quality of this care is controversial, but there is clearly room for improvement. Currently, psychiatrists participate in only a very small proportion of this care and have a minor role in the education of family physicians, despite a longstanding formal commitment to behavioral science training for family practice residents. Psychiatrists have much to offer primary care patients and primary care clinicians and should be more deeply involved as clinicians and educators. This presentation will outline the historical reasons for the marginalization of psychiatry in family practice, the barriers to a deeper, more reciprocal involvement, and suggestions for overcoming these barriers. Particular attention will be devoted to 1) detailing the cultural differences between the practice of psychiatry and the practice of family medicine; 2) suggesting how certain managed care strategies, such as collaborative disease management algorithms, "soft teams," and clinics-within-clinics, might apply to this relationship; and 3) exploring educational models that might bring psychiatric expertise to bear more directly on the mental health problems of primary care patients.

No. 105B
PSYCHIATRIC TRAINING, CONSULTATION-LIAISON, AND PRIMARY CARE

Ronald D. Geraty, M.D., *Continuum Behavioral, One Maynard Drive, Park Ridge NJ 07656*

SUMMARY:

As managed behavioral health care continues to expand its presence in the health care marketplace, it becomes increasingly important for psychiatric training to address current trends that affect health care delivery. This presentation will provide a brief overview of the recent history of the managed behavioral health care industry and its primary goals of cost, quality, and access. Present developments indicating that C/L psychiatry will have a vital role to play in integrating psychiatry with primary care delivery will be outlined.

The current scope of psychiatric care delivery within the primary care sector will be reviewed. The integration of a full continuum of psychiatric treatment settings and services with general medicine is crucial to the efficient and effective management of care. Issues of care coordination will be addressed, including the need for greater collaboration between primary care physicians and psychiatric clinicians in order to optimize treatment outcomes. "Medical cost offset" effect research will also be discussed.

In addition, the implications of evolving roles of care providers within managed care and the expansion of managed behavioral health care into new growth markets will be discussed. Specific areas of professional improvement needed to meet the demands of the marketplace will be identified. Suggestions for reorienting psychiatric training programs to provide the skills necessary for professional success will be detailed.

No. 105C
RAPID CONVERSION OF TRADITIONAL TRAINING SYSTEMS

Leighton Y. Huey, M.D., *Department of Psychiatry, Dartmouth-Hitchcock MC, One Medical Center Dr., Lebanon NH 03756-0001;* Ronald L. Green, M.D., David L. Budlong, M.A.

SUMMARY:

The shift in mental health care reflects payer and patient demands that the most appropriate level of care be provided in the most cost-effective and timely manner. Psychiatry is redefining itself through the benefit of (a) a focus on the importance of careful and consistent diagnostic assessment, (b) large-scale epidemiological studies showing widespread prevalence and comorbidity of psychiatric disorders, (c) controlled studies of psychotherapy and psychopharmacotherapy focusing on efficacy, (d) multidisciplinary collaboration, (e) commitment to elucidating underlying brain mechanisms, (f) understanding the impact of psychiatric disorders on physical disorders, (g) reconfiguring the relationship of psychiatry to other areas of medicine, (h) incorporating a public health perspective, (i) attending to outcomes, utilization, cost, and value. These factors have direct effects on the contemporary training of psychiatrists. This paper presents the impact of a rapid two-year conversion of a traditional four-year training program/clinical operation to a longitudinal model of a multidisciplinary integrated longitudinal treatment teams system (MILTTS) emphasizing continuity of care. Coupled with an accelerating clinical improvement (ACI) paradigm, preliminary data are presented of the effects of this conversion/retrofitting on utilization, costs, outcomes, and reactions of trainees, faculty, and staff. The MILTTS system with ACI provides a framework in which trainees can become functional and competent psychiatrists within the construct of managed care/health care reform.

No. 105D
RECENT GRADUATES' PERSPECTIVE ON RESIDENCY TRAINING

James L. Griffith, M.D., *Department of Psychiatry, George Wash Univ Med Center, 2150 Pennsylvania Avenue, NW, Washington DC 20037;* Nathan B. Smith, M.D., David F. Gitlin, M.D., L. Lee Tynes, M.D.

SUMMARY:

While psychiatric educators, at conferences and in the psychiatric literature, often discuss the future of psychiatric residency training, there has been little empirical data drawn from former residents who are establishing psychiatric practices during the mid-1990's. The APA Committee on Consultation-Liaison Psychiatry and Primary Care Education is conducting a national postgraduate survey of residency training to learn how well recent graduates are fitted for collaboration with primary care clinicians and for work in managed care environments. APA members-in-training who converted to full membership during 1995 are being surveyed by mail questionnaires regarding the relevance and intensity of different training components of their residencies in preparing them for the realities of current psychiatric practice. The findings will suggest priorities for residency programs focused on preparing residents for primary care and managed care work settings. This presentation will summarize these findings.

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SYMPOSIUM 106—CLINICAL ADVANCES IN GERIATRIC PSYCHIATRY
Joint Session with the American Association for Geriatric Psychiatry

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of the symposium participants will recognize recent advances in the management of the most common late-life mental health problems including depression, sleep disturbance, psychosis, and behavioral disturbances in dementia.

No. 106A
GOOD SLEEP PREDICTS SUCCESSFUL INTERPERSONAL PSYCHOTHERAPY IN THE ELDERLY

Charles F. Reynolds III, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh PA 15213*

SUMMARY:

Objective: To identify which elderly patients with remitted depression benefit from maintenance interpersonal psychotherapy (IPT-M), after discontinuation of active antidepressant medication.

Method: We examined maintenance therapy outcomes in 47 elderly patients who were randomly assigned to monthly IPT-M with placebo (n = 19) or to placebo in a supportive medication clinic without IPT (n = 28). A Kaplan-Meier survival analysis was performed based upon treatment assignment and subjective sleep quality assessed by the Pittsburgh Sleep Quality Index (PSQI), in which good subjective sleep quality is indicated by a score of 5 or lower.

Results: 90% (9/10) of patients reporting good subjective sleep quality (by one month into continuation treatment with the combination of IPT and medication) remained well for at least one year when treated with monthly IPT-M, versus 31% (5/16) of patients with good sleep quality treated with placebo, 33% (3/9) of patients with impaired sleep quality treated with IPT-M, and 17% (2/12) of patients with impaired sleep quality treated with placebo (Wilcoxon chi square = 8.13, df = 3, $p < .05$).

Conclusion: Good subjective sleep quality may be useful in identifying which remitted elderly depressed patients will benefit from continued monthly IPT-M following discontinuation of antidepressant medication. *Research supported by MH43832, MH37869, MH00295, MH52247.*

No. 106B
RECENT ADVANCES IN GERIATRIC DEPRESSION

George S. Alexopoulos, M.D., *Department of Psychiatry, Cornell University Medical Col, 21 Bloomingdale Road, White Plains NY 10605;* Barnett S. Meyers, M.D.

SUMMARY:

Studies of geriatric depression have demonstrated that its outcomes, i.e. recovery, relapse/recurrence, disability, and cognitive impairment, are associated with specific clinical, neuropsychological, and neuroradiological characteristics. These findings can be used to identify clinically meaningful subtypes of late-life depression with distinct presentation and biological characteristics.

Comparing late-onset with early-onset major depression has been the classic approach to studying heterogeneity in geriatric mood disorders. Late-onset depression has been found to be associated with a prolonged time to recovery and the presence of both irreversible and reversible cognitive impairment. Some of these findings, including diminished verbal recognition memory, impaired confrontation naming, and initiation/perseveration have been associated with an increased risk for subsequent dementia. Finally, neuroradiological studies have also reported differences between early- and late-onset depression. These include greater cortical atrophy, increased white matter hyperintensities, and diminished volume of the caudate and the putamen.

Late-onset depression is itself heterogeneous. Recent data indicate that late-onset depressed patients with clinical evidence of vascular disease have a distinct clinical presentation, high risk for relapse and recurrence, and prolonged latencies in brain stem and cortical average evoked responses. Based on these findings, we advanced the hypothesis that a "vascular depression" syndrome exists, which is mediated by impairment of specific striato-pallido-thalamo-cortical pathways. The "vascular depression" hypothesis needs to be further tested with neuropsychological, imaging, and pharmacological studies.

No. 106C
PSYCHOSES IN LATE LIFE

Dilip V. Jeste, M.D., *Department of Psychiatry, Veterans Affairs Medical Cntr., 3350 La Jolla Village Drive, San Diego CA 92161-0001;* Sandra S. Kindermann, Ph.D., Laurie A. Lindamer, Ph.D., Shaunna Morris, Ph.D., Shelley C. Heaton, B.A., Barton W. Palmer, Ph.D.

SUMMARY:

There have been a number of recent developments in the area of psychotic disorders in late life. *Neurobiology*: Several interesting differences between late-onset schizophrenia and early-onset schizophrenia have been shown, especially in neuropsychological performance and brain imaging. Dementia does not seem to be a common outcome of schizophrenia except in the chronically institutionalized group. Psychotic depression is similar to schizophrenia in cognitive impairment, while delusional disorder is associated with less severe deficits. There have been some interesting neuropathological findings in Alzheimer's disease patients with psychosis. *Psychosocial aspects*: The quality of life of older psychotic outpatients is comparable to that of ambulatory patients with AIDS. Caregiver stress is a serious problem associated with psychoses in the context of Alzheimer's disease, Parkinson's disease, as well as schizophrenia. *Management*: An exciting development has been the introduction of the newer atypical antipsychotics, which are more effective and have fewer extrapyramidal side effects than conventional neuroleptics. Several studies suggest possible cognitive enhancing effect of these agents in older psychotic patients and their usefulness in difficult cases such as Parkinson's disease patients with psychotic symptoms. However, these drugs have their own adverse reactions and need to be used in much lower dosages than those recommended for younger adults. The role of psychosocial management is also critical.

No. 106D
TREATMENT OF COGNITIVE AND BEHAVIOR DISTURBANCES IN DEMENTIA

Lon S. Schneider, M.D., *Department of Psychiatry, University of Southern CA, 2011 Zonal Avenue, HMR-101, Los Angeles CA 90033*

SUMMARY:

Potential treatment approaches in dementia include symptomatic treatment of cognitive impairment, behavioral symptoms, slowing the rate of cognitive decline, and delaying the age of onset. Several pharmacological approaches toward improvement of cognitive symptoms will be discussed, with an emphasis on cholinergic approaches, since they appear most promising at the moment, and one cholinesterase inhibitor is available clinically. The indications, contraindications, methods of administration, management of side effects, and expected therapeutic responses of cholinergic medications will be discussed. These drugs seem to provide modest, but clinically significant, improvement in cognition and functional activities in some patients. A range of pharmacological interventions are available for treating behavioral symptoms, including the use of newer neuroleptics, antidepressants, anticonvulsants, and buspirone. Efficacy is being documented in controlled clinical trials. Potential approaches to slowing the rate of cognitive decline or time to placement include the use of antioxidants and cholinergic drugs. As studies are completed there will be greater options for physicians. Considerations in pharmacological intervention, including the use of combination drug therapy, will be reviewed. It is important to consider only results from carefully controlled clinical trials, since case reports from pilot studies can be misleading.

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SYMPOSIUM 107—FUNCTIONAL OUTCOME IN BIPOLAR MOOD DISORDERS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

This presentation is designed to provide participants with current knowledge about psychosocial impairment and outcome in bipolar disorders, in relation to syndromal relapse, quality of life, social and economic disability, and current treatment approaches.

No. 107A
SYNDROMAL AND FUNCTIONAL OUTCOME IN BIPOLAR DISORDER

Michael J. Gitlin, M.D., *Department of Psychiatry, UCLA, 300 UCLA Medical Plaza, #2200, Los Angeles CA 90095;* Constance Hammen, Ph.D.

SUMMARY:

The relationship between syndromal and psychosocial outcome in bipolar disorder is more complex than is usually assumed. As opposed to the simple model that posits that poor syndromal outcome predicts poor functional status, the relationship between these two domains of outcome is probably circular, with difficulties in each area contributing to further problems in the other area. In this presen-

tation, we will examine this model, looking at naturalistic data derived from a five-year study of outpatients with bipolar disorder. Despite continuous treatment, the relapse rate in this aggressively treated sample was 73%; most patients suffered multiple relapses. Additionally, evidence from this sample suggests that bipolar patients do not become less sensitive to the effects of stress as triggers for affective episodes. The role of personality traits as modifiers of relapse risk and resiliency from affective episodes is another area just beginning to be explored. Our preliminary data suggest that certain personality traits may diminish the risk of relapse and protect against the effects of stress in triggering episodes.

No. 107B
QUALITY OF LIFE IN BIPOLAR DISORDER

Joseph F. Goldberg, M.D., *Department of Psychiatry, Payne Whitney Clinic, 525 East 68th Street, New York NY 10021;* Martin Harrow, Ph.D.

SUMMARY:

Quality of life (QOL) has increasingly become recognized as an important component of outcome in chronic psychiatric illnesses. We examined QOL in hospitalized bipolar and unipolar patients during a prospective, naturalistic, eight-year follow-up. QOL was assessed from multiple perspectives as a function of syndromal relapse, satisfaction, and outcome.

A total of 206 bipolar and unipolar-depressed inpatients from the Chicago Follow-up Study were assessed at index and followed up after 2, 4.5, and 8 years. Affective relapse and functional outcome were rated using standardized indices. These parameters were compared with a five-point quality of life index based on satisfaction with work, social life, economic status, living conditions, and self-perceived overall mental health.

Results indicated: 1) dissatisfaction with at least one aspect of QOL was evident for 20%-30% of the bipolar sample; 2) nearly one-half of the bipolar patients were dissatisfied with social relationships and activities; 3) overall functioning was associated with greater work and social satisfaction among unipolar patients but *not* among bipolar patients ($p < .05$); 4) affective relapse was strongly associated with work dissatisfaction among bipolar patients but not among unipolar patients ($p < .05$); 5) over 25% of bipolar *or* unipolar patients who were nonsyndromal at follow-up viewed their mental health as impaired.

Overall QOL appears closely tied with objective measures of global functioning among depressed patients and with freedom from affective relapse among bipolar patients. Diminished quality of life is ongoing in one-quarter or more of affectively disordered patients, even in the absence of recent affective relapse.

No. 107C
NEW PSYCHOSOCIAL TREATMENTS FOR BIPOLAR DISORDER

David J. Miklowitz, Ph.D., *Department of Psychology, University of Colorado, Campus Box 345, Boulder CO 80309*

SUMMARY:

There is a renewed interest in the psychosocial risk factors affecting the course of bipolar disorder and in whether psychosocial treatment—delivered in combination with pharmacotherapy—positively influences the long-term course of the disorder. The speaker discusses research on the prognostic role of psychosocial stress factors, with a special emphasis on studies of the family environment and stressful life events. He describes two psychosocial treatments currently under evaluation in controlled experimental trials: a family-focused psychoeducational treatment and an interpersonally focused, individual intervention. Both treatments target recently episodic bipolar patients. They attempt to 1) enhance the patient's attempts to cope with illness-provoking stress agents, 2) restore functional family relationships after the illness episode, and 3) increase the patient's adherence to prescribed medication regimens. The treatments begin during the acute episode and continue through the stabilization and maintenance phases of outpatient treatment. The speaker presents preliminary data on the efficacy of these approaches and on patient retention rates over one-year follow-up periods. Further, he describes a new, more intensive psychosocial intervention program targeting the high-risk bipolar patient, a program that integrates family treatment, individual treatment, and medication.

No. 107D
BIPOLAR I DISORDER: A 15-YEAR FOLLOW-UP

William H. Coryell, M.D., *Department of Psychiatry, University of Iowa, 2887 JPP UI Hospitals & Clinic, Iowa City IA 52242*

SUMMARY:

Earlier reports from the NIMH Collaborative Depression Study—Clinical Branch have quantified, in a five-year follow-up, the profound and pervasive impact of major affective disorder, both nonbipolar and bipolar, on psychosocial adjustment, even among the subset of patients who were in a sustained symptom-free period at the end of follow-up. This presentation will extend the observation period to 15 years and will focus on the likelihood and types of psychosocial impairment and on the predictors of that impairment. Potential predictors will include baseline clinical, demographic, and psychosocial measures. The presentation will also quantify the long-term prognostic significance of symptom levels and psychosocial impairment observed during the first two years of follow-up.

No. 107E
BIPOLAR PATIENTS TREATED IN AN HMO

David J. Katzelnick, M.D., *Dean Foundation, 8000 Excelsior Drive, Ste 302, Madison WI 53717*

SUMMARY:

Data were obtained on 83,167 patients continuously enrolled for an 18-month period (January 1, 1993 to June 30, 1994) in a large group model Midwestern HMO. Of the total sample, 307 patients (0.37%) had a DSM-III-R diagnosis of bipolar (n = 233), schizoaffective (n = 44), or cyclothymic disorder (n = 30). Of the 142 bipolar patients diagnosed during the first six months of the time period, 62% received at least one prescription for lithium carbonate, 18% for VPA, and 13% for carbamazepine.

Patients who took a medication for more than half of the 580-day study were defined as chronic users. Surprisingly, 46% of bipolar patients did not chronically take mood stabilizers and 24% had filled no prescriptions for any mood stabilizer. The rates of chronic use for the other categories of medications were: antidepressants 32%, anxiolytics 4%, and antipsychotics 9%.

Rates of psychiatric hospitalization and rehospitalization in the HMO will be reviewed. Mean costs of mental health services and total medical services utilization per year will be examined. A regression model to evaluate excess medical costs associated with a diagnosis of bipolar disorder will also be discussed. These results will be compared with those from studies done in non-managed-care settings. Future research directions will be explored.

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and Outcome. Washington, D.C.: American Psychiatric Press, in press.
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SYMPOSIUM 108—MANAGING MANAGED CARE: TOOLS TO ENHANCE PRACTICE
APA Consulation Service Board

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to understand the importance of information management in modern practice; to know what information is necessary to treat patients and manage risk; to know what to look for in a management information system.

No. 108A
COMPUTER-ASSISTED SELF-THERAPY

John H. Greist, M.D., *The Dean Foundation, 8000 Excelsior Drive, Ste 302, Madison WI 53717-1914*

SUMMARY:

For disorders where self-help has been shown to be effective, the structure and interactivity provided by computer programs can assist patients in helping themselves. Depression and anxiety disorders are the two areas in which most work has been done. Selmi's cognitive behavior therapy program was effective as human therapy and significantly better than a treatment-on-demand control group, and Ghosh developed a phobia treatment program that was as effective as human therapists. These programs were provided on desktop computers.

Interactive voice response (IVR) permits a computer to respond to key presses on the touch-tone keypad and simple commands ("yes," "no," and numerals from 0 through 10) with spoken text. The telephone thus becomes a computer terminal, and patients use it to give and get information tailored to their particular circumstances. BT Steps and COPE are sophisticated IVR programs that permit patients to effectively assess and treat OCD and depression, respectively. These programs can be available at any time to anyone with access to a touch-tone telephone. Pilot studies of both programs have demonstrated their efficacy.

Computer-assisted self-help therapies can fill part of the gap between what is known and practiced and what is available to sufferers of common psychiatric disorders.

No. 108B
MANAGING CARE AND CAPITATION WITH INFORMATION SYSTEMS

Naakesh A. Dewan, M.D., *Department of Psychiatry, NY Hospital/ Cornell Med Ctr, 21 Bloomingdale Road, White Plains NY 10605*

SUMMARY:

There are varied opinions on the value and values of accepting capitation and risk as a clinician, group practice, or integrated delivery system. Some would argue that accepting risk has the potential of compromising the physician's role as a patient advocate. Others have argued that physicians have an obligation to society to use only medically necessary resources for individuals. No quantitative evidence exists to affirm either perspective. Information systems and measurement technologies that are being implemented today may provide clinicians the necessary tools to accept risk and maintain their primary obligation to individual patients. This presentation will review the need for such systems as psychiatry heads into the next millennium.

No. 108C
THE STRATEGIC ROLE OF INFORMATION SYSTEMS IN MANAGED BEHAVIORAL HEALTH CARE

John L. Koontz, B.A., *Psychconsult Consortium, 1350 East Madison Park, Ste 2A, Chicago IL 60615*

SUMMARY:

This presentation will introduce attendees to Psych Consult, an integrated behavioral health management system whose administrative, functional, and clinical functions are all focused on patient well-being. From the beginning, it was designed to support every aspect of an integrated delivery network. Administrative functions of the system include billing and collections, managed care capitation, scheduling, utilization management, provider credentialing, chart tracking, and compliance with JCAHO and NCQA standards. Clinical functions include case management and contact tracking, compliance with treatment guidelines, and treatment planning with clinical documentation.

No. 108D
BARRIERS TO INFORMATION SERVICES IN PSYCHIATRY

Norman E. Alessi, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor MI 48109;* Milton Huang, M.D.

SUMMARY:

Whether practitioners are in a solo private practice, group practice, a managed care corporation, or an academic medical center, the practice of psychiatry will change considerably in the next several years. Attributed to managed care, the foundation of this change will be accomplished through increased use of advanced information technology. These technologies will make us see our patients differently, collecting information about them and in turn providing information about ourselves, as practitioners. Despite compelling evidence showing the increased use of information technology in psychiatric practice, tremendous barriers to its acceptance and use remain.

The purpose of this presentation is to articulate the barriers that exist to the implementation of information services within psychiatry and approaches for overcoming them. These barriers exist in many arenas. For the individual, changing how one collects clinical information, issues of confidentiality, altered perception of the professional self as a clinician, and monitoring of one's practice, will slow the acceptance of technology. In organizations, these areas translate into the broader issues of workflow analysis, reengineering, and the integration of technology into the clinical culture.

No. 108E
EXPERT SYSTEM DECISION SUPPORT SOFTWARE

Bruce Meltzer, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh PA 15213;* Edmund Pigott, Ph.D.

SUMMARY:

Traditionally, the presence of certain signs and symptoms served as automatic indicators for admission to hospital. Clinicians are now uncoupling the severity of symptoms from treatment interventions and the level of care at which services are delivered. The use of information systems and computer technology has been a major contributor to this change. This presentation focuses on the development and use of expert systems within integrated medical delivery systems. Particular attention is paid to making use of such software integral to the delivery system's clinical quality improvement processes.

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SYMPOSIUM 109—SUICIDE ACROSS CULTURES

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to recognize special issues in the assessment of suicidality in culturally diverse youth; to identify features associated with suicidal behavior in the Chinese; to identify differences among Hispanic groups in attitudes and risk factors for suicide; to understand the significance of reasons for living in the assessment of suicide risk.

No. 109A
CULTURAL ASPECTS OF YOUTH SUICIDE

Cynthia R. Pfeffer, M.D., *Department of Psychiatry, New York Hospital, 21 Bloomingdale Road, White Plains NY 10605*

SUMMARY:

The recognition of the increasing suicide rate among youth under age 25 in many countries has stimulated intense interest in understanding cultural influences on youth suicide risk. This presentation will highlight international epidemiological trends for youth suicide and compare psychosocial characteristics associated with youth suicide. Among the issues discussed are availability of guns, abuse of drugs and alcohol, psychiatric disorders, and family history. Finally, features of underlying biological factors will be reviewed. This presentation will offer insights about working with children and adolescents with diverse cultural backgrounds, with the aim of reducing risk for suicidal behavior.

No. 109B
SUICIDAL BEHAVIOR IN THE CHINESE CULTURE

John A. Chiles, M.D., *Department of Psychiatry, Univ of TX Hlth Sci Ctr, 7703 Floyd Curl Drive, San Antonio TX 78284;* Yan-Ping Zheng, M.D., Kirk D. Strosahl, Ph.D.

SUMMARY:

While Chinese and American patients show similarities in variables related to suicidality, the relationship noted in the West between hopelessness and suicide intent may not occur in Chinese culture. A comparison of age- and sex-matched patients from each country shows hopelessness significantly predicts intent in Americans but not Chinese. Additionally, the American sample has suicidal ideation earlier in life and reports more communication of intent and more suicide attempts. Problems precipitating the suicidal behavior differ between groups, with approximately 50% of the Americans citing problems with significant others (relationships), and approximately 50% of the Chinese citing physical problems. The American group rates suicidality as a more effective problem-solving behavior. The Chinese view social disapproval as a more significant reason for not committing suicide.

These results suggest that some factors cited in Western-oriented theories concerning suicidality may not have universal applicability. Further, since repeated attempts may be less likely in the Chinese, whose culture sees suicidality less as a symptom of illness and more as socially undesirable behavior, some aspects of the more supportive (and reinforcing?) postsuicide-attempt reaction typical in American clinics may merit reconsideration.

No. 109C
REASONS FOR LIVING IN THE SUICIDALLY DEPRESSED

Kevin M. Malone, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, Box 28, New York NY 10033;* Maria A. Oquendo, M.D., J. John Mann, M.D.

SUMMARY:

The variation in suicide rates among different cultures, races, and ethnic groups may be related to different beliefs and family and social networks, which may contribute significantly to a person's reasons for living. We hypothesized that certain "reasons for living" such as coping beliefs, family responsibilities, fear of social disapproval, and moral objections might protect or restrain patients with major depression from otherwise making a suicide attempt.

We studied 97 hospitalized patients with major depression, 49 suicide attempters and 48 nonattempters. Severity of depression, hopelessness, and reasons for living (RFL scale, M. Linehan *et al*) were measured. There were no demographic or clinical differences in severity of depression between suicide attempters and nonattempters. Depressed nonattempters had more RFL than depressed suicide attempters (186.7 ± 40 vs 142.3 ± 40.8, $t = -5.43$, $p < 0.0001$). RFL inversely correlated with hopelessness ($r = -0.62$, $n = 91$, $p < 0.0001$).

Reasons for living, including coping beliefs, family responsibilities, fear of social disapproval, and moral objections, may counteract hopelessness and protect against suicidal behavior during periods of risk, such as major depression, which may account for differences in suicide rates among different cultures. Therapeutic efforts to reduce risk of suicide that target reasons for living should be evaluated.

No. 109D
CULTURAL ISSUES IN DEPRESSION AND SUICIDE: AN OVERVIEW

Renato D. Alarcon, M.D., *Department of Psychiatry, Emory University, 1670 Clairmont Road, Atlanta GA 30033*

SUMMARY:

Objectives: As culture plays a multidimensional role in the production, assessment, understanding, diagnosis, and management of depression, it is important to address such issues in the context of epidemiological findings, social factors, and clinical characteristics of the disorder and its suicidal sequelae.

Methods: Literature review, clinical experiences, comparative and critical analysis of cultural factors in depression and suicide are used, following Manson's model, with an emphasis on variations among different ethnic groups.

Results: The cultural perspectives of depression comprise issues such as the distinction between psyche and soma, delineation of self and loci of emotion, variations in the language of affect, the selective elaboration of emotional experiences, and differences in symptomatology, ethnophysiology, narrative context, and suicidal pathways. Special attention and clinical vignettes are devoted to cases in the Hispanic population.

Conclusions: Familiarity with issues in depression and suicide across cultural and ethnic groups facilitates interpretive/explanatory, pathogenic/pathoplastic, and therapeutic approaches to this important public mental health problem.

No. 109E
UXORICIDE AND SUICIDAL BEHAVIOR IN A MEXICAN MALE

J. Arturo Silva, M.D., *Department of Psychiatry, Audie L. Murphy VAMC, 7400 Merton Minter Blvd., San Antonio, TX 78284*

SUMMARY:

The case of a Mexican male who killed his wife is presented. His homicidal behavior was followed by a serious suicide attempt, resulting in significant brain injury. The man's suicidal and homicidal behaviors are analysed from both psychodynamic and cultural perspectives. Specifically, the role that jealousy and machismo played in this man's suicidal and homicidal behaviors is explored from a biopsychosociocultural framework. A brief overview of suicide and homicide among Hispanics is provided. The value of the perspective of the emerging field of transcultural-forensic psychiatry is emphasized.

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SYMPOSIUM 110—ICD-10 NEURASTHENIA: TRANS-PACIFIC COMPARISONS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to demonstrate an understanding the complex influences of sociocultural factors on the manifestation of neurasthenia and related somatoform disorders and to identify cases compatible with ICD-10 definition of neurasthenia.

No. 110A
CULTURAL EPIDEMIOLOGY OF NEURASTHENIA AND CHRONIC FATIGUE SYNDROME

Mitchell G. Weiss, M.D., *Public Health, Swiss Tropical Institute, Socinstrasse 57, Basel CH-4002, Switzerland*

SUMMARY:

A multicenter study of neurasthenia (NT) and chronic fatigue syndrome (CFS) examined the cultural epidemiology of these disorders among Caucasians in Los Angeles and ethnic Chinese in Los Angeles, Chang-Sha, Kaohsiung, Hong Kong, Los Angeles, and Toronto. In addition to studies of case criteria for various formulations of NT and CFS, this research also considered cultural dimensions of illness experience, known collectively as illness explanatory models. Patterns of distress, perceived causes, history and preferences for help seeking and treatment, and other aspects of illness experience were studied with reference to diagnostic criteria and across ethnic groups using an appropriately adapted formulation of the Explanatory Model Interview Catalogue. Experience from the study has demonstrated an approach for evaluating the cultural validity of NT and CFS and identified distinctive features of these disorders with respect to ethnicity, immigration status, and local cultural setting. Findings indicate the importance of cultural dimensions of illness experience and their direct bearing on practical concerns for effective clinical care and planning of health services for NT, CFS, and related clinical disorders encountered in primary care.

No. 110B
PSYCHIATRIC MORBIDITY OF CHINESE OUTPATIENTS WITH CHRONIC FATIGUE

Char-Nie Chen, M.D., *Department of Psychiatry, Chinese University of Hong Kong, Shatin, NT, Hong Kong;* Song Lee, M.D.

SUMMARY:

Objective: To examine the psychiatric morbidity of Chinese outpatients with medically unexplained chronic fatigue. To establish the prevalence of neurasthenia and chronic fatigue syndrome among such patients and to compare these two apparently similar conditions.

Method: 100 subjects aged 18 to 65 who felt tired or weak in the previous six months were recruited from a primary care family clinic. Medical and psychotic diseases that accounted for their symptoms were excluded. They were examined by the Structured Clinical Interviews for DSM-III-R, the Chinese (CCMD-2), and ICD-10 criteria for neurasthenia, the CDC criteria for chronic fatigue syndrome, and an anthropological interview schedule—the Explanatory Model Interview Catalogue.

Results: The most common psychiatric diagnoses in this sample were somatoform pain disorder (47%) and undifferentiated somatoform disorder (35%). Forty patients had lifetime major depression. Fifty-seven subjects fulfilled the CCMD-2 criteria for neurasthenia,

30 met the ICD-10 criteria for neurasthenia, but only three subjects satisfied the CDC criteria for chronic fatigue syndrome.

Conclusion: Chronic fatigue syndrome in Western countries is rare and not equivalent to Chinese neurasthenia.

No. 110C
DIAGNOSIS AND CULTURAL MEANING OF NEURASTHENIA IN CHINA

Derson Young, M.D., *Department of Psychiatry, Hunan Medical University, Remin Road 156, Changsha Hunan, China;* Yalin Zhang, M.D., Ling-Jian Li, M.D., Keh-Ming Lin, M.D., Yan-Ping Zheng, M.D.

SUMMARY:

Neurasthenia (NT) is a disease concept that is well recognized and regarded as highly prevalent by public as well as professionals in Chinese societies, especially in Mainland China. This study examined the diagnostic validity of NT and cultural influence on illness perception, help seeking, and stigmatization. Seventy-nine subjects who have been diagnosed as having NT based on CCMD-2 diagnostic criteria were recruited. The SCID with supplement for NT and CFS diagnoses, SCL-90 with supplement for NT and CFS symptoms, HAMD, HAMA, and Explanatory Model of Illness Catalog (EMIC) were conducted by face-to-face interview. The results showed that 1) 78.5% (62 cases) fit ICD-10 NT diagnosis; 88.6% (70 cases) fit DSM-IV (draft) NT diagnosis; only 20.3% (16 cases) fit CDC criteria for CFS; 2) 72.2% (57 cases) of the CCMD-2-defined NT had no DSM-III-R diagnoses (pure NT); 27.8% (22 cases) overlapped with depression (10 cases), anxiety disorders (nine cases), and somatoform disorders (three cases); 3) 41% of the patients with pure NT attributed their illness to psychosocial stress, especially stress related to interpersonal relationships. However, these patients initially sought help from general medicine and Chinese medicine because of physical symptoms; 4) they were less stigmatized compared with patients with other psychiatric conditions such as depression and schizophrenia. We conclude that NT is a valid diagnostic category manifested predominantly by somatic symptoms. Cultural determinants, such as psychosocial stress, social support network, health care system, and personal belief system are major components of shaping the patterns of distress, perceived causes, and preferences of help seeking and treatment.

No. 110D
A CROSS-CULTURAL STUDY OF NEURASTHENIA AND CHRONIC FATIGUE SYNDROME IN LOS ANGELES

Keh-Ming Lin, M.D., *Department of Psychiatry, Harbor-UCLA Medical Center REI, 1124 West Carson Street, Torrance CA 90002;* Freda Cheung, Ph.D., Yan-Ping Zheng, M.D., Mitchell G. Weiss, M.D., Gayle Nakasaki, M.S.W., Yue-Lan Ren, M.D.

SUMMARY:

The validity and cultural meaning of neurasthenia (NT) and chronic fatigue syndrome (CFS) have been under intense debate in recent years. Despite substantial morbidity often associated with these conditions, drastic cross-cultural contrasts in their prevalence, and their inclusion in the ICD-10, few systematic efforts have been made to clarify the clinical characteristics and sociocultural correlates of these syndromes. This study utilized innovative structured and semistructured interview instruments to elicit clinical and ethnocultural information from both Chinese-American and Caucasian subjects with prominent fatigue. Results showed striking similarity in symptom profiles between NT and CFS, as manifested in scores and profiles of the SCL-90 and the Hamilton Depression and Anxiety Rating Scales. However, the two conditions diverged remarkably in terms of their perception of the cause of their afflictions as well as their help-seeking patterns, with NT patients reporting significantly more psychological (mostly related to psychosocial stress) and traditional spiritual causes and CFS subjects subscribing predominantly to biological explanations for the fatigue. While both groups were eclectic in their help-seeking patterns, Chinese NT patients were significantly more receptive to mental health interventions and reported better responses to such treatments than did Caucasian CFS subjects.

No. 110E
CHRONIC PERSISTENT FATIGUE: A COMPARATIVE STUDY

Mian-Yoon Chong, M.D., *Department of Psychiatry, Kaohsiung Medical College, 100 Shiuh-Chuan First Road, Kaohsiung 80708, Taiwan;* Yuh Lee, M.D., Jung-Kwang Wen, M.D.

SUMMARY:

Objective: To investigate psychopathology and illness behavior of patients with chronic persistent fatigue.

Method: One hundred patients aged 18 to 65 with problems of chronic fatigue of six months and longer were included in the study. Excluded were those with illness of organic or psychotic origin. They were systematically assessed using the Structured Clinical Interview for DSM-III-R (SCID) and Explanatory Model Interview Catalogue (EMIC).

Results: Patients with fatigue syndrome manifested a highly heterogenous diagnostic entity, most of which were minor psychiatric disorders, with 26% having undifferentiated somatoform disorders. There were no cases diagnosed as chronic fatigue syndrome (CFS); however, 11 cases met the criteria for neurasthenia. Their perceived causes varied, with only 41% of psychological origin. There were no significant relationships between their perceived causes and pattern of distress. A pluralistic pattern of help-seeking behavior was found.

Conclusion: Contrary to most Western studies, this study did not find any cases with CFS. The distribution of neurasthenia in this study was found to be similar to that in Hong Kong but different from Hunan (China). While psychopathology is generally seen as a universal phenomenon, its symptom manifestation, however, could be influenced by cultural variation. This study implied that fatigue syndrome could well be fitted to the above notion.

No. 110F
AN EPIDEMIOLOGICAL STUDY OF NEURASTHENIA IN CHINESE-AMERICANS IN LOS ANGELES

Yan-Ping Zheng, M.D., *Department of Psychiatry, Harbor-UCLA REI, 1124 West Carson Street, Torrance CA 90502;* Keh-Ming Lin, M.D., David T. Takeuchi, M.D., Karen S. Kurasaki, Ph.D., Yongxiao Wang, Ph.D., Freda Cheung, Ph.D.

SUMMARY:

The prevalence, clinical characteristics, and psychosocial correlates of ICD-10-defined neurasthenia (NT) were studied in a large-scale community epidemiological survey of 1,747 Chinese Americans residing in Los Angeles. The enhanced CIDI, with a supplemental NT module, was used for assessing psychiatric morbidity, which generated the diagnosis of ICD-10-defined NT in addition to common DSM-III-R diagnoses. The SCL-90-R was used for measuring psychiatric symptoms. Dimensions of social stress and social support were also measured. The first wave of the study identified a total of 113 NT subjects (6.5%). Of these, 64 (56.6%) did not experience

current or lifetime DSM-III-R diagnoses, yielding a 12 months' prevalence rate of "pure" NT of 3.7%. These rates were much higher than for any of the other psychiatric diagnoses. Compared with normal subjects, "pure" NT subjects had significantly higher SCL-90-R total and factor scores, experienced more psychosocial stress, and perceived less social support (Ps < 0.05 or 0.01). Compared with depression and anxiety disorders, "pure" NT cases reported significantly less SCL-90-R psychological symptoms (Ps < 0.05 or 0.01), but had strikingly similar elevation in the somatization subscale scores. These data suggest that NT is a discreet syndrome overlapping only partially with the other better-recognized diagnostic entities. In view of its high prevalence and the salience of its impact on the health of those afflicted, it is imperative that research efforts be made to further elucidate the temporal stability, natural course, and outcomes of such a condition.

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SYMPOSIUM 111—SUBSTANCE ABUSE AND PSYCHOPATHOLOGY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of the presentation the participant should be able to recognize and identify comorbid psychiatric patients, more accurently diagnose comorbid conditions and enhance their treatment of these patients.

No. 111A
SUBSTANCE ABUSE COMORBIDITY IN PERSONALITY DISORDERS

Kathleen T. Brady, M.D., *Department of Psychiatry, Medical University of SC, 171 Ashley Avenue, Charleston SC 29425-0742;* Susan C. Sonne, Ph.D.

SUMMARY:

Personality disorders are commonly diagnosed in individuals with substance use disorders. Different personality disorder (PD) types may be more commonly associated with different substances of abuse. In a study conducted at our site of PD in cocaine- and alcohol-dependent individuals, the cocaine group was significantly more likely to have Cluster B and less likely to have Cluster A diagnoses. Substances of abuse and the life styles associated with them can mimic PD.

Results from a study in which 67 cocaine-dependent individuals were interviewed for a PD diagnosis upon treatment and 12 weeks later will be discussed. Urine drug screening and self-report of cocaine use were done weekly. At study entry, 66% of cocaine patients met DSM-IV criteria for numerous PD diagnoses. Over the 12-week period, 27% of the patients had a significant reduction in the number of PD's for which the met diagnostic criteria. These individuals were significantly more likely to have been abstinent or used less cocaine during the study period. Considerations for the accurate diagnosis of PD in substance abuse will be discussed.

No. 111B
COCAINE ABUSE IN ACUTE SCHIZOPHRENIA

Mark R. Serper, Ph.D., *Department of Psychology, Hofstra University, Box 127, Hempstead NY 11550;* James C.Y. Chou, M.D.

SUMMARY:

Dopamine function has been hypothesized to be involved in both producing schizophrenic (SZ) symptoms and mediating cocaine's reinforcing properties. As a result, cocaine abuse in schizophrenic patients may be seen as a "natural experiment" that may alter the phenomenology and neurobiology of the disorder. Cocaine intoxication and cessation have profound effects on SZ patients' severity of psychosis, mood symptoms (including anxiety and depression), as well as the negative syndrome.

This presentation will examine the clinical effects of cocaine intoxication and withdrawal in acute SZ patients at two time points: at presentation to the psychiatric emergency service, and again after four weeks of coaine abstinence and remission of psychosis. Assessment instruments included the BPRS, SANS, SAPS, Chapman Psychosis Proneness Scales, and the BDI. SZ nonabusers and cocaine abusers without other Axis I disorders served as comparison groups. A series of MANOVAs revealed that at acute intoxication, SZ cocaine abusers present with significantly more hallucinations, depression, and anxiety symptoms than their nonabuser SZ counterparts (p's < .001), but not more overall psychosis as measured by the SAPS. SZ cocaine abusers also present with significantly fewer negative signs and symptoms than SZ nonabusers at admission. Discriminant function analysis was able to classify over 84.3% of cases correctly. Discussion will focus on the neurobiological impact of cocaine on SZ presentation and course of illness.

No. 111C
PREDICTORS OF SUBSTANCE ABUSE IN HOSPITALIZED ADOLESCENTS

David L. Pogge, Ph.D., *Department of Child and Adolescent Psychiatry, Four Winds Hospital, 800 Cross River Road, Katonah NY 11704*

SUMMARY:

Many mental disorders begin to emerge in adolescence and manifest as serious misbehaviors. Some of the most frequently diagnosed disorders of childhood evolve into patterns of serious misconduct by adolescence. In both instances, these frequently include substance abuse. Analyses of substance abuse patterns indicate that the early-onset variety is often a distinctive and chronic form of this behavior. It is, therefore, critical to characterize substance abuse in adolescents along dimensions that might allow a differentiation of primary, secondary, and comorbid disorders, and to differentiate substance abuse that is likely to become chronic from that which is transient.

In a series of studies we have found that neurocognitive variables, such as attentional control and impulsivity, psychological variables such as depression, and psychosocial variables such as child abuse all appear to contribute to substance abuse patterns and disorders in adolescents. Examination of these variables may provide clues to

substance abuse subtypes, their etiologies, and optimal intervention strategies. The purpose of this presentation will be to present our data and review these issues in the context of studies of these variables. New data will also be presented that suggest important lines of investigation for future research in this area.

No. 111D
SUBSTANCE ABUSE IN RELATION TO SUICIDAL BEHAVIOR IN SCHIZOPHRENIA

Gretchen Haas, Ph.D., *Department of Psychiatry, University of Pittsburgh, Pittsburgh PA 64045*

SUMMARY:

Background: Drug use disorders are common among suicide attempters. Increased rates of suicide are associated with narcotic, cocaine, and polydrug abuse in the U.S., and the presence of comorbid psychiatric and substance use disorders is one of the more sensitive predictors of lifetime risk for suicide. In schizophrenia, suicide is the most common cause of premature death, with a 10% rate of death by suicide and a 40% lifetime prevalence of suicide attempts.

Methods: 160 DSM-III-R schizophrenia inpatients (70 suicide attempters and 90 nonattempters) were evaluated on measures of clinical symptomatology, substance abuse, and psychosocial stressors, on admission to hospital and at one-year follow-up.

Results: One of the principal lifetime antecedents to suicide attempts was the onset of a substance use disorder, conferring a two- to three-fold increase in risk for a suicide attempt in schizophrenia. Alcohol use disorders were the single most common disorder, although the majority of cases had a history of comorbid (primarily marijuana and cocaine) drug use disorders. In a majority of cases, the onset of alcohol and other drug use preceded the first suicide attempt.

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SYMPOSIUM 112—PUBLIC SECTOR USE OF PRACTICE GUIDELINES

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

To evaluate the strategies used by several states to encourage the acceptance and modification of practice guidelines for several major psychiatric disorders, and to consider how these guidelines might be introduced in further settings and areas of practice.

No. 112A
PRACTICE GUIDELINES: A META-ANALYSIS OF RANDOMIZED CONTROLLED IMPLEMENTATION STUDIES

Molly T. Finnerty, M.D., *Department of Psychiatry, NYS Psychiatric Institute, 722 West 168th Street, Unit 92, New York NY 10032;* David A. Kahn, M.D., Mark Olfson, M.D.

SUMMARY:

Political and economic factors have led to an increasing interest in establishing physician-generated practice guidelines. Currently, over 2,000 guidelines have been developed. In psychiatry, practice guidelines are being developed by APA and other agencies, and multiple guidelines have been generated for the treatment of schizophrenia, bipolar disorder, and other select Axis I disorders. However, the experience in general medicine suggests that guideline development is not sufficient. If practice guidelines are to "make good on the promise," implementation is an essential next step. We are not aware of any published reports using psychiatric guidelines, but there is a growing literature of randomized controlled implementation studies for practice guidelines in medicine. We present a meta-analysis of guideline implementation strategies, including computer reminders, feedback mechanisms, and consensus development, and discuss the potential application for psychiatry as we enter a new phase of the guideline development process.

No. 112B
CLINICAL GUIDELINES FOR THE DUALLY DIAGNOSED IN MARYLAND

Brian M. Hepburn, M.D., *Mental Hygiene Administration, 201 West Preston Street, Baltimore MD 21201;* Stuart B. Silver, M.D.

SUMMARY:

In January 1977, the State of Maryland began a managed care program for its medical assistance recipients. Substance abuse will be under the primary medical managed care program. Mental health will be under a separate managed care system. Mental health will be managed by an Administrative Service Organization (ASO). The ASO will evaluate the medical necessity for initial treatment and continued care. The ASO will be responsible for the evaluation of both MA recipients and non-MA recipients who meet the financial criteria for services under the public mental health system. The new managed care programs will present many challenges to clinical care. A particularly challenging area will be in the treatment of individuals with dual diagnoses. This presentation will identify the clinical guidelines established for the dually diagnosed individuals. Substance abuse coexisting with mental illness will be emphasized, because of the unique difficulties presented by having them managed by two different managed care programs.

No. 112C
IMPLEMENTING PRACTICE GUIDELINES IN A STATE SYSTEM

Dale P. Svendsen, M.D., *Medical Director, Ohio Department of Mntl Hlth, 30 East Broad Street, 8th Flr, Columbus OH 43215*

SUMMARY:

States have long had rules and policies to define and regulate mental health care and services. Still there has been great latitude in the care provided. Now, with recognized practice guidelines and with computer technology to assist in monitoring, it is possible to standardize care across the system. However, it takes working together at the local level to get real buy-in. Ohio's hospital reengineering efforts to install practice guidelines on the state level and at the local hospital level will be discussed.

No. 112D
THE TEXAS MEDICATION ALGORITHM PROJECT

Steven P. Shon, M.D., *Department of Psychiatry, UT Southwestern Medical Center, 5959 Harry Hines Blvd, Ste 600, Dallas TX 75235-*

9070; A. John Rush, M.D., Marcia G. Toprac, Ph.D.. M. Lynn Crismon,, Pharm.D., Kenneth Z. Altshuler, M.D.

SUMMARY:

The American Psychiatric Association has developed and disseminated clinical practice guidelines for the treatment of bipolar, major depressive, and schizophrenic disorders. Treatment principles and range of options are outlined in most clinical practice guidelines. However, the next step, implementation, requires somewhat greater specificity (i.e., adaptation of these principles to the particulars of populations and providers). The Texas Department of Mental Health and Mental Retardation (TDMHMR) in collaboration with the University of Texas Southwestern Medical Center and other University of Texas departments of psychiatry has initiated such a project (TMAP). Three phases—definition of specific medication guidelines (or algorithms), feasibility testing, and clinical/economic impact evaluation—are planned. The first two steps will be completed by May 1997. Consensus methods were used to define the algorithms for each of three disorder groupings. The feasibility study (open trial) is ongoing at 16 sites (40 physicians and 400 patients). Physician and patient educational materials have been developed—the latter with critical input by the Texas Alliance for the Mentally Ill, Depressive and Manic Depressive Association, Mental Health Association, and Texas Mental Health Consumers. The design of this prospective comparison of "with" versus "without" algorithms as well as an update of the project will be presented.

No. 112E
SETTING UP A PUBLIC-SECTOR PRACTICE GUIDELINE NETWORK

William M. Tucker, M.D., *NYS Office of Mental Health, 44 Holland Avenue, 8th Floor, Albany NY 12229*

SUMMARY:

A tri-university consortium (Duke, Columbia, and Cornell) produced a set of practice guidelines based on research data and expert opinion that extend APA's guidelines for the treatment of bipolar disorder and schizophrenia. In order to broaden the base of clinical input and to test the applicability of these guidelines to a disabled and often refractory population, the consortium invited public-sector psychiatrists employed by the New York State Office of Mental Health to review, implement, and critique the extended guidelines. Forty-two joined this network on a voluntary basis, motivated by a desire to participate in elaborating the standards by which they would then be expected to practice. Training in the use of the guidelines was provided through the medium of satellite television. The results of the first year of the network's findings, including modification of the original guidelines, degree of satisfaction with network participation, and peer-teaching in the use of the guidelines by network members, will be presented.

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SYMPOSIUM 113—MENTAL ILLNESS AND CHEMICAL ABUSE: A MULTIMODAL MODEL

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to know therapeutic community strategies for peer pressure, behavioral shaping, and a positive identification with the community; to list strategies for increasing motivation; to combine a medical model, community approach, and self-help techniques; to recognize pitfalls of neglecting previous behavior; to work with patients' significant others to sustain care around them.

No. 113A
PSYCHIATRY CAN LEARN FROM THERAPEUTIC COMMUNITIES

Gregory C. Bunt, M.D., *Manhattan Psychiatric Ctr, Ward's Island, New York NY 10035*

SUMMARY:

The drug-free therapeutic community (TC) was developed to provide a structured treatment environment for rehabilitating the behavior and attitudes of the drug addict. Methods employed include cognitive and behavioral modification with positive as well as negative reinforcement. Advantages of applying some of the principles of TC to mental health programs for the dually diagnosed are: promotion of discipline and a work ethic; the provision of an organized functional community; and instilling a sense of individual and social responsibility among members.

However, the application of the TC treatment philosophy to mental health treatment is replete with clinical and administrative challenges. Considerable ambiguity arises from applying the TC approach under the current mental health regulatory guidelines. Examples of clinical and/or regulatory issues with substantial conceptual polarities include: negative reinforcers vs. punishment; work ethics vs. work requirements; voluntariness vs. coercion; social/community disapproval vs. humiliation; self-disclosure vs. privacy/confidentiality; earned privileges vs. preferential treatment.

Programs showing how clinicians can reconcile these ostensible polarities to provide effective contemporary treatment approaches for the dually diagnosed will be described. Also discussed will be proposals for modifying public policy in regard to evolving mental health systems' needs and the rising number of mentally ill chemical abusers.

No. 113B
INCREASING MOTIVATION FOR MICA TREATMENT

Douglas M. Ziedonis, M.D., *Department of Psychiatry, Yale University, 34 Park Street, New Haven CT 06508*

SUMMARY:

Patients who have both substance abuse and other major psychiatric diagnoses are notoriously difficult to engage in treatment. Often they seek alternate states of consciousness, and polydrug abuse is more the norm than the exception it formerly was. A fresh clinical perspective is needed. The Motivation-Based Dual Diagnosis Treat-

ment model integrates the five motivational stages of Prochaska et al. (precontemplation, contemplation, preparation, action, maintenance) with various assessment and treatment approaches. Motivation Enhancement Therapy (MET) can be linked with Dual Diagnosis Relapse Prevention (DDRP). MET describes the patient as self-directed—a person responsible for and capable of changing his/her behavior, the clinician assists such patients in mobilizing their own inner resources—a process that largely depends on the clinician's ability to listen well and empathize sincerely. DDRP is a hybrid therapy that integrates and modifies substance-abuse relapse prevention and psychiatric social skills training.

In the community setting these therapies are modified further as the patient is subject to heavy peer pressure in addition to self-direction. Contemplation is enriched by the many additional perspectives offered on the past, but also by the community's willingness to forget the past and start all over again.

No. 113C
MICA REHABILITATION APPROACHES

Zebulon C. Taintor, M.D., *Department of Psychiatry, NY University Medical Center, 550 First Avenue, NB 20N11, New York NY 10016;* Gideon Nachumi, M.D.

SUMMARY:

We describe a program in which action on all of the following is apparent: 1) A person can separate from a mental illness by identifying symptoms and controlling them. Some people achieve mastery over their symptoms and lead normal lives with little or no medication. 2) Thoughts have no consequences unless they lead to action, so a free range to thoughts and feelings is desirable, since they are key to understanding one's self. But the first step is to understand what thoughts and urges are products of one's illness. 3) Behavioral feedback and affirmation of positive values come from the environment—patient peers, the staff, society at large. Actions speak louder than words. 4) Often, a lot of the persona is occupied by the illness. Treatment of the illness reduces it and allows room for personal development/redevelopment. Not addressing the person apart from the illness predisposes towards relapse. It is best to proceed skill by skill, developing a sense of competence and ability as well as finding out what the person wants to do. 5) Patients should be fully informed about their illnesses and use that knowledge to help each other, so we give them copies of what we write about them.

No. 113D
PERILS OF CROSS-SECTIONAL FUNCTIONAL MEASUREMENTS

Sheldon Zimberg, M.D., *Department of Psychiatry, Manhattan Psychiatric Center, Ward's Island, New York NY 10035;* Rekha Mehta, M.D.

SUMMARY:

One of the problems of the therapeutic community approach and the pressure to adopt a new persona is that a person may seem better than he or she would be in a less structured and caring environment. Patients seem ready for discharge, except that there is no place where they would get care as good as they are presently receiving. Although our unit uses a system of progressing through various settings (while having the same treating psychiatrist) to an open place where the environmental cues are ambiguous and the choices are many, we don't offer the amount of drug-taking opportunities available in the street. A method of assessing and assigning risk using history, records of arrests and prosecutions, and interviews with clinicians not directly involved in patient care has been developed in response to the problem of patients who have been doing well in protected settings running away and committing major crimes. Also useful in attempting prediction is a diagnostic scheme for improved separation of various types of MICA patients that shows that one condition can cause the other, or that they may coexist unrelatedly. We describe our experience with about 300 patients seen by the Privilege Assessment Review Committee.

No. 113E
AMBULATORY PEER-LED MICA TREATMENT

Marc Galanter, M.D., *Department of Psychiatry, NY University Medical Center, 550 First Avenue, New York NY 10016*

SUMMARY:

As society has become increasingly urbanized and relationships are less dependent on a person's immediate surroundings, people suffering from chemical abuse and mental illness can isolate themselves even more successfully. Many are involved in damaging games of the sort described by Berne and other transactional analysts. Network therapy is related to therapeutic community operations in that both attempt to overcome the patient's isolation by creating a community around him/her. The difference involves the lack of the residential setting that determines the community in which treatment starts. The network therapist has to discover the significant people around the person and persuade them to get involved constructively. The therapy draws on sociology and anthropology in addition to being highly practical and requiring specific interventions by particular people at scheduled times. Network therapy results in a small, caring community around the patient while both are involved in the community at large.

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SYMPOSIUM 114—ALGORITHMS FOR MEDICAL TREATMENT OF MOOD DISORDERS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The participants will be able to identify the medical "treatment(s) of choice" for uncomplicated mood disordered patients and for some patients presenting with a variety of comorbid problems on Axis I, II, and III.

No. 114A
ALGORITHMS FOR DEPRESSION: PART I

David N. Osser, M.D., *Department of Psychiatry, Harvard Medical School, 150 Winding River Road, Needham MA 02192*

SUMMARY:

In this presentation a flowchart showing proposals for the best early pharmacotherapies of major depression (nonpsychotic and psychotic), dysthymia and depression NOS, and bipolar (I, II, and mixed/rapid-cycling) depression will be presented. Most patients with dysthymia, nonpsychotic major depression, and bipolar II depression are to be given an SSRI as the first-line choice. After adequate trials (defined) of the initial medication, nonresponders may receive a second SSRI trial if the urgency for relief is moderate. If urgency is high, they may be switched to certain other antidepressants or receive the addition of an augmentation agent. Tricyclics are suggested for initial treatment of severely depressed, mood nonreactive, melancholic patients (nonpsychotic, nonbipolar) without significant cardiac ischemia or dementia, especially if older and hospitalized. Nonresponders are offered augmentation: preferences are indicated. Bipolar I depressed patients receive lithium as first-line treatment unless they are currently on some other mood stabilizer. Otherwise, an SSRI is proposed as the first antidepressant to add, followed by bupropion. Mixed/rapid cycling patients with depression as the predominant problem receive lithium alone as first-line treatment. Psychotic depressed patients may initially be offered ECT or tricyclic/neuroleptic combination initially, then augmentation with lithium or a stimulant. For all depression subtypes, there may be indications for alternative strategies.

No. 114B
AN ALGORITHM FOR TREATMENT-RESISTANT DEPRESSION

J. Craig Nelson, M.D., *Department of Psychiatry, Yale University, 20 York Street, New Haven CT 06504*

SUMMARY:

Algorithms for treatment of psychiatric disorders have become more popular for several reasons. They are an attempt to distill what we know from controlled studies and to explicate what clinicians agree on. Several groups, for example the International Algorithm Committee and the Texas Department of Mental Health and Retardation, have developed algorithms for the treatment of depression. The previous presentation will describe an algorithm for beginning treatment of major depression. This presentation will focus on treatment of resistant depression. The advantages of augmentation versus switching will be examined. A rationale that might influence the selection of the next agent will be considered. A sequence for augmentation will be presented. The timing of these interventions will be discussed. Descriptive aspects of the depression that might lead to the selection of one strategy versus another will be outlined.

No. 114C
ALGORITHMS FOR ACUTE TREATMENT OF MANIA

Philip G. Janicak, M.D., *Department of Research, Psychiatric Institute, 1601 West Taylor Street, Chicago IL 60612;* Rajiv P. Sharma, M.D., Eileen O'Connor, R.N., Edward Altman, Psy.D., Sheila Dowd, M.S., John M. Davis, M.D.

SUMMARY:

For classic manic presentations we start with lithium or divalproex-sodium (DVPX) and attain adequate blood levels as quickly as possible. A loading-dose strategy with DVPX may accelerate response. If the patient is agitated, adjunctive benzodiazepines are used. If response is insufficient and patients are receiving antidepressants, they should be discontinued. If TSH is elevated, consider thyroid supplementation. If response is still unsatisfactory or there are moderate to severe manic symptoms (e.g., psychosis), an antipsychotic may be added to the primary mood stabilizer and/or benzodiazepine (BZD). Low doses of risperidone or a conventional neuroleptic are preferred.

With rapid cycling, mixed states, comorbid substance abuse, organic mood syndromes, or lithium-unresponsive/intolerant patients, DVPX is indicated. It can be used in conjunction with lithium and/or conventional neuroleptics or risperidone, and combined with carbamazepine (CBZ) with or without lithium. For nonresponders, clozapine may be used alone or with DVPX and/or lithium, but not with CBZ.

If a patient has not responded adequately or is in immediate danger, has previously responded to ECT, or there are medical contraindications to pharmacotherapy, ECT is the preferred treatment. Finally, clozapine (or perhaps risperidone) plus ECT may produce additional benefit beyond either therapy alone.

No. 114D
ALGORITHMS FOR BIPOLAR DISORDER: PART 2

Carlos A. Zarate, Jr., M.D., *McLean Hospital, 115 Mill Street, Belmont MA 02178;* Mauricio Tohen, M.D.

SUMMARY:

Detailed algorithms for treatment of mania (including mixed/rapid cycling cases) will be presented in this lecture, with emphasis on treatment-resistant patients and aspects of maintenance pharmacotherapy. Criteria for use of lithium, divalproex, carbamazepine, and their various combinations will be offered. Thyroxine, antidepressants, benzodiazepines, neuroleptics, novel anticonvulsants, calcium channel blockers, electroconvulsive therapy, and clozapine are among the options that may be appropriate for certain patients. This presentation and that of Dr. Janicak will be coordinated to minimize overlap but retain aspects in which there are differences in approach recommended by the speakers.

No. 114E
THE PLACES FOR ECT IN MOOD DISORDER ALGORITHMS

Richard D. Weiner, M.D., *Department of Psychiatry, Duke University Medical Center, P.O. Box 3309, Durham NC 27713*

SUMMARY:

Electroconvulsive therapy (ECT) has long been known to represent an effective treatment for patients with mood disorders, especially those suffering from major depressive episodes (MDE), but also for those with manic presentations. Following the development of effective antidepressant and antimanic agents in the late 1950's, the use of ECT declined until the 1980's when a modest upswing in utilization rates was observed, particularly among elderly patients with MDE. At present, ECT has a distinct role in the treatment of MDE on both a primary and secondary basis, while for mania it exists largely as a secondary treatment alternative.

This presentation will enumerate a set of algorithms for the use of ECT in mood disorders. In particular, the timing and rationale for the choice between ECT and alternative treatments will be discussed as a function of clinical phenomenology, treatment history, and other factors. The type of ECT, e.g., unilateral vs. bilateral stimulus electrode placement, will also be discussed, as will the choice of maintenance ECT for prophylactic purposes. It is hoped that such attempts to formulate objective algorithms for ECT use will help to achieve a higher degree of standardization for this treatment modality in the future.

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2. Nelson JC: An algorithm for treatment of major depression. *Psychopharmacol Bull* 31:475-482, 1995.
3. Janicak PG, Davis JM, Ayd FA. Jr., Preskorn S: Advances in the pharmacotherapy of bipolar disorder. In *Principles and Practice of Psychopharmacotherapy, Update*, Janicak, PG (ed.) Vol 1:(3), 1995.
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5. American Psychiatric Association Task Force on ECT (Weiner RD, Fink M, Hammersley D, Moench L, Sackeim HA, Small I): *The Practice of ECT: Recommendations for Treatment, Training and Privileging*, American Psychiatric Association, 1990.

SYMPOSIUM 115—STEREOTYPIC MOVEMENT DISORDER: NEW DEVELOPMENTS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to recognize the symptoms of stereotypic movement disorder and to consider treatment options for this condition.

No. 115A
SYMPTOMS AND DIAGNOSIS OF STEREOTYPIC MOVEMENT DISORDERS

Dan J. Stein, M.D., *Department of Psychiatry, University of Stellenbosch, PO Box 19063, Tygerberg 7505, South Africa;* Dana Niehaus, M.D., Colin Bouwer, M.D.

SUMMARY:

Stereotypic movement disorder (formerly known as stereotype/habit disorder) is characterized by repetitive nonfunctional motor movements, such as head banging, body rocking, skin picking, and other kinds of self-injury. This presentation reviews studies showing that these kinds of symptoms are seen not only in mentally retarded patients, but also in children and adults of normal intelligence. The symptoms and diagnosis of stereotypic movement disorder are discussed, and its relationship with other disorders such as obsessive-compulsive disorder, trichotillomania, Tourette's disorder, and pervasive development disorder, is considered.

No. 115B
NEUROBIOLOGY OF STEREOTYPY

Cheryl M. Wong, M.D., *Department of Psychiatry, Mt. Sinai Medical School, 1 Gustave Levy Place/Box 1230, New York NY 10029;* Eric Hollander, M.D., Mitchell Brin, M.D., Concetta DeCaria, Ph.D., Bonnie A. Aronowitz, Ph.D., Jee Kwon, B.A.

SUMMARY:

Stereotypies are repetitive, nonfunctional, motor behaviors that are often comorbid with many psychiatric and neurologic disorders and in some cases include self-injurious behaviors, such as mental retardation, autism, obsessive-compulsive disorder, Tourette's disorder, Lesch-Nyhan syndrome, Parkinson's disease, and Huntington's chorea. Stereotypic behaviors seem to be associated with dopamine (DA) activity as well as serotonin and perhaps the opiate pathways. Animal models have used amphetamine, cocaine, phenylcyclidine, and NMDA to induce stereotypies in rats. Earlier studies have shown that nigrostriatal dopamine activation preferentially affects stimulant-induced stereotypies in rats. Later studies have found that D2 and D1 receptors play a role in stereotypy production, with DA receptor agonists decreasing stereotypic behavior in animal models. The role of serotonin (5-HT) has also been raised given its synergistic effect on DA release by amphetamine. Recent studies have also found that 5-HT stimulation of the ventrolateral striatum resulted in orofacial stereotypy, which was abolished by pretreatment with DA receptor antagonist but not with 5-HT antagonist pretreatment. Other neurotransmitters and systems that may be involved in the production/modulation of stereotypic behavior include cholecystokinin (CCK), GABA, opiates, and chloride and calcium channels. This presentation will review the neurobiological aspects of stereotypies and discuss treatment implications.

No. 115C
BEHAVIORAL TREATMENT OF STEREOTYPICAL MOVEMENTS

Nancy J. Keuthen, Ph.D., *Department of Psychiatry, Massachusetts General Hospital, Bldg 149, 13th Street, 9th Flr, Charlestown MA 02129;* Richard L. O'Sullivan, M.D.

SUMMARY:

Stereotypical movement disorders (e.g., head banging, rocking, self-injurious behavior) are receiving increased psychiatric recognition yet still present significant treatment challenges. Behavioral treatment (BT) remains the only psychotherapeutic approach for these disorders with empirical documentation of outcome. Behavioral approaches are based on the principles of operant conditioning and include the techniques of response cost, differential reinforcement of alternative behaviors, overcorrection, sensory extinction, response prevention, and aversive conditioning. In addition to reported efficacy, BT has the advantages of rapid outcome and often maintenance of gains at follow-up.

This paper will summarize the results of a meta-analysis of all published studies in MEDLINE utilizing BT for stereotypical movement disorders. The utilization of different behavioral techniques will be reported as a function of the specific stereotypic behavior, clinical diagnosis, patient age, and gender. Treatment duration and outcome at follow-up will be summarized. The advantages and disadvantages of accelerative (reinforcement) vs. reductive (punishment) techniques will be discussed.

No. 115D
DEVELOPMENTAL ASPECTS OF STEREOTYPED MOVEMENT DISORDER

Bryan H. King, M.D., *Child Psychiatry, UCLA, 760 Westwood Plaza, Los Angeles CA 90024*

SUMMARY:

Stereotyped movements commonly occur during normal child development, but a significant fraction of persons with mental retardation may continue to express these movements to the point of interference with habilitative function. Stereotyped movement disorder with self-injurious behavior is a particularly problematic form of this behavior that is more likely to be expressed in the context of severe to profound mental retardation. This presentation will review the phenomenology of stereotyped SIB in persons with mental retardation, its differential diagnosis, theories of etiology, and treatment

approaches. The latter will highlight recent research in the biological underpinnings of stereotyped self-injury.

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1. Castellanos FX, Ritchie GF, Marsh WL, et al: DSM-IV stereotypic movement disorder: persistence of stereotypies of infancy in intellectually normal adolescents and adults. *J Clin Psychiatry* 57:116-122, 1996.
2. Yeshiayan SK, Kelley AE: Serotonergic stimulation of the ventrolateral striatum produces orofacial stereotypy. *Pharmacol Biochem Behavior*, 52(3): 493-501, 1995.
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4. Lerman DC, Iwata BA: Descriptive and experimental analyses of variables maintaining self-injurious behavior. *J Appl Behav Anal* 26:293-319, 1993.
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SYMPOSIUM 116—IMPLICATIONS OF THE CHANGING FORENSIC LANDSCAPE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

This symposium will describe, discuss, and propose potential solutions for the emerging complexities in forensic psychiatry today. Further, it aims to present a multidimensional approach to addressing these impending dilemmas.

No. 116A
PSYCHIATRIC SERVICES IN JAILS AND PRISONS

Howard J. Osofsky, M.D., *Department of Psychiatry, Louisiana State University, 1542 Tulane Avenue, New Orleans LA 70112-2865*

SUMMARY:

At a time when hospital and community mental health services are being increasingly constricted, jails and prisons, with their court-ordered mandates, fulfill an important role in providing needed services. The number of individuals involved with the correctional system is rising and data indicate that a considerable and growing percentage of these individuals require mental health evaluation and treatment. Arraignments and convictions for drug-related offenses continue to increase as well.

Deinstitutionalization of the chronically mentally ill has meant that these individuals frequently receive inadequate and inconsistent care. Homelessness is common among correctional system inmates; recidivism among inmates with mental health problems appears related to noncompliance and inconsistent care. The incidence of suicide is much higher among jail inmates than in the population at large. Other problems, such as those posed by sex offenders and inmates with antisocial personality disorder, require special consideration. The presentation will include information from the author's experiences as the federal court-appointed expert to a large parish (county) prison, a facility of approximately 6,000 inmates, which functions both as a jail and a prison. The role of the court-appointed expert is a challenging and complex one, at times frustrating but frequently gratifying.

I will describe both my personal evolution and the development of evaluation and treatment programs for inmates with varying, and at times unpredictable, lengths of stay. The need for humane and high quality services, the importance of maintaining professional integrity while working respectfully with security officials, and programmatic efforts that may decrease reincarceration will be discussed.

No. 116B
CHILDREN AND THE CRIMINAL JUSTICE SYSTEM

Debra K. DePrato, M.D., *LSU MC School of Med, 1542 Tulane Ave, New Orleans LA 70112-2822*

SUMMARY:

Statistics reveal the impact juvenile delinquency has upon our families and communities. The Office of Juvenile Justice and Delinquency Prevention reported juvenile arrests for violent crimes increased by 41% from 1982 to 1991. The number of cases handled by juvenile courts has increased; 28% of serious crimes are committed by children and adolescents age 18 and under. The juvenile justice system increasingly looks toward the public and university mental health systems to become involved in treating this difficult population. A large percentage of children and adolescents in the public mental health system are involved in the court for status and delinquent offenses, including drug offenses, at increasingly higher rates and at earlier ages.

Based on work with the criminal justice system and the development of programs for the court and families in need of support, this presentation will focus on the identification of children and adolescents who are involved with both the psychiatric and justice systems, and the methods to work effectively with the justice system in addressing the mental health issues of these children and their families. This presentation will target successful treatment models that address the needs of this subset of children.

No. 116C
THE SHIFTING PUBLIC SCENE: FROM COMMUNITY MENTAL HEALTH SERVICE AND HOSPITAL TO JAIL

Richard C. Lippincott, M.D., *Mntl Hlth Division, 1140 Brooks, McMinnville OR 97128*

SUMMARY:

Changing technology, emphasis on psychosocial rehabilitation, and severe reductions in financial resources have moved significant numbers of seriously mentally ill into the community, work, and independent living situations. For many individuals, this process is one of "recovery," but for a statistically significant number who are difficult, noncompliant, or sociopathic in transactional behavior, this has meant conflict with the law and continuing symptoms of illness within the jail/prison system.

The discussion will highlight the national trends in public mental health systems and some helpful new strategies to fulfill our commitment of care and treatment for those caught up in the judicial system.

No. 116D
MENTAL HEALTH CONSULTATION TO A MUNICIPAL COURT

H. Richard Lamb, M.D., *Department of Psychiatry, U.S.C. School of Medicine, 1934 Hospital Place, Los Angeles CA 90033-1071*

SUMMARY:

This presentation will describe the outcomes of mental health consultation provided to a municipal court and the court's resulting interventions for mentally ill persons who committed minor crimes. One aim of the consultation program was to avoid criminalization of mentally ill people who committed minor offenses.

Clinical and forensic records of 96 persons charged with misdemeanors and referred to a clinical psychologist court consultant for evaluation were studied. Determination of good versus poor outcome during a one-year follow-up period was based on clients' status during the year after the court's disposition. Poor outcome was defined as the occurrence of one or more of four events during the follow-up year: psychiatric hospitalization, arrest, significant physical violence against persons, and homelessness.

Fifty-six defendants (58%) were ordered to receive judicially monitored mental health treatment, as recommended by the psychologist court consultant, and 33 of them (59%) had a good one-year outcome. The relationship was statistically significant.

We believe nonclinicians in the criminal justice system should have psychiatric assistance in making appropriate dispositions for mentally ill persons. If the judge is considering mental health treatment as a condition for eliminating or reducing punishment, then, to the extent justified by the law and the nature of the offense, the judge should both mandate and monitor the treatment on an ongoing basis.

REFERENCES:

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SYMPOSIUM 117—CRIME, VIOLENCE, AND THE INFLUENCE OF MEDIA ON SOCIETY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

To understand a) the way various contextual features of violence are depicted on television; b) that context and explicitness of portrayals of violence are as important as the quantity of violence portrayed; c) the effectiveness of ratings and advisories that can be used to help form the basis of a clear, meaningful, and effective system of content advisories; d) how to become more aware of the role that age and developmental level play in the way that children view violent programming.

No. 117A
TELEVISION VIOLENCE: EPIDEMIC OF AMERICAN CULTURE

Robert T.M. Phillips, M.D., *American Psychiatric Assoc, 1400 K Street, NW, Washington DC 20005*

SUMMARY:

The urge to depict ourselves is a distinguishing trait of our species. Cave paintings show us hunting, ancient hieroglyphics describe forgotten conquests, and Homeric bards recited epic poems of war and retribution that became the narrative tradition of the Western world. Does how we show ourselves change who we are and how we act?

This presentation provides new, reliable, and truly representative information about the ways in which various contextual features of violence are depicted on television. This presentation will a) emphasize that context and explicitness of portrayals of violence are as important as the quantity of violence portrayed; b) provide important information about the effectiveness of ratings and advisories that can be used to help form the basis of a clear, meaningful, and effective system of content advisories; and c) help parents become more aware of the role that age and developmental level play in the way that children view violent programming.

No. 117B
GLORIFICATION OF GRATUITOUS VIOLENCE

Paul J. Fink, M.D., *GSB Building, One Belmont Avenue #523, Bala Cynwyd PA 19004*

SUMMARY:

The glorification of gratuitous violence has long-term and short-term sequelae. It contributes to the massive value shift that has taken place throughout the world, but particularly in the U.S. The important issues to be discussed include 1) profit related to worldwide distribution of films, which have minimal verbal activity, 2) the nature of television's use of stereotypes, 3) the copycat phenomenon, 4) research related to the effect of TV on people's behavior, 5) numbing and desensitization, which results from the overwhelming and repetitive nature of violent images and stories in the press and in the electronic media. Another issue to be discussed is the cognitive and emotional development of children and the effect of television images on children at different ages.

No. 117C
MEDIA: MISLEADING PUBLIC HEALTH EFFORTS TO REDUCE VIOLENCE

Carl C. Bell, M.D., *Community Mental Hlth Council, 8704 South Constance, Chicago IL 60617-2746*

SUMMARY:

The media will be identified as a strong influence on public perceptions that sabotage the efforts towards appropriate public health interventions for problems such as violence prevention and intervention. Specifically, TV constantly bombards the public with adventure and drama shows that portray violence as a "stranger danger" issue. This flooding interferes with the public's acceptance and understanding of the idea that violence occurs most commonly between family and friends as a result of interpersonal altercations. The ramifications of this "brainwashing" are wide, sweeping, and destructive as it promotes a tendency to reduce violence to a phenomenon only occurring in the criminal context. Because of this production of generalized fear, the investment in public health strategies has taken a back seat to a "get tough," "three strikes your are out" criminal justice strategy. Similarly, it is the author's belief that the stereotypic TV presentation of drug addicts as a group of violent individuals is at the root of the U.S. developing a strategy of incarcerating patients who have medical illnesses, i.e. drug addiction, rather than spending equal amounts of funds on treatment that, considering the recovery rate of addicted physicians and pilots, has been shown to be effective. Suggestions to ensure that science directs public health policy and to prevent the media from inadvertently directing public health policy will be given.

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1. Medicascope, Inc. *National Television Violence Study: Executive Summary 1994-1995.* Studio City, CA, 1995.

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SYMPOSIUM 118—CATATONIA AND NMS: SINGLE OR SEPARATE ENTITIES?

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The participant will receive a catatonia rating scale form, recognize motor signs of catatonia, recognize proposed subtypes, and recognize common features of NMS and catatonia. The participant will recognize the increased risk of NMS from exposure to neuroleptic medications in patients with catatonia.

No. 118A
CATATONIA: DIAGNOSIS AND SUBTYPES

Andrew J. Francis, Jr., M.D., *Department of Psychiatry, SUNY Stony Brook, Health Sciences Center T-10, Stony Brook NY 11794;* George Bush, M.D., Georgios Petrides, M.D.

SUMMARY:

Research and clinical interest in catatonia are increasing. Diagnosis, treatment, empirical delineation of subtypes, and overlap with NMS are major themes. We have used the 23-item Bush-Francis rating scale to facilitate diagnosis, delineate subtypes, monitor treatment, and differentiate catatonia from other motor disorders.

We systematically screened for catatonia in four psychiatric populations: acute admissions; emergency cases; a chronic institutionalized elderly sample with a high rate of parkinsonism and dyskinesia; and a retrospective series of NMS cases. We developed operational criteria for case definition and for excited vs. retarded catatonia. The data were compared with Kahlbaum's cases and more recent reports.

We found support for the syndromic concept of catatonia based on the distribution of catatonic signs and propose a case definition of at least two rating scale signs. Separation of excited and retarded catatonia was predictive of clinical outcome and perhaps treatment requirement. Catatonic signs were common in NMS as were autonomic signs in catatonia, highlighting clinical overlap. Acute and chronic catatonia as well catatonia in NMS were similar in motor features, and overlap with other motor syndromes in chronic cases was minimal.

No. 118B
CATATONIA AND NMS: DIAGNOSTIC CONUNDRUM

Denise A.C. White, M.D., *Department of Psychiatry, Groote Schuur Hospital, Observatory Cape 7925, South Africa;* A.H. Robins, M.D.

SUMMARY:

The relationship between catatonia and the neuroleptic malignant syndrome is unresolved. While some writers consider both syndromes to be separate diagnostic entities, most investigators concede that it is often difficult to differentiate one from the other clinically. The similar clinical features have also led to speculation about a possible pathophysiological link between the two syndromes. While it has been suggested that NMS is probably a neuroleptic-induced form of catatonia, we noted in 17 patients that a catatonic state preceded both neuroleptic exposure and the subsequent emergence of the so-called NMS. These finding not only indicate that catatonia predisposes to NMS but also challenge the validity of NMS as a diagnostic entity separate from the broader category of catatonia.

The results of our study of 17 catatonic patients diagnosed as having NMS will be presented. Discussion will focus on a) the relatedness of catatonia and NMS and b) the nosological status of these two syndromes, which are presently categorized as separate entities in the DSM-IV. A videotape of a catatonic patient will be shown that demonstrates the clinical similarities between the syndromes.

No. 118C
RELATIONSHIP BETWEEN CATATONIA AND NMS

Patricia I. Rosebush, M.D., *Department of Psychiatry, McMaster University, HSC-3G15/1200 Main West, Hamilton ON L8N 3Z5, Canada;* Michael F. Mazurek, M.D.

SUMMARY:

Objective: To study the similarities between NMS and catatonia and determine whether patients with catatonia are vulnerable to NMS.

Method: Over the past seven years we diagnosed catatonia by our published criteria in 70 patients admitted to our acute psychiatric inpatient unit. Vital signs, CBC, CPK, and serum iron were measured. A careful review of all records was completed to identify prior NMS episodes, and patients were followed prospectively for episodes of NMS.

Results: During catatonia, all patients were afebrile, EEG's were normal in over 90%, there was no autonomic instability or leukocytosis, and CPK elevations were mild and present in less than 25%. Serum irons were normal. Sixty of the 70 patients either had a history of neuroleptic exposure or were subsequently treated with neuroleptics during follow-up. Seven (11%) of these 60 patients clearly had NMS either in the past or during prospective follow-up. The episodes of NMS included fever, autonomic instability, rigidity, confusion, leukocytosis, elevated CPK, and low serum iron.

Conclusions: 1) The catatonic syndrome itself, unlike NMS, is not typically associated with fever, low serum iron, EEG abnormalities, or significant elevations of CPK; 2) patients who develop catatonia are at significantly increased risk of NMS when exposed to neuroleptics.

No. 118D
CATATONIA SUBTYPES AND THEIR CLINICAL UTILITY

Brendan T. Carroll, M.D., *Department of Psychiatry, VA Medical Center, 17273 State Route 104, #116A, Chillicothe OH 45601*

SUMMARY:

Catatonia is a neuropsychiatric disorder fraught with dichotomies. The most troublesome is the classification of malignant and benign catatonias, with the former being most often compared to neuroleptic malignant syndrome. An historical dichotomy exists between retarded and excited types. DSM-IV separates catatonia along the lines of presumed etiology: bipolar, major depression, schizophrenia, and due to a general medical condition. Finally, the Leonhard classification separates catatonia according to phenomenology: periodic catatonia, parakinetic, proskinetic, speech prompt, speech inactive, manneristic, and negativistic. What is important is to classify it in a way that prediction, treatment, and prevention become more specific.

Recent data show that clinical evaluation can distinguish between benign and malignant, and retarded and excited subtypes using a systematic examination and rating scale. DSM-IV and Leonhard classifications cannot be differentiated by clinical presentation but are supported by outcome studies. Proximal and distal utility of these classifications and the implications for treatment will be discussed.

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1. Bush G, Fink M, Petrides G, et al: Catatonia I: rating scale and standardized examination. *Acta Psych Scand* 93:129-136, 1996.
2. White DAC: Catatonia and the neuroleptic syndrome–a single entity? *Brit J Psychiat* 161:558-560, 1992.
3. Rosebush PI, Hildebrand AM, Furlong BG, Mazurek MF: Catatonic syndrome in a general psychiatric inpatient population: frequency, clinical presentation and response to lorazepam. *J Clin Psychiat* 51:357-362, 1990.
4. Hawkins JM, Archer KJ, Strakowski SM, Keck PE: Somatic treatment of catatonia. *Intl J Psychiat Med* 25:345-369, 1995.

SYMPOSIUM 119—CHRONIC PAIN: MULTIDISCIPLINARY APPROACHES

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to identify the role and appropriate use of different treatment techniques with chronic patients; to demonstrate improved facility with pharmacologic and psychologic treatment modalities; to recognize the different utilization of outpatient versus inpatient treatment.

No. 119A
COMPREHENSIVE INPATIENT TREATMENT OF CHRONIC PAIN

Paul Gusmorino, M.D., *Behavioral Med, Hospital for JT Disorders, 301 East 17th Street, New York NY 10003*

SUMMARY:

For chronic pain patients their struggle to relieve pain has taken over their lives and can lead to a series of treatment failures as they continue to pursue treatments appropriate for acute pain though of limited value with chronic pain. Often patients seek surgical solutions for their difficult pain syndromes that are much more complicated than could ever be corrected by a simple approach to relieving a source of nociception. Their chances for success with successive operations rapidly declines. The major pitfalls for the treating physician are focusing on the acute nociceptive model and failing to realize the extent to which the patient's pain and suffering is being maintained by other elements in the patient's life. Patients need to be evaluated and treated by specially trained multidisciplinary pain centers where the emphasis is on rehabilitation, with a balance between physical and behavioral rehabilitation. Many patients suffer with varying degrees of depression. This must be addressed with psychotherapy as well as appropriate use of antidepressant medications. Often there is severe disruption of the family system caused by continued difficulty with pain, which furthers pain and suffering. Clearly this problem needs experienced family therapy interventions. Additionally, the vast majority of the chronic pain population have become significantly physically deconditioned and need an active physical therapy program to address this. They need to be educated that using pain as a guide to activity is not likely to be a successful strategy and instead learn to use organized preplanned and structured activities independent of pain. Acute pain strategies that focus on looking for sources of nociception, prescribing rest, using pain as a guide to activity, and increasing dosage of analgesic medications to relieve pain are generally not effective strategies for the chronic pain patient. This presentation will review the efficacy of a comprehensive inpatient approach to chronic pain management that addresses these issues.

No. 119B
THE USE OF ANALGESICS IN CHRONIC PAIN

Michel Dubois, M.D., *Anesthesiology, NYU Medical Center, 530 First Avenue, Suite 9T, New York NY 10016*

SUMMARY:

In light of newly emerging analgesic medications, the selection of analgesics often presents a dilemma to the clinician. This presentation will review the latest findings regarding the clinical use and selection of analgesics and will be based on the guidelines of the World Health Organization analgesic ladder. The pharmacotherapy of pain relies primarily on central and peripheral analgesics and is based on the concept of nociceptive pain. The primary peripheral analgesics (which also have considerable central effect) are the nonsteroidal antiinflammatory drugs (NSAIDs). The variety of subclasses that comprise the NSAIDs will be reviewed. The efficacy and side effects vary not only in different subclasses but also within the subclass itself. Ceiling dose as well as guidelines for selection will be discussed. Central analgesia is primarily accomplished through opiates, which appear to stimulate an endogenous system for analgesia. Pharmacologic factors strongly influence selection of drug. Opioid class, weak versus strong opioids, drug toxicities, pharmacokinetic differences, and duration of effect will be outlined. The controversy regarding the appropriateness of chronic opiate therapy in nonmalignant pain will also be addressed, as will the newer pharmacologic agents used for analgesia.

No. 119C
NONANALGESIC PHARMACOTHERAPY OF PAIN

Edward C. Covington, Jr., M.D., *Department of Psychiatry, Cleveland Clinic, 9500 Euclid Avenue, Cleveland OH 44195-5192*

SUMMARY:

Nociceptor-mediated pains are usually treated with central or peripheral analgesics. Other pains may respond to drugs not traditionally considered analgesics. Antidepressants are useful in such neuropathic pains as diabetic neuropathy, postherpetic neuralgia, and complex regional pain syndrome (CRPS-RSD). They provide prophylaxis for migraine and muscle contraction headaches, reduce myofascial pains, and some GI pain syndromes as well. While tricyclics are the best documented, other agents are widely used. The role of SSRIs, MAOIs, and venlafaxine will be discussed.

Anticonvulsants best documented in pain include carbamazepine, valproate, and clonazepam. Gabapentin and lamotrigine may have roles and will be discussed. Traditionally recommended for paroxysmal pains and headaches, newer agents have a broader spectrum. NMDA antagonism may be relevant in some of these agents.

Lidocaine analogs, such as mexilletine, reduce pains related to abnormal neural discharge in animals and humans. Clinical applications include neuromas, CRPS, some other neuropathic pains.

Neuroleptics have been poorly studied but may be useful in neuropathic pains such as PHN, diabetic neuropathy (DN), and thalamic pain. The GABA-B agonist, baclofen, is effective in some neuropathic pains as well as muscle spasm. Potentiation of analgesia with such agents as hydroxyzine and stimulants will be presented.

No. 119D
COGNITIVE-BEHAVIORAL APPROACHES TO CHRONIC PAIN

Allen Lebovits, Ph.D., *Anesth and Psychiatry, NYU Medical Center, 530 First Avenue, Suite 9T, New York NY 10016*

SUMMARY:

The currently accepted standard of practice for the comprehensive treatment of patients with chronic pain includes the incorporation of cognitive-behavioral methods. This presentation will review the basic elements of such an intervention with the focus on short-term, goal-oriented methods that can be readily adapted in a psychiatry practice. Methods to be reviewed include the introductory but essential process of educating the patient regarding the mind-body relationship, which bypasses the patient's natural defensiveness to this process. Relaxation training is the mainstay of cognitive-behavioral therapy. Different methods will be reviewed, particularly when to use imagery-based techniques versus progressive relaxation. Cognitive restructuring can be a very effective technique in the management of chronic pain. Based on the principle of thoughts controlling affect, patients are taught to substitute positive thoughts for cognitive errors. Hypnosis is another effective cognitive-behavioral technique that can be utilized to teach patients self-hypnosis to implement sensation substitution for their pain. Finally, the utilization of thermal and electromyographic biofeedback with chronic pain patients will be reviewed. The integration of cognitive-behavioral techniques in an overall multidisciplinary approach will be discussed.

No. 119E
THE TREATMENT OF AIDS PAIN

Mathew Lefkowitz, M.D., *Anesthesiology, SUNY Health Sciences Center, 44 West 10th Street, #6B, New York NY 10011*

SUMMARY:

Increasingly, attention is being focused on the prevalence and management of pain in patients with AIDS. The advent of new drug regimens associated with longer survival rates makes quality-of-life issues and pain management more important. Pain has a significant negative impact on activities of daily living. Of all the health care challenges posed by AIDS, pain management may be the most significant. The general principles of pain management in AIDS patients are similar to, but somewhat different from, those in cancer patients. The issue of psychological drug dependence is also a formidable treatment obstacle. Adjuvant analgesic drugs, particularly tricyclic antidepressants, play an important role in pain management of AIDS patients. Amitriptyline, nortriptyline, imipramine, and doxepin have been advocated for painful neuropathy. It is particularly surprising that studies have found a very low rate of antidepressant usage in patients with AIDS. Pain management education among the health care providers of AIDS patients is an important initial step for appropriate pain control. Education is required, for example, regarding specific drug interactions. Physicians' fears of addicting patients to analgesics must be specifically addressed. The results of the Lebovits and Lefkowitz studies demonstrate that AIDS patients whose identified risk factor was IVDA did not require more analgesic or psychotropic medications than non-IVDA patients.

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SYMPOSIUM 120—RECENT ADVANCES IN AUTISM AND ASPERGER'S DISORDER

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The participant should be able to recognize and diagnose autism and Asperger's disorder in adulthood; understand the neurocircuitry associated with clinical symptoms; recognize familial genetic modes of transmission; recognize neuropsychological, functional imaging and biological abnormalities; and select appropriate medications.

No. 120A
CLINICAL PRESENTATIONS OF AUTISM AND ASPERGER'S DISORDER IN ADULTHOOD

Serge A. Mosovich, M.D., *Department of Psychiatry, Mt. Sinai Medical School, One Gustave Levy Place, New York NY 10029;* Lucille Horn, Ph.D., Eric Hollander, M.D., Bonnie A. Aronowitz, Ph.D., Lorraine Simon, M.A.

SUMMARY:

The pervasive developmental disorders, including Asperger's disorder, have only recently received the deserved attention of clinicians. These disorders have been fraught with difficulties in classification and the absence of an accepted diagnostic instrument such as the Autism Diagnostic Interview (Le Couteur, Lord, Rutter, 1994). They are characterized by impairments in reciprocal social interaction, communication, and by a markedly restricted repertoire of activities, interests, and imaginative activities. Unlike autism, Asperger's disorder does not involve significant delays in language, cognition, and adaptive behavior. Because of this, and because a developmental history is frequently overlooked or is unavailable, a correct diagnosis is not made, leading to treatment failure.

We present 12 cases of Asperger's disorder at differing ages at the time of diagnosis, their demographics, and phenomenology. All of these cases had been referred for consultation for obsessive-compulsive, ritualistic behavior, or for poor impulse-control, inattentiveness, or learning disabilities. Cases were evaluated using the ADI, and their psychological and neuropsychological profiles. PET and MRI findings are presented. We will discuss these cases, their differing clinical forms, demographic characteristics, and phenomenological findings.

No. 120B
FAMILY/GENETIC STUDY OF AUTISM

Jeremy Silverman, Ph.D., *Department of Psychiatry, Bronx VA Medical, 130 West Kingsbridge Road, Bronx NY 10468;* David M. Greenberg, M.B., Eric Hollander, M.D., Brian A. Lawlor, M.D., Christopher Smith, Ph.D., Kenneth L. Davis, M.D.

SUMMARY:

We studied 35 multiplex families of autistic probands in Ireland and the New York City metropolitan area. Progress toward identification of specific genes involved in autism is impeded by the fact that 1) even core autism is highly heterogeneous and 2) while clinical and biological manifestations of an autism-related gene probably present in individuals without core autism, a clear definition of the boundaries of an autism-related phenotype is lacking. In genetic linkage studies we accomodate this uncertainty through assumptions

of reduced penetrance, but our investigations would be greatly strengthened if we could accurately classify family members. Others employ strategies, such as the sib pair method, requiring less information about the boundaries of an autism-related phenotype (though such strategies resolve the issue of heterogeneity in core autism). We have chosen a linkage analysis approach, which maximizes information from families, but relies on correct classification of each family member. Thus, our assessment approach involves documentation of the more or less clear-cut family cases of autism and characteristics of nonautistic family members that may nevertheless be associated with an autism-related gene. We describe our ongoing study and assessment procedures in the context of these issues.

No. 120C
NEUROPSYCHIATRIC/PSYCHOLOGICAL DEFICITS IN AUTISM

Bonnie A. Aronowitz, Ph.D., *Department of Psychiatry, Mt. Sinai Medical Center, One Gustave Levy Place, New York NY 10029;* Concetta DeCaria, Ph.D., Nicola Weiss, M.A., Eric Hollander, M.D., Lorraine Simon, M.A., Serge A. Mosovich, M.D.

SUMMARY:

Autism and Asperger's disorder are neurodevelopmental disorders characterized by impairments in sociality and information processing/communication, and by compulsivity. A comprehensive neuropsychological test battery assessing these core components of the disorders, neurological soft sign examination, and quantitative EEG were administered to 20 18- to 65-year-old male and female DSM-IV-diagnosed, medication-free, autism and Asperger's disorder subjects. Assessment aims were to both identify convergent and differing neuropsychiatric characteristics of autism and Asperger's disorder and to ultimately aid in their differential diagnosis. Moreover, behavioral response to neuropsychological provocation of the core symptoms of the disorders during biological challenge procedures is presented. Both baseline neurometric, neuropsychiatric, and neuropsychological test performance and neuropsychological behavioral results during challenges are compared with demographically matched DSM-IV-diagnosed obsessive-compulsive disorder and normal control subjects.

No. 120D
PET IN AUTISM AND ASPERGER'S DISORDER

Monte S. Buchsbaum, M.D., *Department of Psychiatry, Mt. Sinai Medical Center, One Gustave Levy Place, New York NY 10029;* M. Mechmet Haznedar, M.D., Tsechung Wei, Ph.D., Jacqueline Spiegel-Cohen, M.S., Robert C. Young, M.D., Eric Hollander, M.D.

SUMMARY:

Autism is a developmental disorder with multiple etiologies. Although the causes are quite diverse, the disorder presents typically at early childhood with deficits in complex social behavior, disturbances in language development and cognition, and abnormalities in the rate of development. Asperger's disorder shares some of the behavioral phenomena with autism: impairment in social interaction and restricted, repetitive, and stereotyped patterns of behavior. Our previous imaging studies using 18-fluorodeoxyglucose (FDG) and positron emission tomography (PET) suggested the heterogeneity of the disorder and seldom found a single anatomical region to show differences from controls in glucose metabolic rates (GMR). In our current study, PET with 18-fluorodeoxyglucose was used to study the GMR in nine adult patients, seven with the diagnosis of childhood autism (six of the patients were diagnosed using the Autism Diagnostic Interview [ADI], one was diagnosed on the basis of records and a clinical interview), and two adults with Asperger's disorder (by ADI) were studied. The patients (mean age 25, range 17-47) and 14 normal controls (mean age 29.6, range 21-53) were scanned with our new high-resolution (4.2-4.5mm. FWHM) scanner. During the FDG uptake period subjects performed a modified version of the California Verbal Learning Task (CVLT). All the subjects' PET images were stretched to the averaged edges of the PET of the normal control group. Next, t-tests were calculated for each pixel in the morphed PET scan. Patients had lower values in the thalamus and higher values in the cerebral peduncles. The significance was confirmed by resampling from a population of 70 normals (independent sets of nine and 14) and counting the number of times a patch of contiguous pixels above $t = 2.10$ occurred by chance.

No. 120E
NEUROTRANSMITTER/NEUROPEPTIDE FUNCTION AND PSYCHOPHARMACOLOGY OF AUTISM

Eric Hollander, M.D., *Department of Psychiatry, Mt. Sinai Medical Center, 1 Gustave Levy Place, New York NY 10029;* Bonnie A. Aronowitz, Ph.D., Concetta DeCaria, Ph.D., Serge A. Mosovich, M.D., Scott Cherkasky, M.D., Elizabeth Spadaccini, B.A.

SUMMARY:

Autism is a neurodevelopmental disorder with three core symptom deficits—social interaction and empathy; speech, communication, and information processing; and compulsive symptoms. We have attempted to link specific neurotransmitter/neuropeptide systems with these three distinct symptom clusters. Namely, serotonergic abnormalities with compulsive symptoms; dopaminergic dysregulation with speech/information processing; and opiate and oxytocin function with social deficits and lack of empathy. Behavioral and neuroendocrine responsivity to serotonergic (m-CPP-(5HT2c), sumatriptan-(5HT1d), fenfluramine-(net 5HT), dopaminergic (dextroamphetamine), opiate (naltrexone), and oxytocin challenges are described, and linked to these specific symptom clusters.

Preliminary studies with serotonin reuptake inhibitors—fluoxetine, clomipramine, fluvoxamine, and sertraline—have demonstrated some modest improvement in autistic symptoms and behaviors. Specifically, the compulsive symptom cluster and to a lesser extent the social component appear responsive to SRI treatment. We have conducted a fluoxetine trial of autism and have linked responsivity on compulsive symptoms measured by YBOCS-autism to changes in caudate function on PET following fluoxetine treatment.

No. 120F
AUTISM: INSIGHTS FROM A PERSONAL PERSPECTIVE

Temple Grandin, Ph.D., *Colorado State University, Ft. Collins CO 80523*

SUMMARY:

Stimuli that do not bother normal people can be confusing and painful for people with autism. When I was a child, loud sounds hurt my ears and felt like a dentist's drill hitting a nerve. Scratchy petticoats were like sandpaper on exposed nerve endings. Often I had tantrums because I was exposed to sounds that I could not tolerate. Sensory sensitivities are highly variable. A sound that hurts the ears of one autistic child may be attractive to another. Sometimes a child will be afraid to enter a certain room because a hurtful sound occurred there. One of the worst sounds is feedback from a microphone. This can cause a child to be fearful of the classroom. At age 3 I could understand what people said to me if they spoke directly to me, but if adults spoke more quickly among themselves it sounded like gibberish. In my book *Thinking in Pictures* I describe auditory processing tests I had had as an adult. I have difficulty

hearing certain speech sounds. Words like "doormat" and "floor lamp" were mixed up when they were out of context. I had a very difficult time with a test where a man said a sentence in one ear and a woman said a different sentence in the other. I could not block out the man to listen to what the woman had said. In more severe cases of autism, sensory problems are much worse. Other people with autism have told me that sometimes sounds and sights mixed together in a confusing jumble. They could not make any sense out of the world.

REFERENCES:

1. Frith U: *Autism and Asperger's Disorder.* Cambridge: Cambridge University Press, 1991.
2. Folstein SE, Rutter ML: Autism: familial aggregation and genetic implications. *Journal of Autism and Developmental Disorders,* 18:3-20, 1988.
3. Szatmari P, Tuff L, Finlagson A, Bartolucci G: Asperger's syndrome and autism: neurocognitive aspects. *Journal of American Academy of Child and Adolescent Psychiatry* 29:130-136, 1990.
4. Siegel BV, et al: Regional cerebral glucose metabolism and attention in adults with a history of childhood autism. *Journal of Neuropsychiatry* 4:406-414, 1992.
5. Cooke EH, et al: Fluoxetine treatment of children and adults with autistic disorder and mental retardation. *J Am Acad Child Adolesc Psychiatry.* 31:739-745, 1992.

SYMPOSIUM 121—SPONTANEOUS DYSKINESIA IN DRUG-NAIVE SCHIZOPHRENIA PATIENTS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The participant should be familiar with epidemiological and individual correlates of spontaneous dyskinesia (SD) in never-medicated schizophrenics. In particular, participants should be able to integrate knowledge of SD prevalence into their understanding of neuroleptic-induced tardive dyskinesia.

No. 121A
TARDIVE DYSKINESIA: ITS VALIDITY AND LIMITATIONS

David G.C. Owens, M.D., *Department of Psychiatry, Edinburgh University, Royal Edinburgh Hosp, Edinburgh Eh10, Scotland*

SUMMARY:

The concept of tardive dyskinesia (TD) is an epidemiological one that rests on a statistical association. Since its early description, the boundaries of the concept have altered substantially in terms of the constituent features, the agents putative in causation, and the time criterion for exposure. Despite this, there is considerable information now available on prevalence (by both the pooled data and the point prevalence methods) as well as on incidence and long-term risk, but there is still a lack of clarity with regard to the demographic correlates and factors leading to predisposition. Investigations of elderly non-psychiatric patients confirm a baseline of involuntary movement disorder phenomenologically similar to the abnormalities comprising TD. The prevalence depends on the setting of the population study, but higher frequencies in those suffering from physical disorder suggest that a neuromedical abnormality may underlie movement disorder in these cases. In considering factors predisposing to TD, it would seem important to include biological aspects of the illness for which the drugs are being prescribed. There is a small but active literature that has found movement disorders in schizophrenic patients never exposed to antipsychotic medication. Quantitative and qualitative comparisons, when these have been possible, have shown striking similarities to the disorders evident in drug-treated patients. The question therefore is raised as to whether antipsychotic medication may act to provoke a tendency that is inherent in certain forms of schizophrenia. While the concept of TD has undoubted validity, an understanding of the association needs awareness of the limitations of a purely epidemiological concept of the disorder.

No. 121B
SPONTANEOUS DYSKINESIA IN THE PRE-NEUROLEPTIC ERA

Wayne S. Fenton, M.D., *Research, Chestnut Lodge Hospital, 500 West Montgomery Avenue, Rockville MD 20850;* Crystal R. Blyler, Ph.D.

SUMMARY:

Objective: The author will describe the prevalence, clinical correlates, and prognostic significance of spontaneous dyskinesias (SD) among patients with schizophrenia and other psychiatric disorders treated at Chestnut Lodge Hospital who had never received neuroleptic treatment up to and including baseline assessment.

Methods: Extensive case records were screened and descriptions of abnormal movements recorded verbatim for blind ratings. Neuroleptic-naive patients with and without abnormal oral-facial movements were compared across diagnostic categories, signs and symptoms, diagnostic and illness natural history variables.

Results: The records of 15% of patients with schizophrenia documented oral-facial dyskinesias with significant detail so that their presence was considered nearly certain. Compared with patients with schizophrenia without oral-facial movements, those with spontaneous dyskinesias were more likely to demonstrate a lower IQ score, had more negative symptoms at index admission, and were more symptomatic at follow-up (an average of 23 years later). The prevalence of SD among patients with schizophrenia spectrum disorders was intermediate between those with schizophrenia and those with affective and personality disorders.

Conclusions: The data suggest that in many cases, oral-facial dyskinesias in patients with intellectual impairment and negative symptoms may represent spontaneous movement disorders and that these are relatively specific to schizophrenia.

No. 121C
MOVEMENT DISORDERS IN ELDERLY INDIAN PATIENTS

Robin G. McCreadie, D.Sc., *Research, Crichton Royal Hospital, Dumfries DG1 4TG, Scotland UK;* R. Thara, M.D.

SUMMARY:

Movement disorders were examined in 308 elderly schizophrenic patients in Madras, India, using the Abnormal Involuntary Movements Scale, the Simpson and Angus Parkinsonism Scale, and the Barnes Akathisia Scale. Patients' mental state was assessed by the Positive and Negative Syndrome Scale. Dyskinesia was found in 15% of normal subjects ($n = 101$, mean age 63 years), 15% of first-degree blood relatives of younger schizophrenic patients ($n = 103$, mean age 63 years), 38% of never-medicated patients ($n = 21$, mean age 65 years), and 41% of medicated patients ($n = 83$, mean age 57 years). The respective prevalences for Parkinsonism were 6%, 11%, 24%, and 36%, and for akathisia were 9%, 5%, 21%, and 23%. Dyskinesia was associated with negative schizophrenic symptoms. We conclude that dyskinesia in elderly schizophrenic patients is an integral part of the illness and not associated with antipsychotic medication.

No. 121D
SPONTANEOUS DYSKINESIA IN MOROCCAN SCHIZOPHRENIA PATIENTS

William F. Hoffman, M.D., *Department of Psychiatry, Portland VAMC, 3710 SW US Veterans Hosp Road, Portland OR 97201;* Nadia Kadri, M.D., Darien S. Fenn, Ph.D., Amina Tilane, M.D., Carla A. Green, Ph.D., Mohamed Lakloumi, M.D., Fahrid Bousaid, M.D., Bachir Bentounssi, M.D., Driss Moussaoui, M.D., Daniel E. Casey, M.D.

SUMMARY:

Tardive dyskinesia (TD) purportedly results from chronic neuroleptic treatment. However, evidence is accumulating that choreoathetoid movements resembling TD occur in patients who have never been treated with neuroleptics. We studied 104 Moroccan patients who met DSM-IV criteria for schizophrenia; 62 had been ill for at least one year and were neuroleptic-naive, while 42 had been chronically treated with neuroleptics for at least one year. Twenty-one control patients, free of psychiatric illness, were studied for comparison. Choreoathetosis was scored on the AIMS scale, and cases of probable TD were identified according to the criteria of Schooler and Kane. Somewhat more neuroleptic-naive patients (26%) than controls (19%) met criteria for TD (McNemar $\chi^2 = 6.48$, $p = .01$); none of the controls met TD criteria.

Mean total AIMS scores did not differ ($F = 0.843$, $p = .4$) between never-medicated (3.9 ± 2.9) and chronically medicated patients (3.3 ± 3.4). Both patient groups differed significantly from controls (mean AIMS = 0.67 ± 0.86). There were no significant differences between the patient groups on any of the AIMS items. These findings provide evidence that choreoathetoid movements are part of the clinical course of schizophrenia, and neuroleptic treatment may only exacerbate a predisposition to hyperkinesia.

No. 121E
COGNITIVE DYSFUNCTION IN MOROCCAN SCHIZOPHRENIA PATIENTS

Darien S. Fenn, Ph.D., *Psychiatry Research, Portland VAMC, 3710 SW US Veterans Hosp Road, Portland OR 97201;* Nadia Kadri, M.D., William F. Hoffman, M.D., Amina Tilane, M.D., Carla A. Green, Ph.D., Mohamed Lakloumi, M.D., Fahrid Bousaid, M.D., Bachir Bentounssi, M.D., Driss Moussaoui, M.D., Daniel E. Casey, M.D.

SUMMARY:

Several studies have suggested an association between cognitive deficits, broadly defined, and the presence of both hyperkinetic and Parkinsonian movement disorders in schizophrenia. Concomitant treatment with neuroleptic and anticholinergic drugs complicates the interpretation of these results. The presence of a group of never-medicated schizophrenics in Morocco allows us to examine cognitive functioning in schizophrenia in the absence of this confounding factor.

We examined a group of 87 never-medicated patients who met DSM-IV criteria for schizophrenia, together with 66 chronically medicated Moroccan and 31 chronically medicated American schizophrenics, matched for duration of illness and symptom profile. We also administered the same battery of neuropsychological tests to 55 Moroccan and 40 American normal controls.

Differences between corresponding Moroccan and American groups were found on most tests, suggesting a strong cultural component. Controls outperformed patient groups on all tests. Never-medicated schizophrenics performed in the same range as chronically medicated schizophrenics on most tests, but performed within the range of Moroccan controls on others. Increasing levels of Parkinsonian symptoms, but not hyperkinetic symptoms, were associated with decreasing performance for the patient groups on many tests, although this varied somewhat between groups. The association of symptom severity and length of illness will also be discussed.

No. 121F
SCHIZOPHRENIC ILLNESS AND TARDIVE DYSKINESIA

John L. Waddington, Ph.D., *Clinical Pharmacy, Royal College for Surgeons, St. Stephen's Green, Dublin 2, Ireland;* David J. Meagher, M.B., John J. Quinn, M.D., James Mullaney, M.D., Conall Larkin, M.B., Eadbhard O'Callaghan, M.B.

SUMMARY:

Recent evidence sustains our earlier proposition that in schizophrenia the contribution of spontaneous disease-related involuntary movements to the totality of "tardive" dyskinesia in medicated patients has been seriously underestimated. In younger outpatients, we found tardive dyskinesia to be associated with a predominance of early craniofacial dysgenesis and greater frontal impairment on neuropsychological testing. In older inpatients followed prospectively over 10 years, tardive dyskinesia was associated with consistently greater general cognitive impairment; significant cognitive deterioration was apparent only among those evidencing the *de novo* emergence of dyskinesia, and this deterioration was restricted to the time-frame over which their dyskinesia emerged. The literature suggests that the prevalence of involuntary movements at the first psychotic episode is very low, while in our ongoing studies on elderly inpatients having decades of illness and antipsychotic therapy, prevalence appears greater than 90%.

Involuntary movements emerging during long-term antipsychotic therapy appear to be a drug-enhancement of dyskinesia that is related intimately to features of the illness for which that treatment was prescribed; vulnerability to such movement disorder, rooted intimately in the disease process of schizophrenia, may approach 100% over a lifetime of severe, medicated illness.

REFERENCES:

1. Fenton WS, Wyatt RJ, McGlashan TH: Risk factors for spontaneous dyskinesia in schizophrenia. *Archives of General Psychiatry*, 51:643-650, 1994.
2. Fenn DS, Moussaoui D, Hoffman WF, et al: Movements in never-medicated schizophrenics: a preliminary study. *Psychopharmacology* 123:206-210, 1996.
3. Waddington JL, Youssef HA: Cognitive dysfunction in chronic schizophrenia followed prospectively over 10 years and its longitudinal relationship to the emergence of tardive dyskinesia. *Psychol Med* 26:681-688, 1996.
4. Fenton WS, McGlashan TH: Natural history of schizophrenia subtypes I: longitudinal course of paranoid, hebephrenic, and undifferentiated schizophrenia. *Arch Gen Psych* 48:969-977, 1991.

Component Workshop 1
RESEARCH ADVANCES IN MAJOR DEPRESSIVE DISORDERS
APA Consortium on Organized Service Systems

Co-Chairpersons: Laurent S. Lehmann, M.D., *Mental Hlth & Behav Scien, (111C) VA Central Office, 810 Vermont Avenue, NW, Washington DC 20420-0002,* Frederick G. Guggenheim, M.D., *UAMS Slot 554, 4301 West Markham, Little Rock AR 72205-7101*
Participants: Marc A. Schuckit, M.D., Brenda M. Booth, Ph.D., Peter Hauser, M.D., John Feussner, M.D.

EDUCATIONAL OBJECTIVES:

After this presentation, participants should be able to: describe the course of alcoholic and depressive symptoms in patients with substance-induced or independent depression, recognize the importance of identification and treatment of major depression in patients with medical illnesses, and describe MRI-identified brain abnormalities in mood disordered patients.

SUMMARY:

Dr. Schuckit, director of the Alcohol Research Center at the San Diego VA Medical Center, will present on "Substance-Induced vs. Independent Major Depressive Disorders in Alcoholics," reporting data from 3,000 subjects from the Collaborative Study in Genetics of Alcoholism (COGA). *Dr. Booth*, associate research career scientist, at the Health Services Research and Development Field Program for Mental Health at Little Rock VAMC, will present, "Longitudinal Outcomes for VA Medical/Surgical Inpatients with Major Depression": results of a longitudinal study of medical and surgical inpatients at three VA medical centers estimating prevalence of psychiatric comorbidity and impacts on outcome over the year from index admission. "Structural Imaging Studies in Mood Disorders: Past, Present and Future," presented by *Peter Hauser, M.D.*, chief of psychiatry at the Baltimore VAMC, reviews the history of structural imaging emphasizing (MRI) studies of patients with major depressive disorders and bipolar affective disorders, discussing possible underlying pathophysiologic mechanisms of structural brain abnormalities in patients with mood disorder. The discussant for the program will be *John Feussner, M.D.*, VA's newly-appointed chief of research and development service. There will be time for questions from attendees at the end of each presentation and after the discussant's talk.

REFERENCES:

1. Schuckit, MA, Smith, TL: Eight-year followup of 450 sons of alcoholics and controls. *Arch Gen Psychiatry.* V53, p.202-210, 1996.
2. Hauser P (ed): *Brain Imaging in Affective Disorders:* American Psychiatric Press, Washington, DC, 1991.

Component Workshop 2
SOUTH AFRICA: MENTAL HEALTH IN THE NEW NATION
APA Council on International Affairs

Chairperson: Mary Jane England, M.D., *WA Business Group on Health, 777 North Capitol St, NW, #800, Washington DC 20002-4239*
Participants: Cliff W. Allwood, M.D., William H. Goldman, M.D., Tiffany Ho, M.D., J. Charles Ndlela

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants will be able to understand the changes that have taken place in South Africa's mental health system. Moreover, a series of topical issues will be discussed geared to sensitize the participants about the current challenges and potential solutions to gaps in the mental health system of their own country.

SUMMARY:

During the last 20 years, major changes have taken place in the political and sociohistorical structure of South Africa. These changes have impacted every sector of the country, including mental health services, education, and research. In the summer of 1996, a delegation of psychiatrists from the U.S., organized by APA under the leadership of Dr. Mary Jane England and in coordination with APA's Council on International Affairs, visited South Africa for the purpose of addressing mental health needs and gaps designated by the psychiatric leadership of South Africa. In this presentation, a review of the observations made will be advanced with emphasis on what has been accomplished in the mental health field as well as what is needed in order to improve the current gaps in the system. In the discussion, avenues for closer collaboration and communication between Africa and the U.S. will be explored. Hopefully, this presentation will serve as an international model of psychiatric collaboration and enhancement of the perspectives involved in a country with a mental health system that has radically changed in the last two decades.

Component Workshop 3
MECHANICAL DEVICES AND THE MENTALLY ILL: AN HISTORICAL VIEW
APA Committee on History and Library

Chairperson: Dilip Ramchandani, M.D., *Department of Psychiatry, Allegheny University, 3300 Henry Avenue, Room 339, Philadelphia PA 19129*
Participants: John R. Lion, M.D., Janet E. Ordway, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to appreciate the conceptual context in which a variety of instruments were used in diagnosis and treatment of psychiatric patients throughout history, and recognize the remnants of such devices and their rationale in our current practices.

SUMMARY:

Psychiatric interventions have traditionally and historically utilized a variety of instruments and devices to treat intolerable distress or behavior. Many of these instruments evoke amusement, distaste, or horror in the modern day psychiatrist and others involved in patient care leading them, sometimes, to view even necessary use of such devices with ambivalence.

However, these instruments also tell a story of the conceptual framework of the early psychiatrist who struggled to find ways and means of dealing with psychopathology. The stone of folly, the "tranquilizer," the circulating swing, Guislain's water treatment apparatus, the leukotome, Horn's standing restraint, or Mesmer's baquet each casts light on the inner workings of the psychiatric mind of the period.

With vignettes and slides this workshop will trace the origins, the logic, the application, and the eventual abandonment of various devices representing important phases of our history. Audience participation will be invited to also focus on the vestiges of such instruments in our current armamentarium as the sophisticated diagnostic and therapeutic devices of the computer age replace these relics of an earlier era.

REFERENCES:

1. Gilman SL: *Seeing the Insane*, John Wiley & Son, NY, 1982.
2. Hunter R. Macalpine I: *Three Hundred Years of Psychiatry 1535-1860.* Oxford University Press, NY 1963.

Component Workshop 4
SPECIAL NEEDS OF PHYSICIANS WITH HIV/AIDS
APA Pennsylvania Psychiatric Society's Task Force on HIV/AIDS

Chairperson: John E. Fryer, M.D., *Department of Psychiatry, Temple University, 138 West Walnut Lane, Philadelphia PA 19144-2691*
Participants: Edward O. Nix, M.D., Donald W. Fennell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the factors that are most important in evaluating the physician impaired with HIV/AIDS, treat the special needs involved in care of physicians with HIV/AIDS, and recognize the ethical issues that arise in the care of physicians with HIV/AIDS.

SUMMARY:

Physicians who are ill with HIV/AIDS present many unique problems to those who are concerned with impaired physicians. What is their responsibility to disclose their HIV status to patients? Who is monitoring their degree of impairment so that their ability to care for patients can be monitored? What is the role of a hospital physician health committee and of a state physician health program?

This workshop faculty includes a psychiatrist who is leading a group of HIV-infected physicians, as well as a physician who is HIV positive. The panel includes psychiatrists who have worked extensively with impaired physicians as well as with persons with HIV/AIDS and they will provide the framework for an active discussion.

REFERENCES:

1. Feldman MK: Physicians with AIDS. Healing the crisis of confidence. *Minnesota Medicine* 74:(10):18-23. Oct. 1991.
2. Rzepkowski N: Report from an HIV positive physician. *Seminars in Neurology* 12(2):141-146. June, 1992.

Component Workshop 5
FOR A FUTURE IN ETHNICITY, AGING AND MENTAL HEALTH
APA Committee on Ethnic Minority Elderly

Chairperson: Jacobo E. Mintzer, M.D., *Department of Psychiatry, Medical University of SC, 171 Ashley Avenue, Room PH141, Charleston SC 29425*
Participants: Rose C. Gibson, Ph.D., W. Ladson Hinton IV, M.D., Keh-Ming Lin, M.D., Ramon Valle, Ph.D.

EDUCATIONAL OBJECTIVES:

To review the current "state of the art" available information in ethnic aging and mental health and propose specific questions around which future efforts in this area should be the focus.

SUMMARY:

Background: For many years little information about ethnicity, aging, and mental health was available. In the last decade, however, a number of projects have been funded by both the National Institute on Aging and the National Institute of Mental Health to study different aspects of these complex issues. The majority of these studies have now been completed, and those researchers have important information on the results of their work and they are ready to share in order to broaden our knowledge in this area and focus future efforts.

Method: To this end, the members of the APA ethnic elder component have invited four prominent researchers in the field of aging, ethnicity, and mental health along with *Dr. Barry Leibovich,* director of the aging branch of the National Institute of Mental Health to address these issues. Specifically, the following researchers will participate in the workshop: *Ramon Valle, Ph.D.,* who will discuss assessment measures; *Rose Gibson, Ph.D.,* who will discuss retirement and social measures of health; *Ladson Hitton, M.D.,* who will discuss issues of dementia care giving; *Kim Min Lin, Ph.D.,* who will discuss diagnosis and pharmacological treatments; and *Barry Leibovich, Ph.D.,* who will serve as discussant.

In addition personal invitations will be forwarded to all federally funded researchers studying issues related to ethnicity, aging, and mental health to participate in the workshop and the debate.

Conclusion: Members of the component anticipate that this workshop will initiate a process that will lead to a future concensus conference aimed at formulating a future agenda on issues of ethnicity, aging, and mental health.

REFERENCES:

1. Kleinman A: Anthropology and psychiatry. The role of culture in cross-cultural research on illness. *Brit J Psych* 151:447-54, Oct, 1987.
2. Gibson RC: The age-by-race gap in health and mortality in the older population a social science research agenda. *Gerontologist.* 34(4):454-62. Aug, 1994.

Component Workshop 6
AUTOMATED REVIEW OF OUTPATIENT PSYCHOTHERAPY
APA Committee on Quality Assurance and Improvement

Chairperson: Sheila H. Gray, M.D., *Box 40612/Palisades Station, Washington DC 20016-0612*
Participants: Gregory A. Miller, M.D., Norman A. Clemens, M.D., Barton J. Blinder, M.D., Roger L. Coleman, M.D., Katherine E. Grimes, M.D., Leon R. Wanerman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will learn how to identify essential features of a computerized review system designed to assure appropriate use of clinical resources and to protect the privacy of individual patients. They will be able to discuss the impacts of computerized and "live" quality assurance review on the psychotherapeutic alliance.

SUMMARY:

The workshop will consider the feasibility of constructing a computerized interface between dynamic medical psychotherapists and a managed care organization. The development and evolution of a system of automated review of scannable individual treatment plans for a commercial managed care population will be presented. The rationale for a set of review algorithms, and their statistical and clinical utility will be presented. Sample cases will be "screened" by the algorithmic sets in a dialogue between panelists and audience. Specific attention will be paid to issues of privacy and confidentiality and to the effect of the review process on psychotherapeutic technique.

REFERENCES:

1. Gray SH: Quality assurance and utilization review of individual medical psychotherapies. in: Mattson R (ed): *Manual of Psychiatric Quality Assurance Review.* Marlin Washington, D.C.: American Psychiatric Press, 159-166, 1992.

2. Woodward B: The computer-based patient record and confidentiality. *New England Journal of Medicine* 333:1419-1422, 1996.

Component Workshop 7
LITIGATION AND RISK MANAGEMENT IN PSYCHIATRIC ADMINISTRATION
Co-Sponsored by the American Association of Psychiatric Administrators and the APA Committee on Administrative Psychiatry

Chairperson: William H. Reid, M.D., *PO Box 49817, Austin TX 78711-2668*
Participants: W. Walter Menninger, M.D., Dave M. Davis, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation participants will be aware of recent litigation and risk management issues affecting mental health systems and programs.

SUMMARY:

Recent case law and other litigation affecting mental health programs will be discussed including new theories of malpractice and standards of care, separation of practioner and system (e.g. managed care organization), responsibility for care, new assertions of federal privilege, confidentiality of internal reporting processes, and boundary violations.

Component Workshop 8
BELIEF AS A PSYCHIC FUNCTION
APA Committee on Religion and Psychiatry and APA Council on National Affairs

Chairperson: George T. Harding, M.D., *Harding Hospital, 445 East Granville Road, Worthington OH 43085*
Participants: Ana Maria Rizzuto, M.D., Elizabeth S. Bowman, M.D., Rev. Clark S. Aist, Ph.D., David H. Rosen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should understand Dr. Rizzuto's thesis, that belief is a psychic function, which not only is essential to the development of one's individual construct of God but is a key element of each individual's psychic life. Psychoanalytic, object relations, jungian and other viewpoints will be voiced and audience participation will be encouraged.

SUMMARY:

In this workshop, the panelists will highlight, critique, and offer alternative understandings of Dr. Rizzuto's thesis that the formation of private god representations is a process that occurs in dialetical integration with the formation of self-representations. She states in her book, *The Birth of the Living God*, "A person's private god is neither everybody's god nor the god of official doctrine but the only god that particular individual is able to have. Once created, god's watchful presence, protecting of persecutory, becomes a fact of psychic life so real that no human power, not even the wishes of the child god maker, could make it disappear." Belief, once established, requires major psychic shifts to be changed. In her Oskar Pfister lectureship Dr. Rizzuto further develops her position regarding the role our belief system plays in developing our concept of God. In addition, Dr. Rizzuto expands our understanding of the role our belief system plays in the development of our total psychic functioning. Dr. Rizzuto's thesis will be analyzed and discussed from diverse viewpoints and theoretical positions by psychiatrists and theologians as they are applied to our understanding of religious groups and individual persons.

REFERENCES:

1. Rizzuto AM: *The Birth of the Living God: A Psychoanalytical Study.* University of Chicago Press, Chicago, 1979.
2. Rizzuto AM: *Exploring the Sacred Landscapes: Religious and Spiritual Experiences in Psychotherapy.* Columbia University Press, New York, 1993.

Component Workshop 9
DRUG LUNCHES: LOVE 'EM OR LEAVE 'EM?
APA/Glaxo Wellcome Fellows

Chairperson: Colleen J. Northcott, M.D., *Department of Psychiatry, University of British Columbia, 2255 Wesbrook Mall, Vancouver BC V6T 2A1, Canada*
Participants: William L. Clayton, M.D., David W. Crumpacker, M.D., Maria Daehler, M.D., Lisa A. Kotler, M.D., Mary B. O'Malley, M.D., Diana R. Sanderson, M.D., L. Lee Tynes, M.D., Sandra C. Walker, M.D., Mary Jane England, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will have a greater understanding of how psychiatry residents and their programs currently interact with pharmaceutical companies, of conflicts that may arise within training programs around this relationship, and of potential solutions.

SUMMARY:

The influence of pharmaceutical companies (PCs) on residency programs is a complex one. It raises ethical and pragmatic issues, which can lead to conflict between program administrators and residents, and among residents themselves. We ask to what extent this is occurring and how it is being addressed in North American psychiatry residencies.

This workshop will explore these interactions through vignettes of residents' experiences and through discussion of the various aspects of our professional involvement with PC sponsorship. Results from a survey of residents and program directors will be presented including data on residency programs' current policies and practices, attitudes on PC activities, and areas of perceived conflict on these issues within the training programs.

Workshop participants are encouraged to share their experience. Our discussant, *Dr. MJ England*, will contribute her perspective as a former APA president. Together, this input and survey data will help develop flexible and ethical educational strategies. Residents and directors may find these useful in designing future policy to guide the relationship with pharmaceutical companies and with each other.

REFERENCES:

1. Lichstein PR, et al: Impact of pharmaceutical company representatives on internal medicine residency programs: A survey of residency program directors. *Arch Intern Med* 152:1009-1013, 1992.
2. Lazar EJ, et al: Drug company sponsorship of education: The response to the FDA draft concept paper (letter). *JAMA* 268:53-54, 1992.

Component Workshop 10
INTERNATIONAL EDUCATION IN PSYCHIATRY
APA Committee on International Education

Chairperson: Winston W. Shen, M.D., *Department of Psychiatry, St. Louis University, 1221 South Grand Boulevard, St. Louis MO 63104-1016*
Participants: Michael J. Napoliello, M.D., Robert R. Franklin, M.D., Houshang G. Hamadani, M.D., J. Randolph Hillard, M.D., Prakash N. Desai, M.D., Renato D. Alarcon, M.D., Marc Galanter, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be more knowledgeable about international aspects of psychiatric educa-

tion, and more culturally sensitive in delivering the psychiatric care to ethnic minority patients in America.

SUMMARY:

The world becomes smaller as transportation and communication technologies advance rapidly. Interactions among US and international colleagues are numerous. This workshop is intended to explore the international curricula of psychiatric education for medical students, postgraduate trainees, practicing psychiatrists, primary care physicians, and subspecialists in psychiatry. The participants, who are members of the APA Committee of International Education, will take turns highlighting specific geographic (i.e., Sub-Saharan Africa, Middle East, Indian Subcontinent, East Asia, South America, etc.), linguistic (i.e., French, German, Spanish, Italian, Persian, Indian, Japanese, Chinese, Taiwanese, etc.), and specialty areas (i.e., cultural psychiatry, addiction psychiatry, psychopharmacology, Internet communication, etc.). The audience will have ample opportunity to exchange their firsthand experience in psychiatric education from all parts of the world. From this workshop, the audience will obtain a better understanding of the educational needs in and outside the US, learn from psychiatrist colleagues in other parts of the world, and enhance cultural sensitivity in delivering psychiatric care to ethnic minority patients in America.

REFERENCES:

1. Ruiz P: Clinical care update: The minority patient. *Comm Ment Health J* 21:3:208-216, 1985.
2. Sata LS, Shen WW: An update study of Asian psychiatric resources in the United States. *NATMA Newsletter* (St. Louis) 5:1:19-25, 1989.

Component Workshop 11
PROBLEM-BASED LEARNING AND GENDER
APA Committee on Women

Chairperson: Donna E. Stewart, M.D., *Women's Health, Toronto Hospital, 200 Elizabeth Street, EN 1-222, Toronto ON M5G 2C4, Canada*
Participants: Cheryl F. McCartney, M.D. Lori E. Kaplowitz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to develop PBL cases and tutor guides that address and are sensitive to gender issues.

SUMMARY:

Medical schools are introducing problem-based learning (PBL) using patient cases to direct learning. PBL is taught in small groups requiring greater student involvement in analytic thinking, problem-solving skills, collaboration, assertiveness, and leadership. Men and women students' proficiency with these skills often differ, especially in mixed gender learning groups. Sensitivity to gender issues is essential to make optimal use of patient data, small group learning, and to develop effective treatment plans. *Dr. McCartney* will provide an overview of the changing demographics and value systems of medical students. She will add a brief description of PBL and recent analyses of its effectiveness. *Dr. Kaplowitz* will discuss gender related group dynamics in PBL from her experience with medical students educated in single gender PBL tutorial groups. The differential gender effects of this experience on students' comfort in PBL and later medical practice will be described. *Dr. Stewart* will present a Gender Issues Committee review of PBL for gender content and the effects of feedback in changing case content and educational climate. Audience participants will discuss their examples of gender difficulties and successes in PBL, experienced in their teaching, mentoring, and/or psychotherapy of medical students.

REFERENCES:

1. Albanese MA, Mitchell S: Problem-based learning: A review of literature on its outcomes and implementation issues. *Academic Medicine* 68: 52-81, 1993.
2. Robinson G, Stewart DE: A curriculum on physician-patient sexual misconduct and teacher-learner mistreatment. Part 2: Teaching method. *CMAJ* 154: 1021-1025, 1996.

Component Workshop 12
SAME-SEX MARRIAGE: EVOLVING PERSPECTIVES
APA Committee on Gay, Lesbian and Bisexual Issues

Chairperson: Lowell D. Tong, M.D., *Department of Psychiatry, San Francisco VAMC 116N, 4150 Clement Street, San Francisco CA 94121*
Participants: Mark H. Townsend, M.D. Leslie G. Goransson, M.D. Cheryl A. Clark, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to:

1. understand current mental health, social, and legal issues of same-sex marriage and its denial.
2. understand clinical implications of marriage and its denial, on lesbian and gay individuals, couples, and families.

SUMMARY:

This workshop will expand upon the work presented at a prior workshop on the topic same-sex marriage. As the national debate on same-sex marriages heats up, it is important to explore the psychological and intellectual underpinnings of this debate. There will be four presentations:

- the role of ritual and ceremony in gay and lesbian unions, including documentary video footage,
- parallels between the debate over same-sex marriage and the movement to end miscegenation laws,
- same-sex marriages in the context of traditional family constellations and alternative committed relationships among lesbians and gay men, and
- an update on the international legislation on same-sex marriage.

Following the presentations, the audience will be encouraged to participate in a discussion of these topics.

REFERENCES:

1. Zieklin G: Deconstructing legal rationality: The case of lesbian and gay family relationships, *Marriage & Family Review* (The Haworth Press) Vol. 21 No. 314, p 55-76, 1995.
2. Boswell J: *Same Sex Unions in Premodern Europe,* Villard Books, New York, 1994.

Component Workshop 13
FAMILY VIOLENCE: GETTING PSYCHIATRY INVOLVED
APA Committee on Family Violence and Sexual Abuse

Chairperson: Sandra J. Kaplan, M.D., *Department of Psychiatry, N Shore University Hospital, 300 Community Drive, Manhasset NY 11030*
Participants: Larry S. Goldman, M.D. Edward K. Rynearson, M.D. Carolyn A. Hightower John R. Lion, M.D. Martha Hashimoto, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will have increased knowledge of ways to overcome barriers to providing psychiatric care for families who experience violence.

SUMMARY:

This workshop, sponsored by the American Psychiatric Association's Committee on Family Violence and Sexual Abuse, will address methods of overcoming barriers to the provision of psychiatric care for families experiencing violence. The barriers that will be addressed are the following: the difficulties of providing care as a sole clinician and the need to work in interdisciplinary, interagency, and regional settings; crime victims' compensation resources for treatment funding strategies; psychiatric workplace safety when caring for these families; and the need for increased psychiatric residency education on family violence. *Larry Goodman, M.D.* of the American Medical Association, and *E.K. Rynearson, M.D.* of the Washington State Psychiatric Society, will discuss models of psychiatric involvement; the funding of services will be discussed by *Carolyn Hightower*, deputy director, Office for Victims of Crime, U.S. Department of Justice; workplace safety will be discussed by *John Lion, M.D.*; and educational status and needs will be discussed by *Martha Hashimoto, M.D.*

REFERENCES:

1. Kaplan J: *Family Violence: A Clinical and Legal Guide,* American Psychiatric Press, Inc., 1996.
2. *Diagnostic and Treatment Guidelines on Family Violence and Mental Health,* American Medical Association, 1995.

Component Workshop 14
PSYCHIATRIC LEADERSHIP IN MANAGED CARE
APA Committee on Administrative Psychiatry

Chairperson: L. Mark Russakoff, M.D., *Department of Psychiatry, Phelps Memorial Hospital, 701 North Broadway, North Tarrytown NY 10591*
Participants: W. Walter Menninger, M.D. Philip E. Veenhuis, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe changes in psychiatric administration driven by managed care; understand some of the current trends and tools including reengineering, downsizing and continuous improvement; and appreciate their interrelationships.

SUMMARY:

The changes in psychiatric practice driven by managed care have caused concomitant changes in what is required of psychiatric leaders and administrators. For example, the request for short-term, problem-focused therapy has created acute staff training and development needs, accompanied by demands to reorganize the service delivery system to make it more efficient. Psychiatrists in leadership positions must prepare staff to function in environments that are radically different from the structures they were familiar with from their training and that have traditionally existed until now. Managed care has forced administrators to carefully examine the costs of providing services from the perspectives of time efficiency as well as cost effectiveness. Organizations find themselves forced into situations of reducing costs by downsizing, usually without the benefit of having considered how to alter their processes to make them more user friendly. The workshop leaders will present material from a state mental health system, a large not-for-profit mental health system, and a community hospital. Participants will be exposed to the concepts of reengineering and how they apply to psychiatric care systems. The relationships between continuous quality improvement, downsizing, and reengineering will be explained. Other areas of importance to psychiatric leaders to help them survive in the current managed care environment, such as alterations in motivation, incentives, and ethics, will be discussed. Participants will be invited to share their experiences with the presenters in an ongoing dialogue during the workshop to insure that the material is directly relevant to them.

REFERENCES:

1. Hammer M, Champy GJ: *Reengineering the Corporation: A Manifesto for Business Revolution,* Harper Business, NY, 1993.
2. Walton M: *Deming Management at Work,* G. P. Putnam's Sons, NY, 1990.

Component Workshop 15
IMG'S AND ABPN PERFORMANCE: PROBLEMS AND STRATEGIES
APA Task Force to Facilitate Communication Between APA & ABPN

Chairperson: Nyapati R. Rao, M.D., *Department of Psychiatry, Brookdale Hospital, One Brookdale Plaza, Brooklyn NY 11212*
Participants: Richard Balon, M.D. Arifulla Khan, M.D. Frederick C. Miller, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the issues that affect IMGs' performance on the Boards and the strategies to improve their pass rates.

SUMMARY:

Certification by the ABPN is increasing in importance in the field. Manage care companies require board certification as a minimum requirement for employing a physician. IMGs, who account for over one-third of current psychiatry residents, and over a quarter of the membership of the APA, have traditionally had low pass rates on the boards. In 1989, the last year that annual data on Board pass rates were available, only 35% of IMGs who qualified to take Part II of the Board examination passed, compared with 69% of USMGs. Several factors such as language, poor preparation, and poor training are seen as contributing to the low pass rates of IMGs on the board examinations. Although the discussion of IMG performance may be avoided for fear of reinforcing stereotypes, lack of such discussion is not likely to lead to an improvement in the situation. In this workshop, participants will share their views on this issue from their individual perspectives as private practitioners, educators, and researchers. A survey of members of a district branch of APA on their Board certification, training, and professional experiences will be presented. There will be ample time for discussion.

REFERENCES:

1. Val E, Quick S: Foreign medical graduates and Board certification - Myths and realities. *Am J Psychiatry,* 140:184-188, 1983.
2. Chen R: *Foreign Medical Graduates in Psychiatry: Issues and Problems.* New York, Human Science Press, 1981.

Component Workshop 16
CAREER TRANSITIONS: LEADERSHIP SKILLS YOU'LL NEED
APA Committee on Occupational Psychiatry

Chairperson: Elmore F. Rigamer, M.D., *Sisters of Charity, 3838 North Causeway Boulevard, Metairie LA 70002.*
Participants: Stephen H. Heidel, M.D. Miles F. Shore, M.D. Jeffrey P. Kahn, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participants should be able to identify their strengths and weaknesses for working with/ in organizations and identify training opportunities to acquire the necessary skills.

SUMMARY:

Changes in the health and mental health care systems mean that psychiatrists will have to learn new ways to manage their careers. The first part of the discussion distinguishes between those aspects of psychiatric training that foster and those that hinder effective leadership. The second part discusses the contribution the psychiatrist makes to an organization undergoing change. Most change efforts fail not for lack of a brilliant strategy but because of human resistance. Applying a knowledge of psychodynamics makes a psychiatrist uniquely qualified to consult in this area. The third part itemizes specific skills psychiatrists need to learn to be effective in organization settings. The fourth part addresses training needs and specific training resources in residency programs and post residency to enhance the psychiatrist's role in the new health systems.

REFERENCES:

1. Berwick DM, et al: *Curing Health Care,* Jossey-Bass Publishers, San Francisco, 1990.
2. Gauthier A: The challenge of stewardship: Building learning organizations in healthcare," in *Learning Organizations,* Productivity Press, Portland, 1995.

Component Workshop 17
TYING BENEFITS TO BEHAVIOR: INCENTIVE OR INJUSTICE?
APA Committee on Poverty, Homelessness and Psychiatric Disorders

Chairperson: Stephen M. Goldfinger, M.D., *Department of Psychiatry, Massachusetts Mental Hlth Ctr, 74 Fenwood Road, Boston MA 02115-6106*
Participants: Carl I. Cohen, M.D. Francine Cournos, M.D. Joel S. Feiner, M.D. Walter S. Jennings Jr, M.D.

EDUCATIONAL OBJECTIVES:

To better understand the relationship between clinical state, financial support, treatment compliance, and rehabilitation.

SUMMARY:

Long-standing programs that provide cash benefits and other supports to a wide array of individuals face unprecedented change. Welfare reform, changes in Medicaid and other federal entitlement programs, and an increasing emphasis on "managing" not only benefits but beneficiaries, raise critical questions about the nature of how we should provide support and to whom. In this workshop, the Committee on Poverty, Homelessness, and Psychiatric Disorders will explore the interface between entitlement, disability, coercion, and treatment. Are efforts to limit the length of time an individual can receive welfare benefits an effective way to motivate competitive employment, or are they a punitive measure? Should those with high levels of drug and alcohol use continue to receive SSI payments as direct cash benefits? Is it reasonable to require treatment for substance abuse as a precondition to receiving entitlements? Should supports be provided financially or by providing housing and vouchers for food and clothing? Should virtually all recipients be expected to work and, if so, at what kind of jobs? What can we expect from those with partial or circumscribed disabilities, and what should we expect?

As professionals, and as knowledgeable citizens, how do we provide input into the state and local policies that are being developed? At our meeting during the Fall Components, it became clear that even among committee members, there were widely divergent opinions on all of these topics. In this workshop we will actively engage attendees in an exploration of how to use what we know about illness, rehabilitation, treatment, and functional status and (at least TRY to) forge a coherent approach to these issues.

REFERENCES:

1. Cohen CI, Thompson KS: Homeless mentally ill or mentally ill homeless? *American Journal of Psychiatry* 149(6):816-823, 1992.
2. Cohen CI: The political economy of mental health. *Psychiatric Services* (in press).

Component Workshop 18
WORKING WITHOUT A NET
APA Council on Medical Education and Career Development and APA Committee on Administrative Psychiatry

Chairperson: Philip E. Veenhuis, M.D., *Medical Director, Division of MH/DD/SAS, 325 North Salisbury, Raleigh NC 27603*
Participants: Alan A. Lipton, M.D. Robert Fisher, M.D. Stuart B. Silver, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant will have information regarding the impact of managed care on public psychiatry.

SUMMARY:

Managed care has had a dramatic impact on public psychiatry. This impact has not been the same in all states. This workshop will consist of reports from four states: Florida, Maryland, North Carolina, and Tennessee. The workshop panel will be led by the commissioners of mental health of Florida, North Carolina, and Tennessee. Traditionally, there has been a public perception of the public sector as safety net that is provider of last resort. The advent of managed care has changed the ability of public sector to play this role. In some states public sector has been prioritized, while in others public sector agencies have become managed care organizations. Questions to be dealt with are what's going on? What's working? What's not? What does the future of public psychiatry seem to be?

REFERENCES:

1. Talbott JA, Hales RE, Keill SL, (eds): *Textbook of Administrative Psychiatry.* Washington, D.C., American Psychiatric Press, 1992.

Component Workshop 19
MANAGED CARE: STRATEGIES FOR MINORITY/IMG PSYCHIATRISTS
APA Committee of International Medical Graduates and APA Committee on Managed Care

Chairperson: Altha J. Stewart, M.D., *7150 Crittenden Street, Philadelphia PA 19119*
Participants: Norma C. Panahon, M.D. Francis G. Lu, M.D. Lonnie Snowden, Ph.D. Harriet McCombs, Ph.D.

EDUCATIONAL OBJECTIVES:

To understand basic principles of managed care and its impact on the practice of psychiatry; to recognize the impact of managed behavioral health care on changing practice behaviors of ethnic minority and IMG psychiatrists; to demonstrate ability to more effectively market a culturally appropriate and cost-effective psychiatric practice.

SUMMARY:

The current trend toward managed health care raises concerns among ethnic minority and IMG psychiatrists. Managed care, as practiced in the private sector, initially ignored the concerns of these psychiatrists and the diverse communities they served. As the industry evolves, managed care programs and ethnic minority and IMG psychiatrists face new challenges. Forced to work in an increas-

ingly competitive environment, with a focus on quality, consumer satisfaction, and cost-effectiveness, these psychiatrists are uniquely positioned to offer a "value-added" service. They must, however, learn new strategies to market these services to both the public and private sectors if they are to avoid the potential "double-edged sword" effect that could result in further marginalization within their profession.

This workshop will provide an overview of managed care principles and the impact of managed care on the practice styles of ethnic minority and IMG psychiatrists. In addition, the presenters will offer strategies for ethnic minority and IMG psychiatrists to compete more effectively in today's managed care environment by providing culturally and clinically appropriate, cost-effective services. Specific issues related to practice setting, contracting, credentialing, marketing, and the role of government and professional organizations will also be discussed in this session.

REFERENCES:

1. "Is Managed Care Ignoring Skills of IMG's and Minorities?" *Psychiatric News,* vol. XXX, no. 14, July 21, 1995.
2. Snowden LR: Emerging trends in organizing and financing human services: Unexamined consequences for ethnic minority populations." *American Journal of Community Psychology. 21:1-13, 1993.*

Component Workshop 20
THE RESPONSIBILITIES OF ADULT PSYCHIATRISTS WHO TREAT PATIENTS WITH CHILDREN
APA Council on Children, Adolescents and Their Families

Chairperson: Deborah A. Zarin, M.D., *Office of Research, American Psychiatric Assn., 1400 K Street, NW, Washington DC 20005*
Participants: Martin A. Irwin, M.D. Carl B. Feinstein, M.D. V. Susan Villani, M.D. Helen K. Abramowicz, M.D.

EDUCATIONAL OBJECTIVES:

Participants should 1) appreciate the need to consider the status of the children of their patients, and 2) have a greater appreciation of the special need of certain groups of children.

SUMMARY:

General psychiatrists who treat adult patients need to be aware of specific issues for their patients with children. An assessment of the patient's parenting abilities is an important component of assessment of the overall functional status. This requires knowing the ages of the children, the care arrangements, and having an understanding of the physical and emotional needs of children at different ages. Children of parents with mental disorders are at particular risk of psychosocial problems as a result of many factors, including genetics, parenting style, separations and interruptions in parenting, abuse and neglect, comorbid substance use, and increased risk of exposure to traumatic events.

The discussants will focus on three groups of children who are at particular risk: infants, children of parents with major mental illness, and children of parents who are divorced. Relevant research will be reviewed briefly to form the basis of a discussion of the clinical issues that arise and the ways in which the parent's psychiatrist can play a beneficial role for the child(ren). Participants will receive an annotated reading list.

REFERENCES:

1. Goodman SH, Brumley HE: Schizophrenic and depressed mothers: Relational deficits in parenting. *Developmental Psychology* 26:31-39, 1990.
2. Seifer R, Dickstein S: Parental mental illness and infant development in: Zeanah CH (ed): *Handbook of Infant Mental Health.* Guilford Press, New York, 1993.

Component Workshop 21
ISSUES FACING SAME-SEX COUPLES
APA Northern California Psychiatric Society's Committee on Gay, Lesbian and Bisexual Issues

Chairperson: Ellen Haller, M.D., *Department of Psychiatry, University of CA at SF, 401 Parnassus Avenue, San Francisco CA 94143*
Participants: Eugene Lee, M.D., Karin L. Hastik, M.D., Dan H. Karasic, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the similarities and differences in the issues facing same-sex couples and implications of these issues in individual and couples therapies.

SUMMARY:

The increased visibility of gay, lesbian, and bisexual issues in multiple disciplines such as sociology, politics, law, and medicine has heightened the need for psychiatrists to be cognizant of these issues and of their ramifications for patients. This workshop will present how same-sex couples become related, organize that relatedness, express affection, and maintain their relationships through maturation. We will explore the concepts of intimacy and sexuality in gay and lesbian relationships, focusing on how the developmental process can create self-sabotaging external and internal homophobia. We will discuss the diversity in gay/lesbian arrangements and in their expressions of sexuality, particularly focusing on the concepts of monogamy and marriage. The workshop will highlight psychological aspects of roles in lesbian relationships and the impact of HIV/AIDS on gay couples. Finally, we will complete the life cycle perspective by discussing issues of parenting by homosexuals and the resulting impact on their children. Clinical vignettes, individual experiences, and comments on the presented material will be elicited and discussed with the audience.

REFERENCES:

1. Harmon L, Volker M: HIV-positive people, HIV-negative partners. *Journal of Sex and Marital Therapy* 21:127-140, 1995.
2. Deenen AA, Gijs L, van Naerssen AX: Intimacy and sexuality in gay male couples. *Archives of Sexual Behavior* 23:421-431, 1994.

Component Workshop 22
EDUCATION ABOUT ADDICTION DURING RESIDENCY: THE CHALLENGE OF MANAGED BEHAVIORAL HEALTH CARE
APA Council on Addiction Psychiatry

Chairperson: Roger E. Meyer, M.D., *Association of Academic Health, 1400 16th Street, NW, Washington DC 20036*
Participants: William H. Goldman, M.D., Michelle Riba, M.D., David R. McDuff, M.D., Leighton Y. Huey, M.D., Marc Galanter, M.D.

EDUCATIONAL OBJECTIVES:

The participant should learn the needs of managed behavioral health care organizations for psychiatrists who can work with patients with addictive and comorbid disorders, the challenges facing residency training to produce psychiatrists with these skills, and the efforts by two departments to develop responsive clinical and educational programs.

SUMMARY:

Managed behavioral health care has forced residency training program directors to rethink traditional approaches to education based upon discrete rotations (inpatient, outpatient, C/L, etc.) and long-term psychotherapy. The most enlightened leaders of the behavioral health care industry have identified critical roles for psychiatrists of the future, within population-based systems of care. How can these models work in addiction and alcoholism treatment, where there has been a dramatic change in the venues of care in the past five years—as well as efforts to legitimize certification of specific physician providers through ASAM and/or Added Qualifications following the completion of a fellowship in addiction psychiatry? As *Dr. William Goldman* will describe, the need is for general psychiatrists who can diagnose, treat, and/or appropriately refer patients with an alcohol or drug problem. *Dr. Michelle Riba,* the residency director at Michigan, will describe the challenge facing residency training directors in bringing the best clinical experiences in addiction psychiatry to the general residency. *Dr. David McDuff* will describe the model developed at Maryland, and *Dr. Leighton Huey* will describe how the diagnosis and treatment of alcoholism can be incorporated within the "Firm Model" of residency education. *Dr. Marc Galanter* will serve as discussant.

REFERENCES:

1. Johnson J, McDuff D, Bell L: Evaluation of addiction training for psychiatric residents. *Subst. Abuse* 16:1-8, 1995.
2. Hucy LY, Budlong DL, Green RL: Managed Care and Training Reform: Dartmouth Multidisciplinary Integrated, Longitudinal Treatment Teams System. Paper presented at the American Psychiatric Association Annual Meeting, May, 1996.

Component Workshop 23
STRATEGIES TO COMBAT MENTAL ILLNESS STIGMA IN THE MASS MEDIA
APA Scientific Program Committee's Media Subcommittee

Chairperson: Francis G. Lu, M.D., *Department of Psychiatry, University of CA at SF, 1001 Potrero Avenue, San Francisco CA 94131*
Participants: Otto F. Wahl, Ph.D., Paul J. Fink, M.D.

EDUCATIONAL OBJECTIVES:

To understand strategies used by the National Stigma Clearinghouse and other organizations to reduce mental illness stigma in the mass media; to understand specific ways that mental health professionals themselves can combat stigma in the mass media.

SUMMARY:

This workshop expands on the Public Advocacy Award Lecture by Otto F. Wahl, Ph.D., titled "Media Madness: Public Images of Mental Illness." The lecture describes the frequency, nature, and impact of mass media depictions of mental illness and underscores the need for mental health advocates to attend and respond to media depictions that contribute to mental illness stigma. The workshop will focus on specific strategies for attending and responding to media depictions. In particular, the model used by the National Stigma Clearinghouse, among others, to combat media stigmatization of those with mental illnesses will be described and discussed.

The workshop leaders will discuss the philosophy and activities of the clearinghouse, give some examples of how the clearinghouse has handled specific media depictions (and with what outcomes), and guide participants through the clearinghouse's "Stigma Busters" kit. Participants will be encouraged to select recent media depictions that they feel contribute to misunderstanding of mental illness, share opinions about the need to respond to such depictions, and strategize about appropriate actions.

REFERENCES:

1. Montgomery K: *Target: Prime Time.* New York, Oxford University Press, 1989.
2. Wahl OF: *Media Madness: Public Images of Mental Illness.* New Brunswick, N.J., Rutgers University Press, 1995.

Component Workshop 24
MUSIC IN THE LIVES OF FOUR PSYCHIATRISTS
APA San Diego Psychiatric Society

Chairperson: Edward A. Siegel, M.D., *Department of Psychiatry, UCSD, 255 Hill Street, Solana Beach CA 92075-1141*
Participants: John P. Feighner, M.D. Dominick Addario, M.D., Stephen R. Shuchter, M.D.

SUMMARY:

From the womb to the tomb, our lives are intertwined with music. Exploring the relationship that each person has with music can often lead to greater knowledge and understanding of that person, as well as provide underutilized avenues to effective therapy.

This entertaining workshop will feature performances by four very different types of psychiatrists who have not been out of touch with the place that music can have in their own lives and in the lives of others. Renowned clinical researcher *John Feighner, M.D.* will begin the program with some classical piano; then gerontologist and medico-legal specialist *Dominick Addario, M.D.* will follow with a Dixieland presentation. Next, UCSD Director of Outpatient Psychiatric Services *Steve Shuchter, M.D.,* will share some Rock 'N Roll featuring an appearance (or apparition) of Elvis. Finally, general outpatient psychiatrist *Ed Siegel, M.D.,* will provide a musical montage on the piano before being joined by "the cast" and members of his regular sing-along group for a grand finale.

It is anticipated that a lively discussion among the participants and the audience will ensue.

REFERENCES:

1. McIntyre J: "Notes on Music." *Psychiatric News,* Vol. XXIX No, 1, January 7, 1994.
2. Davis WB, et al: *An Introduction to Music Therapy;* Dubuque, IA, William C. Brown Publications, 1992.

Component Workshop 25
PSYCHIATRIC CONSULTATION TO SPECIAL EDUCATION
APA Committees on Psychiatry and Mental Health in Schools and Chronically Ill and Emotionally Handicapped Children

Chairperson: Irving H. Berkovitz, M.D., *Suite #710, 11980 San Vicente Blvd, Los Angeles CA 90049-5012*
Participants: Mark L. Magulac, M.D., Andrew C. Wang, M.D., Ana E. Campo-Bowen, M.D.

EDUCATIONAL OBJECTIVES:

To recognize the values of psychiatric consultation, the most appropriate techniques and procedures, and the types of children who will be best served in classes for seriously emotionally disturbed (SED) children in the public schools.

SUMMARY:

Since the passage of P.L. 94-142, psychiatrists and psychologists have played a special role in consulting to the personnel and children in the special day classes (SDC) for disabled children and especially for those diagnosed as seriously emotionally disturbed (SED). This type of consultation has had special value in improving the education and treatment of these children who often have no other access to

mental health experts. Examples will be given of the values provided in a school for SED children in San Diego, and in classes in Miami and Los Angeles. Cases of problematic diagnosis and appropriate psychopharmacology are obviously well served. The morale and confidence of the teacher and aides are crucial to a well functioning class. Consultation can be very helpful to these personnel. Examples will be given in which the consultant helped these personnel, and especially one case where the negative status associated with a SED class in a junior high school was reversed. In these days of emphasis on full inclusion of disturbed children into regular classes, the special values of the contained class for certain children will be demonstrated.

REFERENCES:

1. *Psychiatric Consultation In Schools: A Report of the American Psychiatric Association,* Wash. D.C., 1993.
2. Mattison RE: Principles in Common School Case Consultations, pp 161-186. in *Child and Adolescent Mental Health Consultation in Hospitals, Schools and Courts*, Fritz GK, Mattison RE, Nurcombe B, and Spirito A. American Psychiatric Press, 1993.

Component Workshop 26
CROSS-CULTURAL DYADS IN RESIDENT SUPERVISION
APA/CMHS Minority Fellowship

Chairperson: Robin R. Randall, M.D., *Department of Psychiatry, UCSF, 401 Parnassus Avenue/Box R0984, San Francisco CA 94122-2720*
Participants: Jennifer King-Vassel, M.D., Tiffany B. Ho, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize and address the unique aspects of cross-cultural supervision.

SUMMARY:

With the increasing diversity of psychiatric trainees, it is important to explore the unique challenges and opportunities presented to both the supervisor and trainee when supervision occurs across cultural lines. The cultures of the patient, trainee, and supervisor can combine in ways that both complicate and enrich the supervisory experience. This workshop seeks to explore the added dimensions created by cross-cultural supervision. It is intended to begin a dialogue between trainees and supervisors on this issue. Presentations will be by both trainees and supervisors. Audience members will participate in this workshop by filling out a brief worksheet during the initial presentations and then discussing their responses to issues raised by the worksheet and workshop presentations.

REFERENCES:

1. Clarke DM: Supervision in the training of a psychiatrist. *Australian and New Zealand Journal of Psychiatry* 27(2):306-310, 1993.
2. Beigel A, Santiago JM: Redefining the general psychiatrist: Values, reforms, and issues for psychiatric residency education. *Psychiatric Services* 46(8):769-74, 1995.

Component Workshop 27
ACCULTURATION AND STIGMATIZATION: MYTH OR REALITY?
APA Committee of Hispanic Psychiatrists and APA Council on National Affairs

Chairperson: Silvia W. Olarte, M.D., *37 East 83rd Street, Apt 1, New York NY 10028*
Participants: Renato D. Alarcon, M.D., Lourdes M. Dominguez, M.D., Karen A. Venegas-Samuels, M.D., J. Fernando Bayardo, M.D., Oscar E. Perez, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this presentation, the participant should be able to recognize the effect of acculturation and stigmatization in the diagnosis and treatment of the Latino patient and the mental health of the Latino professional.

SUMMARY:

By the year 2020 the Hispanic population is expected to be the most numerous minority in USA. Acculturation is a problem experienced beyond the first generation of immigrants. The nature of this acculturation is colored by multiple factors such as generational status, gender, and economic and educational levels. The problems motivated by the acculturation process are often difficult to separate from the problems consequent to stigmatization of a minority by the host culture and at times by members of their own community as they "acculturate." Often minority patients are treated by professionals who are also members of the same minority, especially if professionals and patients share a language that is different from that of the host culture. The professional's acculturation plays an important role in his/her adaptation to the host culture and his/her ability to treat patients of his/her culture.

This presentation will address issues of acculturation and stigmatization and their effect on mental health from the standpoint of the established professional, the professional in training, the "acculturated" minority patient, and the recent immigrant. Latino professionals working in Texas, California, and New York will share their clinical and personal experiences utilizing case vignettes.

REFERENCES:

1. Vega WA, Rumbaut GR: Ethnic minorities and mental health. *Annual Revision of Sociology*, 17:354-383, 1992.
2. Malgady RG, Rodriguez O (eds): *Theoretical and Conceptual Issues in Hispanic Mental Health.* Krieger Publishing Co, Malabar, Fla. 1994.

Component Workshop 28
MANAGING DUAL RELATIONSHIPS IN CLINICAL PRACTICE
APA Ethics Committee

Chairperson: Richard S. Epstein, M.D., *10401 Old Georgetown Rd, #400, Bethesda MD 20814-1911*
Participants: Peter B. Gruenberg, M.D., Donna E. Frick, M.D., M. Marshall Overstreet, J.D., M.D.

SUMMARY:

The Principles of Medical Ethics require that psychiatrists deal in an honest manner designed to benefit their patients. Psychiatrists must guard against dual relationships that create a conflict of interest during treatment, because of the danger to patient well-being. Honest dealing with patients necessitates that psychiatrists understand potential dual relationships that may arise, be prepared to inform the patient about the risks involved, and be able to resolve such conflicts in ethical ways. In this workshop, members of the APA Ethics Committee will discuss various types of dual relationships that occur during treatment. An initial overview will describe problems that arise when psychiatrists have extra-therapeutic social contact with patients, business dealings with patients, independent relationships with other persons known to patients, and other potentially injurious conflicts. A review of the forensic and legal aspects of dual relationships in psychiatric practice will be followed by a discussion of ethical methods of working with patients who recall memories of childhood sexual abuse during treatment, and who are considering legal action against alleged perpetrators.

REFERENCES:

1. Epstein RS: Professional ethics and boundaries of the clinical relationship, in Tasman A, et al, (ed.): *Psychiatry.* Philadelphia, W.B. Saunders, 1996.

Component Workshop 29
RISK MANAGEMENT ISSUES IN PSYCHIATRIC PRACTICE
APA Psychiatrists' Purchasing Group, Inc.

Chairperson: Alan I. Levenson, M.D., *75 North Calle Resplendor, Tucson AZ 85716*
Participants: Ellen R. Fischbein, M.D., Edward Hanin, M.D., F. Goodrich Feeley, Martin G. Tracy

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize diagnostic categories that reflect the highest risk for suit. S/he should be familiar with risks presented by managed care constraints, as well as common risk management issues that arise out of supervisory relationships. S/he should gain insight into general methods of protecting against risks inherent in these relationships. S/he should understand the part malpractice insurance plays in an overall risk management strategy.

SUMMARY:

Malpractice suits pose a significant problem for psychiatrists, regardless of whether they work in private practice, academic, or institutional settings. At least 8% of practicing psychiatrists are sued each year. It is important that psychiatrists understand the sources of malpractice suits, and become aware of malpractice in terms of their own work as clinicians, teachers, and administrators. Residents also must be able to join with their teachers in implementating the principles of good risk management during residency, and to incorporate these principles in their work after graduation as well. The workshop will present data from the APA-sponsored Professional Liability Insurance Program, identifying common sources of malpractice actions against psychiatrists. The nature of malpractice lawsuits will be described, and data will be presented on the cause and outcome of such lawsuits. Special emphasis will be placed on malpractice as it relates to the process of supervision, working with nonpsychiatric providers, and the changes managed care brings to psychiatric practice. Information will be provided regarding malpractice insurance policies and questions that must be addressed when purchasing such a policy. Finally, risk management/risk prevention techniques for practicing psychiatrists, psychiatry residents, educators, and administrators will be discussed.

REFERENCES:

1. Slawson PF: Psychiatric malpractice: Recent clinical loss experience in the United States. *Medicine and Law* 10:129-138, 1991.
2. Levenson AI: Risk management in psychiatry. *Clinical Psychiatry Quarterly* 16 vl: 2-3, 1993.

Component Workshop 30
PSYCHIATRY CAREER TRAINING FOR A NEW MILLENNIUM
APA Council on Medical Education and Career Development and APA Committees on Medical Student Education, Graduate Education and APA Committee of Residents and Fellows

Chairperson: Ronald L. Martin, M.D., *Department of Psychiatry, University of KS SM-Wichita, 1010 North Kansas Street, Wichita KS 67214-3124*
Participants: Jeffrey S. Akman, M.D., Michael J. Vergare, M.D., Eva M. Szigethy, M.D., David G. Bienenfeld, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop the participant should be able to better anticipate the potential changes that will occur in the practice of psychiatry by the year 2000 and thereafter, and be able to conceptualize the training needs necessary to prepare themselves for this future.

SUMMARY:

Major changes are occurring in the practice of psychiatry involving an improved scientific basis with refinements in psychiatric diagnosis and the understanding of psychiatric illness, as well as new advances in brain imaging and psychopharmacology. Simultaneous with these advances are changes involving the practice of psychiatry in terms of expectations, accountability, and limitations from managed care forces, which will influence the nature of practice, redefining the role of the psychiatrist and the specific tasks which he/she will provide. There will be departures from traditional delineations, with many tasks increasingly performed by other mental health care professionals including psychologists, nurses, and social workers. With such changes, medical students and residents need to anticipate future developments and select an appropriate training program, and also know how to shape training experience within their programs so as to gain the skills and perspectives they will need to prepare themselves for clinical, academic, or research careers in this changing field. Collectively, this workshop will outline the potential changes and provide a forum for medical students and residents to discuss with educators and senior residents what their needs are expected to be and how they should proceed to ensure their fulfillment.

REFERENCES:

1. Coyle JT: The neuroscience perspective and the changing role of the psychiatrist: The challenge for psychiatric educators. *Academic Psychiatry* 19:202-212, 1995.
2. Verhulst J, Tucker G: How many psychiatrists do we need? *Academic Psychiatry* 19:219-22, 1995.

Component Workshop 31
NURSING HOME PSYCHIATRY: PROBLEMS AND SOLUTIONS
APA New Jersey Psychiatric Association

Chairperson: Marc I. Rothman, M.D., *Department of Psychiatry, Hampton Hospital, 650 Rancocas Road, Westampton NJ 08060*
Participants: Istvan J.E. Boksay, M.D., Patricia A.J. Kay, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to improve geropsychiatric care skills of nursing home staff, effectively utilize psychotropic medicines in the nursing home within federal guidelines, manage marital and intimacy issues in nursing home residents, and intervene with families experiencing a crisis due to the nursing home experience.

SUMMARY:

The workshop will address difficult challenges commonly encountered by psychiatrists working in nursing home settings. These are: (1) enhancing the psychiatric assessment and management skills of all levels of personnel interacting with nursing home residents to increase problem prevention and make psychiatric consultation efforts more effective; (2) understanding the manner of optimizing use of psychotropic medicines while practicing in accordance with federal "OBRA 87" prescribing guidelines; (3) reconciling issues of privacy, safety, and autonomy in working with both married couples in nursing homes and intimate behaviors between nonmarried residents; and (4) assisting family members through the emotional and behavioral crises that they and their elderly relatives in the nursing home often experience. Each problem area will be introduced with a vignette designed to elicit approaches from the audience. The audience's comments and responses will be integrated into the

discussion of potential approaches and solutions by each workshop presenter. In addition, related topics and concerns of the audience will be encouraged and discussed.

REFERENCES:

1. Streim JE, Katz IR: Federal regulations and the care of patients with dementia in the nursing home. *Med Clin North Am* 78:895-909, 1994.
2. Reichman WE, Katz IR: *Psychiatric Care in the Nursing Home* New York: Oxford University Press, 1996.

Component Workshop 32
NEW NATIONAL PROGRAMS AND RESEARCH: AGE 0-3 YEARS
APA Committee on Pre-School Children

Chairperson: Harry H. Wright, M.D., *Neuropsychiatry, University of South Carolina, 3555 Harden Street Extension, Columbia SC 29203*
Participants: Robert N. Emde, M.D., Irene Chatoor, M.D., Bettye M. Caldwell, Ph.D., Mark Appelbaum, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to demonstrate why research studies in early childhood are important for prevention of childhood disorders and the strengthening of mental health competencies, and recognize the relevance of research into practice findings for social policies pertaining to young children and families.

SUMMARY:

In the 0-5 population, practice and research are truly becoming partners. We will highlight the following three areas that have relevance for psychiatry: (1) Practitioners who care for infants and toddlers have in the past been frustrated by not having coverage for common clinical problems. An overview of a new diagnostic classification system, designed by experts and resulting from preliminary field testing, which includes disorders not covered in DSM IV, will be presented. (2) Early Head Start, one of the few federal social programs initiated in recent years, has been set up as a national research laboratory for evaluation of its early childhood interventions. A national collaborative study links common and sites-specific measures in a design that includes random assignment to program and comparison nonprogram groups. (3) The NICHD study of early child care is a large-scale, multi-site study with a common research protocol initiated by NICHD, designed and directed by a steering committee consisting of the major investigators of the 10 funded applications, scientific, and administrative personnel from NICHD, as well as methodological and data management specialists. The overall design and methodology of the study will be described and early results in both the socio-emotional and cognitive domain will be presented.

REFERENCES:

1. Zero to Three: *Diagnostic Classification:0-3,* Zero to Three/National Center for Clinical Infant Programs, Arlington, VA, 1994.
2. National Institute of Child Health and Human Development Early Child Care Research Network. Infant child care and attachment security; results of the NICHD study of early child care. Symposium presented to the International Conference of Infant Studies; Providence, RI., April 1996.

Component Workshop 33
A DISTRICT BRANCH RESPONDS TO THE CHALLENGE OF MANAGED CARE
APA Orange County Psychiatric Society

Chairperson: Barton J. Blinder, M.D., *400 Newport Center Drive, #706, Newport Beach CA 92660-7661*
Participants: Himasiri De Silva, M.D., Michael D. Doucette, M.D., Diane B. Harris, M.D., E. James Stanley, M.D.

EDUCATIONAL OBJECTIVES:

This presentation traces the inception, evolution, managed care response, and first stages of successful organization, marketing, and clinical operation of an APA District Branch *launched, physician owned* and *directed,* psychiatric specialty IPA. At the conclusion the participant should recognize the vicissitudes, technical demands, and professional rewards of this prototypical venture.

SUMMARY:

In August 1993 OCPS launched a concerted response to the challenge of a laissez faire, cost-cutting, treatment-restricting, managed care presence in the community. Our mission was to create a physician owned and directed specialty care organization devoted to high quality patient care, open to all OCPS (APA) members, preserving the doctor-patient covenant, following APA guidelines of practice, levels of care, and ethics, creating cost effective interventions, with active internal peer review, and continued development of precision in diagnostic and treatment specificity through education and research.

Presenters will describe the process in achieving these goals in creating IBMG (Integrated Behavioral Medical Group). The audience will be asked to share experiences and critique of several dimensions critical to progress: values (profession and ethical), governance and structure, physician compatibility, capitalization and long-term stability, contract negotiation strategies, capacity to evolve education and research, and long-term stability. Among the several possible models of effective compassionate care, the presenters and audience will assess the potentials and limitations (clinical, professional, financial, legal) of the IBMG prototype.

REFERENCES:

1. Li JTC: The patient-physician relationship: Covenant or contract? *Mayo Clinic Proc.* 71:917-918, 1996.
2. Eist HI: Response to the Presidential Address: Why we must prevail. *American Journal of Psychiatry* 153:1123-1125, 1996.

Component Workshop 34
USING THE NEW MEDICARE G-CODES APPROPRIATELY AND EFFECTIVELY
APA Work Group on Codes and Reimbursements and APA Work Group on Harvard Resource-Based Relative Value Scale Study

Chairperson: Chester W. Schmidt, Jr., M.D., *Department of Psychiatry, Hopkins Bayview, 4940 Eastern Avenue, A4C, Baltimore MD 21224-2735*
Participants: Donald J. Scherl, M.D., Tracy R. Gordy, M.D., Ronald A. Shellow, M.D., Melodie Morgan-Minott, M.D., Edward Gordon, M.D., David I. Berland, M.D., Sharon Cohen, Eugene Cassel, Jay Cutler, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participant should be familiar with the new documentation requirements for E/M and

psychiatric codes including required elements of a comprehensive single system (psychiatric) examination. Participants will also be updated on the status of RVU's for psychiatric codes and the regulations for reimbursement of teaching physicians.

SUMMARY:

The goal of the combined component workshop (RBRVS Study and Codes/Reimbursements) is to familiarize practitioners (including teaching psychiatrists) about changes in the federal regulations, the Medicare RBRVS physician payment system, and CPT coding/documentation, which will have substantial impact on their clinical income. New documentation guidelines have been developed by HCFA and the AMA for E/M coding including the elements of a comprehensive single system, psychiatric examination. New federal regulations have been promulgated governing the payment of teaching physicians. The workshop will be a forum for introducing these changes, which affect reimbursement to practitioners, and engaging the participants in the development of the APA's position with regard to these changes.

REFERENCES:

1. Schmidt CW: *CPT Handbook for Psychiatrists.* American Psychiatric Press, Inc., May 1993.
2. *Federal Register,* Vol. 60, No. 236. pp. 63135-63188, December 8, 1995.

Component Workshop 35
CONFIDENTIALITY WHEN FAMILIES NEED TO KNOW
APA Committee on Confidentiality

Chairperson: Grace O. Young, M.D., *Department of Psychiatry, Ketchikan General Hospital, 3100 Tongass Avenue, Ketchikan AK 99901-5794*
Participants: Camille M. DiRenzio-Callahan, M.S.W., Elisa Stone, B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the risks to confidentiality and the appropriate actions to preserve confidentiality when working with families/caregivers of the seriously mentally ill person.

SUMMARY:

The seriously mentally ill often need the assistance of family members in order to sustain themselves outside an institutional setting. Family members need to know about the disease and its treatment, including the treatment plan of their relative, to be of most benefit to the patient. The right of the patient to confidentiality must be respected while providing good care.

After the presenter(s) have elucidated the issue, inter-presenter and audience participation by questions and discussion will be invited.

REFERENCES:

1. Petrila & Sadoff: Confidentiality and the family as caregiver. *Hospital & Community Psychiatry,* 136-139, Feb, 1992.
2. DiRienzo-Callahan: Confidentiality and the family's need to know. *CAMI Statement,* Nov, 1994.

Component Workshop 36
BECOMING A RURAL PSYCHIATRIST: GUIDELINES AND EXAMPLES
APA Corresponding Task Force on Rural Psychiatry

Chairperson: James L. Day, M.D., *Golden Triangle, 162 Highland Road, Great Falls MT 59405-8118*
Participants: Thomas S. Jensen, M.D., Karen L. Boudreau, J.D., Diane K. Fast, M.D.

EDUCATIONAL OBJECTIVES:

Upon completing this workshop participants will be aware of opportunities in rural psychiatry, be able to develop a business and marketing plan for a rural private practice, be able to locate and assess positions in rural public psychiatry, and be aware of benefits and problems women face in practicing rural psychiatry.

SUMMARY:

One of the effects of managed care has been to decrease the need for psychiatrists in urban areas. The workshop is intended to help prepare psychiatrists who are considering relocating to a rural area. It will provide the essential information necessary to set up a rural private practice or a practice in rural public psychiatry. It will also focus on problems women face in rural psychiatry and on solutions to those problems.

The workshop will be divided into three areas: Developing a rural private practice including how to develop a business plan and marketing plan for rural private practice, locating and evaluating opportunities in rural public psychiatry, and women in rural psychiatry, with 30 minutes allocated to each topic. In each area there will be a presentation, followed by questions and answers and discussion. Workshop participants who currently practice in rural areas will be encouraged to share their experiences. Participants considering a move to a rural area will be encouraged to ask questions and use the workshop to clarify their plans.

REFERENCES:

1. Copans S, Racusin R: Rural child psychiatry. *Journal of the American Academy of Child Psychiatry* 22, 2:184-190, 1983.
2. Reed DA: Adaptation: The key to community psychiatric practice in a rural setting. *Community Mental Health Journal* 1992 April 28(2) 141-150 Discussion 150-154.

Component Workshop 37
APA'S ELECTRONIC COMMUNICATION PROJECT
APA Committee on Information Systems

Chairperson: Bertram Warren, M.D., *86 North Martine Avenue, Fanwood NJ 07023-1330*
Participants: Norman E. Alessi, M.D., Edmund C. Burke, Jr., M.D., Tal Burt, M.D., James L. Day, M.D., Ivan K. Goldberg, M.D., Sol Herman, M.D., Steven E. Hyler, M.D., Thomas A.M. Kramer, M.D., Dean X. Parmelee, M.D., Allen Y. Tien, M.D., Ronnie S. Stangler, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation the participant will understand APA's electronic communications project, how to access the World Wide Web and use e-mail, and how to find their own online service or Internet provider. Participants will recognize relational databases and applications that support key business areas within the Association.

SUMMARY:

In May 1996, the Committee on Information Systems presented a workshop on the APA's electronic communications project, describing APA's World Wide Web site, the development of an Association-wide relational database, and efforts to improve communication between the central office and the district branches. The committee will update the membership on the progress of this project.

There will be a demonstration on how to access the APA homepage and other sites on the World Wide Web, including a tour of major areas within the site. There will detailed instructions for members on how to use e-mail and how to obtain online access and e-mail through online services or Internet providers. In addition, there will be a demonstration of relational database applications that have been developed to support key business areas within the Association (e.g., governance, finance and control, and membership) and how these applications are assisting district branches.

REFERENCES:

1. Krol E: *The Whole Internet: User's Guide and Catalog.* O'Reilly & Associates, Inc., 1992.
2. Levine JR, Baroudi C, Young ML: *Internet for Dummies, 3rd ed.* IDG Books Worldwide, 1995.
3. Stout R: *The World Wide Web: Complete Reference.* Osborne McGraw-Hill, 1996.

Component Workshop 38
MANAGED CARE STRATEGIES FOR ASIAN-AMERICANS
APA Committee of Asian-American Psychiatrists

Chairperson: Chang H. Lee, M.D., *University of CA-Irving, 2534 N Santiago Boulevard, #A, Orange CA 92667-1862*
Participants: Edmond H. Pi, M.D., Wun Jung Kim, M.D., Geetha Jayaram, M.D., Paul K. Leung, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able (1) to describe the psychiatric needs of Asian-American patients;
(2) to outline a set of treatment principles and interventions; and
(3) to emphasize how strategies are congruent with managed care objectives.

SUMMARY:

Asian patients are at greater risk for untreated psychiatric illness. Reported factors influencing treatment have been described under the following: (1) Accessibility to care, (2) Incompatibility of therapists with patients, (3) Social, cultural, religious, and political beliefs/concerns, (4) Pharmacological responses, and (5) Degrees of assimilation in a host culture.

With managed care organizations now increasingly penetrating the marketplace, cost of care is the primary emphasis in care delivery. Accessibility to care, appropriateness of care, and quality of care rendered have not yet been researched for the general consumer of care, let alone minority populations.

Given the concern of appropriate care for Asian Americans, it is timely for psychiatrists to think about devising interventions to overcome barriers to care. Some suggested modes are education of health care providers and groups of Asians; specialty carve-outs for them; providing therapists with relevant language facilities; and linkages with religious/social ethnic groups to identify psychiatric morbidity.

Managed care concerns must include bimultilingual education and marketing material to address needs of Asian patients, visual or oral teaching methods, and a specialty team compatible with their needs to retain patients. With such strategies it is possible to reduce costs, prevent relapses or extended care, and offer comprehensive and timely interventions in a managed care setting.

REFERENCES:

1. Leong FTL, Whitfield J (eds): Bibliographies in Psychology, No. II, Asians in the United States. Abstractions of the Psychological and Behavioral Literature, 1967-1991.
2. Gaw AC (ed): *Culture, Ethnicity and Mental Illness.* American Psychiatric Press, Washington, D.C., 1993.

Component Workshop 39
SPECIAL TOPICS FOR GAY, LESBIAN AND BISEXUAL PATIENTS
APA Southern California Psychiatric Society's Committee on Gay, Lesbian and Bisexual Issues

Chairperson: Daniel E. Fast, M.D., *2901 Wilshire Blvd, Ste 431, Santa Monica CA 90403-4907*
Participants: Stanley E. Harris, M.D., Howard C. Rubin, M.D., Alicia J. Salzer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize important issues facing various subpopulations of gay, lesbian, and bisexual patients, i.e. adolescents, male college students, children raised by lesbian mothers, and substance abusers.

SUMMARY:

Four panel members will each present a topic: "Troubled Gay, Lesbian, Bisexual and Transgendered Adolescents," "Gay and Bi Men's Group Therapy in a University Setting," "Experiences of Children Raised by Lesbian Mothers" (with videotaped interviews), and "Substance Abuse in the GLB Community." There will be time for discussion with the audience as to their experience and questions in these little discussed areas.

REFERENCES:

1. Cabaj R, Stein TS (eds): *The Textbook of Homosexuality and Mental Health* APPI, 1996.
2. Seidman SN, Rieder RD: A review of sexual behavior in the United States, *Am J Psychiatry* 151:330-341, 1994.

Component Workshop 40
INTERNATIONAL MEDICAL GRADUATES IN PSYCHIATRY
APA Committee of International Medical Graduates

Chairperson: Carlos Blanco-Jerez, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, Box 81, New York NY 10032*
Participants: Molly T. Finnerty, M.D., Dolores Garcia-Moreno, M.D., Silvia W. Olarte, M.D., Norma C. Panahon, M.D., Stephen D. Jeffries, Esq.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able (1) to understand the main difficulties of IMG's trying to integrate into American psychiatry.
(2) to be familiar with some strategies that can help IMG's minimize those difficulties.

SUMMARY:

Internation Medical Graduates (IMGs) represent an increasing percentage of U.S. psychiatrists. Most of the discussions regarding IMGs evolve around workforce issues and differences in practice patterns. However, little attention has been paid to the difficulties IMGs face as they struggle to integrate in American psychiatry. Those difficulties include linguistic and cultural barriers, prejudice, immigration and visa requirements, and loss of support systems. In this workshop the panelists will present practical solutions to these daily concerns of IMGs, including alternatives to J-1 visa status. In addition, participants will be encouraged to share their experiences with an aim of generating successful problem-solving strategies. The panel will include an immigration lawyer, an IMG who worked in an underserved area for two years, the chairs of the committes on IMGs and Hispanic psychiatrists, a researcher in the field of health care policy, and a resident (MIT) representative from New York State.

REFERENCES:

1. Mullan F, Politzer RM, Davis CH: Medical migration and the physician workforce: International medical graduates and American medicine. *JAMA* 273:1521-1527, 1995.

2. Cole-Kelly K: Cultures engaging cultures: International medical graduates training in the United States. *Family Medicine* 26: 618-624, 1994.

Component Workshop 41
PSYCHIATRY AND THE HISPANIC-AMERICAN COMMUNITY
APA Joint Commission on Public Affairs

Chairperson: Nada L. Stotland, M.D., *Department of Psychiatry, Illinois Masonic, 5511 South Kenwood Avenue, Chicago IL 60637*
Participants: Edward G. Ruelas, M.D. Rodrigo A. Munoz, M.D. Silvia W. Olarte, M.D. Oscar E. Perez, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant will be aware of effective means of communicating mental health information to the Hispanic community and will know how to use available information and communication techniques in outreach to local Hispanic communities.

SUMMARY:

APA, just like the U.S. and Canada, is increaslingly diverse; the fastest-growing population in the U.S. is the Hispanic community, itself enormously diverse. Spanish-speaking cultures have their own values, customs, and biases about psychiatry, and Spanish-speaking communities experience particular barriers to information and care. Individuals suffering from mental illnesses can be isolated in unicultural, Spanish-speaking neighborhoods that are mistrustful and unfamiliar with the medical care system. Psychiatrists and their public affairs representatives in widely dispersed areas of North America are faced with the challenge of reaching out to these communities. The APA Division of Public Affairs has developed and gathered many useful resources, and the APA Hispanic Committee and Caucus offer rich expertise about the needs and concerns of their patient constituents. This workshop/symposium brings together this expertise and these resources along with representatives of the lay Hispanic community and media, to interact directly with clinicians and public affairs representatives. Printed patient education material in Spanish will be distributed and discussed at the workshop, and participants are encouraged to present their experiences, problems, and suggestions for collaborative implementation by APA components and staff as an inherent part of APA's public education mission.

Component Workshop 42
THE IMPACT OF NEW HIV TREATMENTS ON PSYCHIATRY
APA Commission on AIDS

Chairperson: Marshall Forstein, M.D., *Department of Psychiatry, The Cambridge Hospital, 24 Olmstead Street, Jamaica Plain MA 02130*
Participants: Pedro Ruiz, M.D., Angela Pedraza, M.D., Silvia W. Olarte, M.D., Victor J. Llado, M.D., Rodrigo Munoz, M.D.

EDUCATIONAL OBJECTIVES:

Participants will understand the significant psychological and pharmacological consequences of protease inhibitor treatment.

SUMMARY:

The development of new antiviral treatments for HIV and laboratory tests that provide more accurate diagnosis and prognostic indicators for the progression of HIV disease to AIDS have brought to light significant social, ethical, biological, pharmacological, and economic dilemmas. While new agents have dramatically increased hope that both quality of life and survival might improve, they have also caused many earlier issues related to the epidemic to resurface, and have engendered many new ones that require psychiatrists to be fully informed and involved in the treatment of people with HIV.

This workshop will use a short presentation format to present brief but current information on (1) new laboratory tests and their clinical significance; (2) the newest class of agents, protease inhibitors; (3) the pharmacokinetics and pharmacodynamics of these agents with other currently used opportunistic prophylaxis agents; (4) the impact of protease inhibitors on HIV in the central nervous system; and (5) the significant psychological aspects of treatment such as treatment adherence, and how hope and despair over treatment failure continue to be important issues for psychiatrists.

REFERENCES:

1. Bartlett J: Protease inhibitors for HIV infection. *Annals of Internal Medicine*, 124:1086-1087, 1996.
2. Moyle G, Gazzard B: Current knowledge and future prospects for the use of HIV protease inhibitors. *Drugs*, 51:701-712, 1996.

Component Workshop 43
PSYCHIATRIC DIMENSIONS OF DISASTER
APA Committee on Psychiatric Dimensions of Disaster

Chairperson: Robert J. Ursano, M.D., *Department of Psychiatry, US Univ Health Services, 4301 Jones Bridge Road, Bethesda MD 20814*
Participants: Michael Blumenfield, M.D. Ann E. Norwood, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to identify the role of psychiatry in disaster preparedness, response, and rehabilitation, and to develop strategies for providing policy making information to other sectors of the emergency response system.

SUMMARY:

Disasters have affected the U.S. in recent years with significant losses. Recent examples include the explosion of TWA Flight 800 and the ValuJet crash in Florida. The mental health impact of a disaster extends both before the disaster and for a long time afterwards. The providers of mental health care need to be responsive to the shifting needs of the affected population throughout these protracted time periods. This workshop will continue to elaborate upon the roles that a psychiatrist is well-suited to assume in disaster planning and response. Psychiatrists who have worked on recent disaster responses will share their experiences. Follow-up will be provided on the American Psychiatric Association/American Red Cross retreat sponsored by the American Psychiatric Foundation for the exploration and development of areas of mutual interest. Historically, many workshop attendees have a wide range of experiences in disasters at both national and international levels. The workshop provides a forum for sharing expertise and raising issues of concern for further exploration by the Committee on Psychiatric Dimensions of Disaster.

REFERENCES:

1. Ursano RJ, McCaughey BG, Fullerton CS (eds): *Individual and Community Responses to Trauma and Disaster: The Structure of Human Chaos*. Cambridge, England, Cambridge University Press, 1994.

2. Ursano RJ, Fullerton CS, Norwood AE: Psychiatric dimensions of disaster: Patient care, community consultation, and preventive medicine. *Harvard Review of Psychiatry* 3:196-209, 1995.

Component Workshop 44
TRAGEDY HITS TRAINING: WHEN A PROGRAM IS STRUCK WITH ILLNESS OR DEATH WITHIN
APA Committee of Residents and Fellows

Chairperson: Gabriela Cora-Locatelli, M.D., *LCS/NIMH/NIH, Building 10, Room 3D41, Bethesda MD 20892*
Participants: Eva M. Szigethy, M.D. Michael J. McClure, M.D. Derek Puddester, M.D. Zachary Solomon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be able to recognize the dynamic processes that take place when a tragic event occurs during training, and to address helpful ways that will, hopefully, facilitate in coping with such extreme circumstances.

SUMMARY:

Often times, our training as psychiatrists-to-be is marked by intense and sometimes exhausting work, particularly dealing with the disturbances of the mind and anguish of the soul. Training is a time of introspection, where it occasionally becomes easier to deal with others' suffering rather than our own.

In our workshop, we plan to explore what happens within ourselves and among ourselves when tragedy occurs just before our eyes, when tragedy hits home, when it's one of "us": a resident in training, a medical student, a faculty member, or training director. We will address the impact that death, either intentional or unintentional, or mental or physical illness may have on the working place. Boundary violations and violence in the workplace are but related aspects of significant events. We also will explore the dynamics that come to play in this situation, its impact on a personal, professional level as well as direct patient care. Our goal is to share with the workshop's participants ways of coping with such stressful events.

REFERENCES:

1. Kirsling RA, Kochar MS: Suicide and the stress of residency training: A case report and review of the literature. *Psychol Rep* 1989; 64:951-9.
2. Klamen D, Grossman, Kopacz: PTSD symptoms in resident physicians related to their internship. *Academic Psychiatry,* Vol 19 (#3): 142-149. Fall 1995.

Component Workshop 45
PLANNING FOR TELEPSYCHIATRY
APA Committee on Telemedical Services

Chairperson: Jane H. Preston, M.D., *Center for Telepsychiatry, Menninger Clinic, 5800 SW 6th Avenue/PO Box 829, Topeka KS 66601*
Participants: Alex MacIntosh, Ph.D. Todd Baker, M.A.

EDUCATIONAL OBJECTIVES:

To learn sequential planning; to attain clear perception of a system as a primary clinical service, supported on "tracks" of telecommunication technologies; and to show that clinical and economical sustainability are indivisible.

SUMMARY:

The Telemedicine Services Committee workshop will deal with sequences in planning an economically and clinically sustainable telemedical distributed health care service. A telepsychiatric-liaisoned, system-planning strategy will be described sequentially. Curriculum will include analysis of the clinical structure of an identified "community," clinical needs, economic structures and opportunities, efficiencies and problems in clinical flow, technology net availability and deficiencies, clinical-technology scheduling and emergency interdigitation, and outcome/satisfaction data. Pacing is designed to include a problems section for discussion.

REFERENCES:

1. Brown F: A survey of telepsychiatry in the USA. *J of Telemedicine and Telecare* 1:19-21, 1995.
2. Preston J, Brown FW, Hartley B: Using telemedicine to improve health care in distant areas. *Hospital and Community Psychiatry* 43:25-32, 1992.

Component Workshop 46
TASK FORCE ON SEXUALLY DANGEROUS OFFENDERS
APA Task Force on Sexually Dangerous Offenders

Chairperson: Howard V. Zonana, M.D., *Yale Univ. Dept. of Psych, Connecticut Mental Health, 34 Park Street, New Haven CT 06519-1187*
Participants: John M.W. Bradford, M.B. Jeffrey L. Metzner, M.D. W. Lawrence Fitch, J.D. Gene G. Abel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will understand the history and development of sexual psychopath and sexual predator legislation as well as the characteristics of individuals seeking evaluation and treatment for paraphilias. In addition, he or she will become familiar with the scope and methods of assessment and treatment and of the current understanding of the effectiveness of treatment.

SUMMARY:

This Task Force on Sexually Dangerous Offenders was created in response to the passage of statutes designed to civilly commit sexual offenders to mental hospitals after they have served their entire prison sentences. These "sexual predator" statutes emerged in the context of some offenders committing heinous crimes against women and children after serving sentences for similar crimes. The public seems to be demanding that sexual offenders never recidivate and that any method of incarceration or deterrence is acceptable. California recently passed legislation requiring surgical or chemical castration as requirements for parole of sex offenders. The Supreme Court has granted certiorari on a case involving the sexual predator statute and will issue an opinion this year. The task force has reviewed literature on diagnosis, treatment, and recidivism and attempted to provide a summary of that literature along with a comprehensive bibliography. Some of the policy questions are difficult and have not received much discussion in the literature. The task force has tried to identify those areas and develop guidelines and policy statements. The task force report is working its way through the APA approval process, and we would like audience participation in discussing some of the policy recommendations. Some of the interesting questions are: (1) Is an antisocial personality disorder a sufficient basis for the mental illness requirement for the purpose of civil commitment?, (2) Is pedophilia a mental disorder that justifies involuntary civil commitment?, (3) Why is the literature on recidivism so conflicted or unclear?, (4) Is inappropriate civil comment at the end of a penal sentence an appropriate legal remedy for offenders deemed likely to recidivate?

REFERENCES:

1. *In the Matter of the Care and Treatment of Leroy Hendricks, Appellant,* 912 P.2d 129; 1996 Kan.

2. Bradford JW: Pharmacological treatment of the paraphilias, in: Oldham J, Riba M, (eds), *Review of Psychiatry*, Vol. 14, American Psychiatric Press, 1995, pp 755-778.

Component Workshop 47
MENTAL HEALTH AND THE AFRICAN-AMERICAN ELDERLY: INTERGENERATIONAL PERSPECTIVES
APA Committee of Black Psychiatrists and APA Committee on Ethnic Minority Elderly

Chairperson: Herbert I. Harris, M.D., *20 Lowell St, Cambridge MA 02138-4741*
Participants: F.M. Baker, M.D. Rick A. Martinez, M.D.

EDUCATIONAL OBJECTIVES:

The participant should become familiar with cultural factors that shape and define mental illness that are unique to African-American elderly. The impact of these factors on diagnosis, treatment approach, and outcomes will be explored in detail.

SUMMARY:

Changing demographic factors, along with advances in technologies such as brain imaging and molecular biology, have made the care of the elderly one of the most rapidly evolving areas of psychiatry. In parallel with these changes in the field, sweeping social movements have altered our perceptions of mental illness, its diagnosis, and treatment. African-American elders have witnessed particularly dramatic changes in our society that have had profound impact on their attitudes toward mental illness and its manifestations. The realities of the segregated world in which they came of age have been transformed into a new social order that has changed the meanings and contexts of mental illness.

Our workshop will highlight intergenerational perspectives on the mental health of the African-American elderly. Presentations on issues of diagnosis and treatment will be made by two psychiatrists of different generations whose training and life experiences span the vast changes in the field over the last several decades. Case material pertaining to the care of African-American elders will then be solicited from the audience and discussed by the psychiatrists. Intergenerational similarities and differences in interpretation and approach will be underscored by a discussant in concluding remarks.

REFERENCES:

1. Baker FM: Psychiatric treatment of older African Americans. *Hospital and Community Psychiatry 45:* 32-37, 1994.
2. Baker FM: A research agenda for the mental health concerns of African Americans. *J Assoc Academic Minority Physicians* 5:74-76, 1994.

Component Workshop 48
SELF-DISCLOSURE AND THE GAY PSYCHIATRIST
APA New York County District Branch's Committee on Gay and Lesbian Issues

Co-Chairpersons: Laura J. Bernay, M.D., *Department of Psychiatry, New York University, 44 West 10th Street, #5E, New York NY 10011-8762,* Kenneth B. Ashley, M.D., *85 East 10th Street, #1F, New York NY 10003-5407*
Participants: Robert J. Mitchell, M.D. John A. Gosling, M.D. Julie K. Schulman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the personal and clinical issues involved in disclosure or revelation of one's sexual orientation. Participants will learn new ways of conceptualizing clinical boundaries and how to make informed decisions regarding coming out to patients and others.

SUMMARY:

Gay and lesbian psychiatrists face the question of revealing our sexual orientation throughout our careers. Applicants to medical school and residency may feel conflicted about coming out during the application process; they fear prejudice and discrimination if they disclose their orientation, yet worry about appearing dishonest or schizoid if they don't. These conflicts deepen as one progresses professionally and the stakes get higher. The most controversial question is whether to come out to patients. Traditionally, analytically oriented therapists presented themselves as a "blank screen," revealing little or nothing of their personal lives in order to foster the development of the transference. Self-revelation by the analyst was conceptualized as a kind of boundary violation. Yet the therapist—gay or straight—inevitably reveals aspects of the real self, and we will discuss some of the benefits of disclosing our sexual orientation to our patients. Patients may specifically request homosexual therapists, and we have found that knowledge of the therapist's orientation does not preclude successful psychodynamic treatment. After brief presentations by the panel on aspects of coming out to patients, colleagues and supervisors, the audience may participate in a discussion of theoretical and personal aspects of coming out as a gay or lesbian psychiatrist.

REFERENCES:

1. Cabaj RP: Sexual orientation of the therapist in Cabaj and Stein, *Textbook of Homosexuality and Mental Health*, APPI, Washington 1996.
2. Magee, M and Miller DC: Psychoanalysis and women's experience of "coming out": The necessity of becoming a "bee-charmer" in Domenici and Lesser, *Disorienting Sexuality*, Routledge, New York, 1995.

Component Workshop 49
EXTENDED HOSPITALIZATION: WHO NEEDS IT?
APA Council on Psychiatric Services

Chairperson: Raymond F. Patterson, M.D., *1904 R St NW, Washington DC 20009-1031*
Participants: Arthur T. Meyerson, M.D. Seymour Gers, M.D. Ludwik S. Szymanski, M.D. Elie M. Francis, M.D. Dave M. Davis, M.D.

EDUCATIONAL OBJECTIVES:

To identify and evaluate the clinical indications for extended hospital stay for individual patients; to recognize and consider the other factors influencing extended stays including funding, alternative community placements, and managed care criteria; and to increase understanding of other systems including the VA and developmental disabilities/mental retardation.

SUMMARY:

Average length of stay for psychiatric hospitalization has changed dramatically in the last 25 years. Many factors have influenced this change including more effective pharmacologic interventions, deinstitutionalization, and managed care. This component workshop, cosponsored by the Consortium on Special Delivery Settings and Consortium Funding of Psychiatric Services, both of the Council on Psychiatric Services, is designed to present a review of inpatient extended hospital stay as a "special delivery setting" largely affected by funding issues. How is "extended" stay defined and by whom? When is extended stay necessary and for which patients? What services are available in the community and what impact do alternative settings have on extended stay? How has managed care influenced extended stay? These issues will be discussed by the panel. Additionally, two other service delivery systems will be presented for comparative analysis: (1) the comprehensive VA system and (2) developmental disability/mental retardation delivery systems. Expe-

rience from the field of developmental disabilities has shown that replacing long-term hospitalization of retarded persons (many with comorbid mental illness) with community-based care can be successful. Relevant literature on the psychosocial rehabilitation model of services and various care, living, and work settings in the community, will be presented.

REFERENCES:

1. Finch ES: Deinstitutionalization: Mental health and mental retardation services. *Psychosocial Rehabilitation Journal*, 8:36-48, 1985.
2. Mattson M: (Vol. Editor) *APA Manual of Psychiatric Quality Assurance APPI,* 1992.

Component Workshop 50
CERTIFICATION IN ADMINISTRATIVE PSYCHIATRY
APA Committee on Administrative Psychiatry

Chairperson: William H. Reid, M.D., *PO Box 49817, Austin TX 78711-2668*
Participants: Carmel A. Foley, M.D. W. Walter Menninger, M.D. Philip E. Veenhuis, M.D. H.G. Whittington, M.D.

EDUCATIONAL OBJECTIVES:

Participants will be aware of the benefits of APA administrative psychiatry certification, general topics important to certification, and application requirements.

SUMMARY:

The APA Committee on Administrative Psychiatry will describe the purpose and process of APA administrative psychiatry certification, as well as the knowledge candidates are expected to possess in four main areas of mental health system management: administrative theory and human resources, law and ethics, budget and fiscal management, and psychiatric care management.

Issue Workshop 1
PSYCHIATRY AND NEW WELFARE AND ECONOMIC POLICIES

Chairperson: Carl I. Cohen, M.D., *Department of Psychiatry, SUNY Health Sciences Center, 450 Clarkson Avenue, Brooklyn NY 11203*
Participants: Stephen M. Goldfinger, M.D., Bonnie T. Zima, M.D., William Arroyo, M.D., Kenneth S. Thompson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able (1) to learn about the effects of the new welfare legislation and the intensification of corporate restructuring on various mental health indices, on the course of chronic mental disorders, and on mental health settings; (2) to devise clinical, educational, and sociopolitical strategies for addressing this issue.

SUMMARY:

Psychiatrists have focused primarily on clinical concerns and biomedical research while sociopolitical forces have been viewed as beyond the purview of psychiatric expertise. The latest welfare legislation in tandem with an intensification of corporate restructuring signals an end to the illusion that psychiatrists must eschew involvement in the sociopolitical arena. It is estimated that the new welfare legislation may drop 3.5 million children from the welfare rolls by 2001; funding for food stamps will be cut by $28 billion. This country already has child poverty rates that are two to three times that of other developed nations. Moreover, legislation may deny food stamps, SSI, and Medicaid to legal immigrants. Along with legislation directed at indigent persons and immigrants, corporate restructuring has created job insecurity and stagnant wages. The median wage fell 3.3% from 1992-94 and three-fourths of households report a close encounter with layoffs since 1980.

This workshop will: (1) review research that has established causal links between poverty, social stress, unemployment, diminished job satisfaction, and powerlessness, with serious mental illness, suicide, substance abuse, domestic violence, physical disease, and the erosion of the social fabric; (2) examine the legislation's effects on the course of chronic mental disorders; (3) examine how welfare legislation and economic restructuring manifest themselves in psychiatric settings; (4) illustrate clinical, educational, and sociopolitical strategies for psychiatrists.

REFERENCES:

1. Cohen CI: The political economy of mental health. *Psychiatric Services* (in press).
2. Cohen CI: Poverty and the course of schizophrenia: Implications for research and policy. *Hospital and Community Psychiatry* 44:951-958, 1993.

Issue Workshop 2
HIV AND HISPANICS: SOCIOCULTURAL CONSIDERATIONS

Chairperson: Pedro Ruiz, M.D., *Department of Psychiatry, University of Texas, 1300 Moursund Street, Houston TX 77030*
Participants: Francisco Fernandez, M.D., Rodrigo A. Munoz, M.D., Humberto L. Martinez, M.D., Lourdes M. Dominguez, M.D., Jorge L. Maldonado, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this workshop, the participants should be able to recognize sexual practice patterns among Hispanic Americans, as well as clinically manage and treat HIV-infected and AIDS-suffering Hispanic-American patients. Finally, participants should be able to design and implement preventive approaches directed at combating the AIDS epidemics among Hispanic Americans.

SUMMARY:

Current trends in the HIV/AIDS epidemic clearly demonstrate a shift toward the ethnic minorities, particularly Hispanic substance abusers. As of December 1995, 25% of all adult AIDS cases have occurred among intravenous drug users, particularly Hispanics. This shift in HIV/AIDS incidence calls for a better understanding of the patterns of sexual practice among "Latinos/Latinas," as well as how to best design and apply methods of intervention directed at early detection and prompt clinical intervention with HIV-infected or AIDS-suffering Hispanic-American patients. In this workshop, we will address and discuss the unique cultural characteristics that affect, positively or negatively, the patterns of sexual practice of "Latinos/Latinas." Also, we will present and discuss appropriate clinical and sociocultural methods of intervention directed to Hispanic-American HIV-infected or AIDS-suffering patients, as well as their families and significant others. Moreover, attention will be given to the role of intravenous drug use in the current HIV/AIDS epidemics, particularly among Hispanics. Along these lines, focus will be made on the special problems confronted by the Mexican-American population in the Southwest region of the United States.

REFERENCES:

1. Marin B, Marin G: Predictors of condom accessibility among Hispanics in San Francisco. *American Journal of Public Health,* 82(4):592-594, 1992.
2. Parra EO, Shapiro MF, Moreno CA, Linn L: AIDS-related risk behavior, knowledge, and beliefs among women and their Mexi-

can-American sexual partners who used intravenous drugs. *Archives of Family Medicine* 2(6):603-610, 1993.

Issue Workshop 3
TWA 800: NEW YORK'S MENTAL HEALTH RESPONSE TO DISASTER

Chairperson: Leila B. Laitman, M.D., *CMHS, Visiting Nurses Services, 1601 Bronxdale Avenue, Bronx NY 10462*
Participants: Isaac Monserrate, A.C.S.W., Linda Sacco, C.S.W., Madeline O'Brien, M.D., David C. Lindy, M.D., Neil Pessin, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) understand the essential parts of a mental health disaster plan for a large urban area; (2) recognize the issues involved in doing direct counseling of adults and children in disaster situations; (3) be aware of factors affecting use of medication in treating those affected by a disaster.

SUMMARY:

On July 17, 1996, TWA Flight 800 exploded and fell into the Atlantic Ocean shortly after takeoff from JFK Airport. All 230 people who were taking the trip from New York to Paris lost their lives. Family members of the victims gathered from around the world in a hotel near the airport to await word of recovery of their loved ones' remains from the ocean floor off the south shore of Long Island. They also waited for word of why such a terrible tragedy had occurred.

A metropolitan area the size of New York City has long recognized that events such as this can cause serious psychological stress to all affected—the victims' families, witnesses to the crash, emergency responders, the victims' communities, etc. To deal with this devastation, an Emergency Mental Health Disaster Plan has been developed to ensure that there is a well-organized response to all mental health needs, that the response is available quickly, and that it is linked with follow-up and aftercare, which will address the needs of those who continue to be affected by a disaster.

This crash had international impact and required ongoing on-site assistance from responders on the city, state, and national levels. This workshop will describe the Emergency Mental Health Disaster Plan that was immediately put into effect as well as what it was like to be a responder in the plan. Brief presentations will be made describing experiences in counseling of both adult and child family members as well as providing psychiatric medical support with medication. Audience participants will be encouraged to relate their own experiences in dealing with such disasters and to share knowledge of mental health disaster plans that exist in their own varying locales.

REFERENCES:

1. Austin L: *Responding to Disaster: A Guide for Mental Health Professionals.* Washington, DC: American Psychiatric Press (Clinical Practice Series #24), 1992.
2. Raphael B: *When Disaster Strikes: How Individuals and Communities Cope With Disaster.* New York: Basic Books, 1986.

Issue Workshop 4
EXPLORING BICULTURAL IDENTITY THROUGH FILM

Chairperson: Nalini V. Juthani, M.D., *Department of Psychiatry, Bronx-Lebanon Hospital, 1276 Fulton Avenue, 4th Floor, Bronx NY 10456*
Participants: Sudha Prathikanti, M.D., Angel Khush, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) recognize the complex nature of bi-cultural identity and see limitations with using a simple "spectrum" model to understand an individual's familiarity with two cultures; (2) differentiate between ritualistic and ideological cultural identity; (3) apply a nonlinear model of cultural identity to understand the behaviors and feelings of two Anglo-Indian characters in the film, "Bhaji on the Beach."

SUMMARY:

Ethnic identity has been defined as the way one views oneself based on the sharing of a cultural heritage, a sense of social relatedness, and symbolic ties to other members of the group. Ethnic identity can be divided into external and internal aspects, with the internal aspects more resistant to change from generation to generation. Internal and external dimensions can vary independently, with four ethnic identity orientations possible for an individual with exposure to two cultures:

bicultural identity/integration
strong identity with culture of origin/separation
strong identity with new culture/assimilation
uncomfortable with both cultures/alienation

Depending on the situation, a given individual can potentially move between all four orientations; this posits a multidimensional, nonlinear model for ethnic identity. These concepts will be vividly illustrated by film clips featuring two Anglo-Indian characters from "Bhaji on the Beach." With audience comments/questions following each film clip, we will explore how intrafamilial trauma can exacerbate the conflict that women of South Asian origin may experience around their roles as wives and joint-family members. We will also explore how a westernized daughter faces her parents' conflicting values about sexuality and succeeds in forging a strong bicultural identity on her own terms.

REFERENCES:

1. Das Gupta SD: Marching to a different drummer? Sex roles of Asian Indian women in the U.S. *Women and Therapy* 5(2-3), 297-311, 1986.
2. Kanekar S, Kolsawalia MB: Sex and respectability: The double standard, Indian style. *Personality Study & Group Behavior* 3(1), 12-15, 1983.

Issue Workshop 5
WORK STRESS: A PROBLEM AT ALL ORGANIZATIONAL LEVELS

Chairperson: Brian L. Grant, M.D., *Department of Psychiatry, University of Washington, 1200 6th Avenue, Suite 1800, Seattle WA 98101*
Participants: Stephen H. Heidel, M.D., Kathryn D. McKee

EDUCATIONAL OBJECTIVES:

Participants will learn about sources of workplace stress. These include individual psychopathology along with systemic and workplace factors. The unique problems of executives and managers, as well as lower level staff will be discussed. Interventions to reduce stress, as well as inherent problems in stress reduction will be presented.

SUMMARY:

Stress, an inherent component of work, is experienced at all organizational levels. While potentially useful in attaining organizational goals, it can be disturbing. The changing nature of work, including corporate restructuring, resource reduction, greater technical and world economic challenges are a reality for many companies. Sources of stress differ for those at different organizational levels. General staff may face the challenges of meeting daily needs, lack of autonomy, control, and creativity in their work. Managers and executives may be more concerned with managing multiple, at times conflicting priorities, excessive work hours and demands, along with significant responsibility and accountability for results. Executives also face the

challenges of leadership, which rely on having superior technical and interpersonal skills. All workers risk psychopathological conditions that affect their ability to function. Also, work-family conflicts are on the rise, as single parent, and two income families challenge the ability to balance home and work. The workshop will discuss both executive stress and stress among line employees. The audience will be invited to contribute their clinical observations of workplace stress in patients and organizations from their practice and consulting experience. Individual and organizational strategies to reduce workplace stress will be discussed.

REFERENCES:

1. Sperry L: Distressed executives and organizations in crisis. *Psychiatric Annals.* Volume 25(4). 238-241, April 1995.
2. Lasky R: Occupational stress: A disability management perspective from *Principles and Practice of Disability Management in Industry* Winter Park, FL. G.R. Press Inc. 371-409, 1995.

Issue Workshop 6
ISSUES IN PSYCHOTHERAPY TRAINING OF IMG RESIDENTS

Chairperson: Nyapati R. Rao, M.D., *Department of Psychiatry, Brookdale Hospital, One Brookdale Plaza, Brooklyn NY 11212*
Participants: Dinko Podrug, M.D., Soumitra Chatterjee, M.D., Arthur Meinzer, Ph.D., Fayek L. Nakhla, M.D.

EDUCATIONAL OBJECTIVES:

As a result of this workshop, the participants should be better able to understand major issues in teaching psychodynamic psychotherapy to IMGs, and to incorporate new attitudes and approaches to seminars and supervision of IMGs.

SUMMARY:

More than 40% of all psychiatric residents are IMGs, and are represented in increasing numbers of training programs. Teaching psychodynamic psychotherapy to IMG residents has always presented challenges because of the degree to which the interpersonal and intrapsychic events, which are the subject of its discourse, are culture-bound. There are numerous features of psychotherapy that are alien to many IMGs' cultures (e.g. a talking cure as a medical function, and unconscious mental events determining behavior). Psychotherapy training provides the resident with a deeper understanding of the psychological and social aspects of the doctor-patient relationship, but, in the era of managed care, its place in the psychiatric formulary, and thus its place in the curriculum, is threatened. However, our program has continued to emphasize psychotherapy training as providing many core psychiatric skills for our residents who come from various cultures. Brief presentations will provide stimuli for discussion among the workshop participants: the training director will discuss issues in psychotherapy training of IMGs, the interviewing seminar leader will discuss his approach, a PGY-4 will present his experiences, and an ongoing psychotherapy observation seminar will be discussed, with videotape examples.

REFERENCES:

1. Rao NR: An alternate method of teaching psychotherapy to a foreign medical graduate in psychiatry (letter to the editor). *Psychiatry Journal of the University of Ottawa* 12:25-26, 1987.
2. Rao NR, Meinzer AE, Berman SS: Countertransference: Its continued importance in psychiatric education. *Journal of Psychotherapy Practice and Research,* in press.

Issue Workshop 7
ON THE EDGE WITH MANAGED CARE: THE DELAWARE STORY

Chairperson: Anita Amurao, M.D., *Terry Center, 10 Central Avenue, New Castle DE 19720*
Participants: Michael Longo, M.A., Sam Blumberg, Ph.D., Ilene Joseph, M.S.W., Richard L. Cruz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to conceptualize crisis with a systems model, design a crisis model that "fits" their organization, identify key areas of organizational change needed to implement a community based crisis model, and generate effective leadership necessary to implement these changes.

SUMMARY:

Psychiatry is faced with increasing pressure from managed care to reduce the cost of services. This workshop will show how the State of Delaware and the Terry Childrens' Psychiatric Center have implemented a new model of acute treatment, which is able to "do more with less" as response to the decision to assume risk by managing Medicaid clients through a 1115 waiver. This model expands the focus of care from the child to include the family, extended family, and treating professionals. Facing this increased pressure with a new and expanded model of treatment has enabled the Terry Center to shift dramatically from institution based services to community based services in a matter of months. Children that were hospitalized are now successfully treated in their home or school. The key ingredients of this model include a unique team approach, the use of story, and interventions that help clients and their helpers quickly refocus their efforts to produce dramatic change. Workshop participants will try out these ingredients through case discussion and role play. In small group discussion participants will "custom fit" this model to their clinical setting in order to meet the unique financial and clinical pressures facing them.

REFERENCES:

1. Oseroff C, Longo M: *Finding Our Way Home-Home and Community Based Care, The Handbook of Community Psychiatry* American Psychiatric Press, 1997.
2. O'Hanlon W: *The Third Wave. The Family Therapy Networker,* 1994.

Issue Workshop 8
MISSOURI'S APPROACH TO TREATMENT REFUSAL

Chairperson: Stephen M. Soltys, M.D., CPS, *Department of Mental Health, 1706 East Elm Street, Jefferson City MO 65101*
Participants: Lori Derosear, D.O., Joseph J. Parks III, M.D., Roy C. Wilson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the ethical, legal, and political system issues relevant to the provision of involuntary psychiatric treatment and to be able to apply that knowledge to develop statutory and administrative solutions for similar situations in their own states.

SUMMARY:

One of psychiatry's great dilemmas is how to balance the right of patients to refuse treatment with societal interests in assuring that the mentally ill get effective treatment. The literature suggests that judicial review of treatment refusal situations contributes little to the process except delays in treatment.

In Missouri, statutory and administrative strategies (rather than court-based solutions) have been utilized to deal with treatment refusal by individuals with serious mental illness. Legislation passed in 1996 has significantly reformed commitment laws to remove barriers to hospitalization and treatment. Based on statute, the Missouri Department of Mental Health has policies for the involuntary administration of psychotropic medication, which have survived legal challenges to date and balance patient rights and statutory treatment expectations. The substance of these reforms, the process utilized to develop them, and ethical issues related to the topic will be the focus of presentations in this highly interactive workshop. The panel includes the co-chairperson of the McBride Commission (which developed the commitment law reforms), the department director, and two statewide medical directors.

Because these reforms and policies may be seen by some as controversial, audience questions or opposing points of view will be encouraged at intervals throughout the workshop.

REFERENCES:

1. Ciccone JR, Tokoli JF, Gift TG, Clements CO: Medication refusal and judicial activism: A reexamination of the effects of the Rivers decision. *Hospital and Community Psychiatry* 44:555-560, 1993.
2. Schwartz HI, Vingiano W, Perez CB: Autonomy and the right to refuse treatment: Patients' attitudes after involuntary medication. *Hospital and Community Psychiatry* 39:1049-1054, 1988.

Issue Workshop 9
THE ROLE OF PSYCHIATRY IN CONFLICT RESOLUTION: RWANDA

Chairperson: Lawson R. Wulsin, M.D., *Department of Psychiatry, University of Cincinnati, 231 Bethesda Avenue (ML 559), Cincinnati OH 45267-0559*
Participants: Pierre Mugabo, M.D., Athanase Hagengimana, M.D., Froduald Gatarayiha, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) to specify what roles psychiatrists can play in the prevention, control, and resolution of large-scale regional conflict. (2) examine the proposition that the psychiatric treatment of trauma provides a model for conflict resolution on the community level after civil war.

SUMMARY:

The sharp rise in psychiatric disorders during and following civil wars and regional conflicts (in Cambodia, Bosnia, Angola, Rwanda, for example), combined with the scarcity of psychiatric services in these regions, raise the question of what role psychiatry should play in the process of conflict resolution. How can psychiatric services be delivered in developing countries where, at best, most people have access only to primary care services? How prevalent and how disabling are the psychiatric disorders that follow regional conflicts? To what extent can the principles of the treatment of post-traumatic stress disorder in the individual extend to the treatment of traumatized families, communities, and ethnic groups?

This workshop addresses these and other questions related to the role of psychiatry in regional conflict resolution. Using the Rwanda genocide and massacres of 1994 as the lead example, the chairperson will present a brief review of the historical events and some data on the medical consequences of this conflict (15 min). The presenters will then discuss two current projects directed at helping with the conflict resolution process: (1) the development of the Rwanda National Trauma Center, and (2) a general health survey to assess the current functioning of Rwandan citizens and refugees (15 min). The chairperson will initiate the discussion with an outline of the conflict resolution process and some possible options for the role of psychiatry (10 min). Participants will then discuss their experiences and opinions about the role of psychiatry in conflict resolution (30 min). We will spend the last 20 min trying to come to some concensus, if it is possible to generalize across conflicts, about the top priorities for the roles of psychiatry in conflict resolution.

REFERENCES:

1. Wilson J, Linday J: *Countertransference in the Treatment of PTSD.* Guilford, New York, 1994.

Issue Workshop 10
COMPUTER ANXIETY AMONG PSYCHIATRISTS

Chairperson: Tal Burt, M.D., *Department of Psychiatry, New York University, 120 East 37th Street, #3F, New York NY 10016*
Participants: Waguih W. Ishak, M.D., Carol A. Bernstein, M.D., Mary Kay Smith, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participants will understand the nature of computer anxiety, its extent, and consequences. The participant will also learn how to address computer anxiety.

SUMMARY:

A significant proportion of psychiatrists experience computer anxiety, and subsequently avoid the use of computers. Computer use is increasingly becoming an essential tool in the medical arena, and in a decade or two will be expected to be as indispensibile as is telephone use today. Computer technology can contribute to the professional experience by enhancing the quality of patient care, efficiency of education, and the feasibility of research. The reasons for computer anxiety include, but are not limited to, lack of knowledge in operating, fear of machines, and perceived conflict between mind and machine. The participants will be engaged in discussing the nature and consequences of computer anxiety, and will learn how to address it. The co-chairs of this workshop have established a time-limited computer literacy group. In this group, members learned basic skills through a task-oriented model. Resolving computer anxiety could improve the clinician's ability to deal with the contemporary increase in information load and demands for delivery of standardized care.

REFERENCES:

1. Brown SH, Coney CD: Changes in physician's computer anxiety and attitudes related to clinical system use. *J Am Med Inform Assoc,* 1:381-94, 1994.
2. Cohen BA, Waugh GW: Assessing computer anxiety. *Psychol Rep,* 65: 735-8, 1989.

Issue Workshop 11
FACE-TO-FACE UTILIZATION REVIEW: THE NEXT STEP?

Chairperson: Kenneth M. Certa, M.D., *Department of Psychiatry, Jefferson Medical College, 111 South 11th Street, Philadelphia PA 19107-4824*
Participants: Kevin P. Caputo, M.D., Kathleen C. Dougherty, M.D., Linda McComas, M.S.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to demonstrate familiarity with different models of utilization review, and the practical concerns involved in face-to-face review.

SUMMARY:

One innovation in the many attempts to manage utilization of services has been the use of direct patient interviews by reviewers. These have been termed "face to face," as compared to telephone or chart review. A reviewer, usually an independent contractor paid by the managed care organization, visits the emergency room, outpatient service, or hospital unit, and meets with the patient to review his needs and proposed treatment. Utilization management companies have insisted that this is simply a refinement of more widely used practices of review, but it is clearly qualitatively different than providers phoning 800 numbers, or reviewers paging through records. Direct patient contact highlights questions of the credentialing of the reviewer, liability, and the fine line between assessment for medical necessity and treatment. From the care management perspective, cost effectiveness is also at issue.

Panel members will present a review of utilization review techniques from the provider, managed care reviewer, and forensics/ethical perspectives. Participants will be expected to share experiences with different forms of review in a variety of settings.

REFERENCES:

1. Garnick DW, Hendricks AM, Dulski JD, et al: Characteristics of private sector managed care for mental health and substance abuse treatment. *Hospital and Community Psychiatry* 45(12):1201-5 Dec 1994.
2. Restuccia JD: The evolution of hospital utilization review methods in the United States. *International Journal for Quality in Health Care* 7(3):253-60 September 1995.

Issue Workshop 12
PSYCHIATRY IN THE NURSING HOME: MODELS OF PRACTICE

Chairperson: Melinda S. Lantz, M.D., *Department of Psychiatry, Jewish Home & Hospital, 120 West 106th Street, New York NY 10025*
Participants: Eric N. Buchalter, D.O., Mary G. Shelkey, G.N.P.

EDUCATIONAL OBJECTIVES:

The participant will gain an understanding of the role of the psychiatrist in the nursing home, review the types of treatment available to elderly nursing home residents, and become acquainted with team approaches and the Geriatric Nurse Practitioner-Psychiatrist collaboration model. Knowledge of the psychiatric needs of the short-stay, subacute, and hospice resident and both new and traditional reimbursement models will be acquired.

SUMMARY:

Nursing home psychiatry is a dynamic field that is evolving as more attention is focused on the treatment of patients outside of acute care settings. Services provided in the nursing home include traditional long-term care, short-stay treatment with transition back to the community, hospice, subacute, rehabilitation, and transitional care services. Specialty units such as those for dementia care, ventilator-dependent patients, and other special needs populations have become increasingly prevalent. The needs of the population, types of services offered, models of care, and means of reimbursement are varied. The goal of this workshop is to provide an overview of models of clinical practice within the nursing home, including the psychiatrist-nurse practitioner collaboration, individual and group psychotherapy, and the management of disruptive behaviors. Psychopharmacological approaches and the use of cognitive enhancers in the nursing home population will be discussed. Regulatory issues will be addressed relative to both the long-term and short-stay resident. Medicare and Medicaid reimbursement as well as managed care approaches to payment for psychiatric services in the nursing home will be discussed through the use of selected case studies. Participants will be encouraged to add to the vignettes and contribute their experiences to the case discussions.

REFERENCES:

1. Streim JE, Katz IR: Clinical psychiatry in the nursing home, in Busse EW, Blazer DG (eds): *Textbook of Geriatric Psychiatry, Second Edition.* Washington DC: American Psychiatric Association Press, Inc., 413-432, 1996.
2. Class CA, Hendrie HC: The role of the psychiatrist in nursing home settings. *Psychiatric Annals.* 25:449-452, 1995.

Issue Workshop 13
CLOZAPINE UTILIZATION: PUBLIC VERSUS PRIVATE SYSTEMS

Chairperson: Jean-Pierre Lindenmayer, M.D., *Department of Psychiatry, Manhattan Psychiatric Center, Wards Island, Dunlop 14A, New York NY 10035*
Participants: John W. Rosenberger, M.D., Richard H. McCarthy, M.D., James P. Halper, M.D.

EDUCATIONAL OBJECTIVES:

The participant will better understand the differences and similarities in the patterns of clozapine utilization in both the public and private psychiatric settings and how to optimize clozapine utilization in these two settings.

SUMMARY:

Clozapine remains the most effective antipsychotic compound for treatment refractory schizophrenic patients. These patients have traditionally been treated in long-term public institutions where clozapine utilization has expectedly been high. Increasingly, with changes in the economics of health care delivery systems, private clinical settings have also been treating such patients and have therefore turned to the use of clozapine. This workshop will compare indices of clozapine utilization in public and private settings. Using as one public setting an urban state psychiatric center, and as private settings a general hospital outpatient clinic and a stand alone suburban psychiatric hospital, the following indices will be comparatively examined: clozapine eligibility criteria, rates of induction, types of diagnosis of patients on clozapine, demographics of clozapine patients as compared to average patient profiles, average dosages, rates of side effects, length of treatment course and patterns of response with clozapine, patterns of treatment payors, incidence of patient as well as staff resistance to the use of clozapine, and patterns of discharge. Discussion with audience participation will focus on reasons for differences and similarities among these settings as well as ways to optimize clozapine utilization patterns taking into account differing institutional constraints, patient demographic profiles, and financial issues.

REFERENCES:

1. Meltzer HY, Cola P, Way L, et al: Cost effectiveness of clozapine in neuroleptic resistant schizophrenia. *Am J Psychiatry* 1630-1638, 1993.
2. Reid WH, Mason M, Toprac M: Savings in hospital bed days related to treatment with clozapine. *Hosp Community Psychiatry* 261-264, 1994.

Issue Workshop 14
THE ROLE OF ENACTMENT IN PSYCHIATRIC TREATMENT

Chairperson: Eric M. Plakun, M.D., *Admissions, The Austen Riggs Center, PO Box 962/25 Main Street, Stockbridge MA 01262*
Participant: Edward R. Shapiro, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to define enactment, differentiate it from near neighbor phenomena,

list clinical situations in which enactments frequently occur, understand the use of enactments to advance treatment, and apply this new learning in his/her own work setting.

SUMMARY:

As psychiatric practice and training change in response to recognition of the limitation of resources for treatment, fewer clinicians think psychodynamically about their clinical work. The psychodynamic concept of enactment, defined as nonverbal interactional behavior in which *doctor and patient* unwittingly collude in repeating conflicted events in the patient's life, is a useful one for psychiatrists, regardless of whether they practice psychodynamic therapy. This is because enactments arise frequently in any kind of clinical work with treatment resistant patients, particularly those with personality disorders and/or trauma histories. Further, treatment in a managed care environment often unwittingly leads to enactments involving doctor, patient, and managed care reviewer. This workshop will define enactment, clarify its components (including countertransference and projective identification), review commonly encountered enactments, and offer paradigms for advancing treatment by bringing the meaning of the enactment into the treatment relationship. After the presentation, the remaining hour will be used for an interactive discussion of case material. Although cases will be offered to initiate discussion, workshop participants will be encouraged to offer case examples from their own practices. The result should be a highly interactive opportunity to discuss ways of responding to challenging treatment problems.

REFERENCES:

1. Shapiro ER: The boundaries are shifting: Renegotiating the therapeutic frame. In Shapiro, ER (ed): *The Inner World in the Outer World: Psychoanalytic Perspectives,* Yale, 1997 (in press).
2. Plakun EM: Economic grand rounds: Treatment of personality disorders in an era of resource limitation. *Psychiatric Services* 47:128-130, 1996.

Issue Workshop 15
GAY AND LESBIAN PSYCHIATRISTS: A EUROPEAN PERSPECTIVE

Chairperson: Siegmund Dannecker, M.D., *Department of Psychiatry, Krankenhaus Spandau, Griesinger Str 27-33, D-13589 Berlin, Germany*
Participants: Juergen Graffe, Dr. Nico F.J. Hettinga, Dr. Sebastian Oele, Dr. Elisabeth Rohrbach, Kurt Wiesdanger

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to identify anti-homosexual bias in themselves and in psychiatry in general, learn about the situation of lesbian and gay colleagues to overcome discrimination and exclusion, and learn about the process of coming out.

SUMMARY:

Gay and lesbian psychiatrists and psychotherapists from several European countries will share and exchange with the participants their experience and views on different issues concerning homosexuality and psychiatry. *Dr. Rohrbach* (Germany) will address the issue of being out as a lesbian psychiatrist in a supervising position in a hospital and in a psychoanalytic institute. *Dr. Dannecker* (Germany) will discuss the clinical question: can patients with schizophrenia be gay—homosexuality as a symptom versus identity. The issue will be underlined by clinical cases. *Mr. Graffe* (Germany) presents results of his research about psychoanalytical discrimination against homosexual applicants for training, and *Mr. Wiesendanger* (Switzerland) will talk about the Swiss situation in Psychotherapy to treat gay men. The presenters want to raise and discuss with the participants of the workshop the following issues: the impact and origin of anti-homosexual bias in psychiatry with special regard to gender differences, the change from psychiatric pathologization to gay and lesbian affirmative psychiatry, whether psychoanalysis has something to offer homosexuals and how to induce change in the new psychoanalytical theories in order to foster gay-affirmative therapy.

REFERENCES:

1. Isay R: *Becoming Gay,* New York, 1996.
2. Nakajima, et al: *Textbook of Homosexuality,* APA press, 1996.
3. Domenici, et al: *Disorienting Sexuality,* Simon and Schuster, 1995.

Issue Workshop 16
ROSES AND ONIONS: LESBIAN AND GAY PARENTING

Chairperson: Victoria L. Harris, M.D., *Department of Psychiatry, University of Washington, 1001 Broadway, #217, Seattle WA 98122*
Participants: Karina K. Uldall, M.D., Terry S. Stein, M.D., Margery S. Sved, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will be able to discuss the joys and sorrows unique to same-gender parenting.

SUMMARY:

Past workshops have addressed gay and lesbian (G-L) relationships, patients, and other professional issues. The focus of this workshop is same-gender parenting. This workshop was suggested and is endorsed by participation of the American Medical Association Foundation on Physician Health. Members and their significant others of the Curriculum Committee on Spouses, Significant Others, Traditional & Non-Traditional Families are panelists for this workshop. All are psychiatrists with parenting experience.

The panelists bring a vast array of professional diversity. Academia, community, administrative, and private psychiatry are all represented. The panelists will share personal and professional issues such as: choosing a method of insemination, pregnancy and/or adoption; raising children with special needs; issues of geographical, emotional, and/or financial isolation; changing family structures; current outcomes research; and case studies of G-L in therapy and HIV-related treatment.

Attendees and panelists are asked to bring photos to share. The photos will be used in small groups to discuss family constellations. The large group will revisit commonly elicited themes. At least one third of the workshop's allotted time will be used for discussion in this manner.

REFERENCES:

1. Patterson C: Lesbian and gay families. *Current Directions in Psychological Science,* 3(2); 62-64, 1994.
2. Turner PH. Scadden L, Harris MB: Parenting in gay and lesbian families. *Journal of Gay and Lesbian Psychotherapy.* 1(3); 55-66, 1990.
3. Bigner JJ, Brooke JR: Adult responses to child behavior and attitudes toward fathering: Gay and nongay fathers. *Journal of Homosexuality.* 23(3); 99-112, 1992.

4. Ricketts W, Achtenberg R: Adoption and foster parenting for lesbians and gay men: Creating new traditions in family. *Marriage and Family Review.* 14(3-4); 83-118, 1989.

Issue Workshop 17
MEDITATION AND THE QUESTION OF TRANSFERENCE

Chairperson: Kathryn J. Lee, M.D., *Department of Psychiatry, University of CA at SF, 2627 Piedmont Avenue, Berkeley CA 94704*
Participants: Charlotte J.K. Beck, Patricia L. Speier, M.D., Tony Stern, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) better understand different ways to work with transference, and (2) better understand and treat patients who are involved in meditation practices.

SUMMARY:

In this workshop, the theory and technique of transference in psychotherapy from an object relations and ego psychology perspective will be contrasted with the practice of sitting meditation as taught by a well-known American Zen teacher, Charlotte Joko Beck. The format will include a brief summary of psychodynamic transference principles and Zen practice fundamentals as delineated by Beck. The program will continue with open dialogue between the workshop presenters, Beck, and the audience. This will allow an excellent opportunity for workshop participants to experience how a Zen teacher works with the audience's transference to her. The workshop will close by comparing the psychotherapist's and Zen teacher's style of working with transference in the moment. This topic is of growing interest as the traditions of great Eastern perennial philosophies become widespread. Psychiatrists are likely to treat patients with active spiritual practices, which require consideration. Better understanding and appreciation of the differences and similarities in the utilization of transference in these two arenas of self-growth will lead to psychiatrists' improved ability to work with patients with meditative practices, thus enhancing these patients' well-being.

REFERENCES:

1. Beck CJ: *Everyday Zen.* San Francisco: Harper & Row, 1989.
2. Beck CJ: *Nothing Special: Living Zen,* San Francisco: Harper and Row, 1993.

Issue Workshop 18
MAKE OR BREAK MY DAY: IT'S PEER REVIEW TIME AGAIN

Chairperson: Michael Buxbaum, M.D., *Department of Psychiatry, Delaware Valley Men Hlth, 833 East Butler Avenue, Doylestown PA 18901*
Participants: Mary Ann Venezia, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should be able to advocate for their patients more effectively through comprehensive understanding of their countertransference reactions toward managed care review process.

SUMMARY:

One of the most disturbing aspects of psychiatrists' everyday professional lives is the managed care review process for the stated purpose of justifying the medical necessity for patients' treatment. The psychiatrist may feel as though his competency, integrity, and judgment are being challenged. His emotional experience can be compared to the countertransference one feels toward a difficult patient in long-term treatment. To lose such a patient may mean loss of revenue; keeping him involves everyday struggles to keep one's emotions in check, using one's mind to keep the heart in control, and proceeding with cautious optimism. Things might get better after all! Common reactions include reluctance to return phone calls, providing less than ideal treatment in order to avoid confrontations with reviewers, excessive passivity or aggressivity toward the reviewer, pessimism about the profession in general, and feelings of victimization. Patients may project their anger toward the third party, which can hinder exploration of the transference. The ever present though unseen third party becomes the evil force against which both the patient and the psychiatrist are helpless. Participants in this workshop will be encouraged to share their experiences and reactions to the review process and discuss strategies they have found to be effective in advocating for their patients and avoiding the pitfalls of counter-transference.

REFERENCES:

1. Gabbard GO, Takahashi T, Davidson J, Bauman-Bork M, Ensroth K: A Psychodynamic Perspective on the Clinical Impact of Insurance Review *Am J of Psych,* 148:318-323, 1991.
2. Macbeth JE, Wheeler AM, Sither JW, Onek JN: *Legal and risk management issues in the practice of psychiatry,* 8:1-14 Psychiatrists' Purchasing Group, Inc., 1994.

Issue Workshop 19
COMORBIDITY CONUNDRUMS

Chairperson: Frances R. Levin, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, Unit 66, New York NY 10032*
Participants: David M. McDowell, M.D., Kathleen T. Brady, M.D., Edward V. Nunes, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the challenging and complex clinical issues that research clinicians face in the diagnosis and treatment of dually diagnosed patients.

SUMMARY:

There has been an increased recognition that psychiatric patients seeking treatment often have comorbid substance use disorders. Unfortunately, the research literature is scant regarding some of the frequently encountered problems that occur when treating dually diagnosed patients. Specific subgroups pose various diagnostic and treatment dilemmas. For example: (1) Does a distinction need to be made between a primary versus a secondary depression in order to initiate a pharmacologic intervention with a depressed substance abuser? (2) Are stimulants contraindicated in cocaine abusers with adult attention-deficit hyperactivity disorder (ADHD)? (3) Is exposure therapy appropriate for recently recovered individuals with post-traumatic stress disorder (PTSD)?

Research clinicians who have expertise in working with specific psychiatric subpopulations of substance abusers, namely, patients with depressive symptoms, ADHD, or PTSD, will briefly discuss how they approach the diagnosis and treatment of their dually diagnosed patients. After each presentation, a discussant will summarize the information presented and highlight the areas where there is a lack of consensus. Ample time will be provided at the conclusion of the workshop for the audience to present any challenging clinical issues or questions that have occurred when treating their dually diagnosed patients.

REFERENCES:
1. Levin FR, Kleber HD: Attention-deficit hyperactivity disorder and substance abuse: Relationships and implications for treatment. *Harvard Rev Psychiatry* Vol. 2(5):246-258, 1995.
2. Nunes EV, Deliyannides D, Donovan S, McGrath PJ: The management of treatment resistance in depressed patients with substance use disorders. *The Psychiatric Clinics of North America* Vol. 19(2), 1996.

Issue Workshop 20
THE HOMELESS MENTALLY ILL AND SEXUALLY RISKY BEHAVIOR

Chairperson: Steven E. Samuel, Ph.D., *Sheridan Building, Thomas Jefferson University, 125 South 9th Street, Ste 1003, Philadelphia PA 19107*
Participants: William B. Lynch, Ezra S. Susser, M.D., Christine Simigrilia,

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will (1) have an updated knowledge base concerning characteristics and service needs of homeless mentally ill individuals at risk for HIV, and (2) have learned how to design an HIV prevention program to reduce sexual risk behaviors for HIV transmission among homeless mentally ill persons.

SUMMARY:

Seriously mentally ill homeless adults are at high risk of acquiring human immunodeficiency virus (HIV) infection. It has been estimated in some urban areas of North America that 10% to 20% of homeless mentally ill persons are infected with HIV. The need for sexual risk-reduction is both a clear and challenging undertaking in this population. HIV prevention programs for mentally ill homeless persons are few, and there is little apparent consensus as to how to standardize, implement, and monitor the effects of their interventions. This highly interactive workshop will present for discussion our ongoing educational and sexual risk-reduction intervention programs with populations of inner-city homeless mentally ill individuals. Practical suggestions regarding how to design and implement an HIV prevention program for this population will be presented. Participants will discuss a variety of AIDS prevention curriculums focusing upon how these could be implemented in their setting. Videotape educational demonstrations as well as research strategies for evaluating this population will also be presented for discussion.

REFERENCES:

1. Susser E, Valencia E, Sohler N, et al: Interventions for homeless men and women with mental illness: Reducing sexual risk behaviors for HIV. *Int J of STD & AIDS.* 7 (Suppl. 2):66-70, 1996.
2. Susser E, Valencia E, Miller M, et al: Sexual behavior of homeless mentally ill men at risk for HIV. *Am J Psychiatry* 152:4, 583-587, April 1995.

Issue Workshop 21
THE POLITICS OF MENTAL HEALTH CARE: 1997

Chairperson: Robert E. Hertzka, M.D., *CA Medical Association, 11825 Semillon Boulevard, San Diego CA 92131*
Participants: Rodrigo A. Munoz, M.D. Steven Thompson, Susan Davis, Brian Bilbray

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will have a greater appreciation of the political context surrounding mental health care issues at both the state and federal levels. Perspectives will be provided by state and federal legislators and lobbyists as well as that of politically experienced physicians.

SUMMARY:

In recent years health care policy decisions have increasingly been made not by physicians but by legislators and government bureaucrats, leaving the practicing physician frustrated and in many cases confused. This workshop is designed to address that confusion by explaining the broad political context in which state and federal legislators make their decisions about health care policy, with an emphasis on mental health care. Issues likely to be discussed by the panel include mental health parity in health insurance, managed mental health care, and the role of nonphysicians in mental health care.

Issue Workshop 22
ETHICS COMMITTEES: THE GOOD, THE BAD AND THE UGLY

Chairperson: Jeremy A. Lazarus, M.D., *Department of Psychiatry, Univ of CO, Hlth Sciences Ctr., 8095 East Prentice Avenue, Englewood CO 80111*
Participants: Jeffrey S. Janofsky, M.D., Linda M. Jorgenson, J.D., Janet W. Wohlberg, A.B.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should have an enhanced understanding of professional, legal, and consumer concerns about the strengths and potential pitfalls of ethics committee procedures and should be able to be active and thoughtful contributors to the reformulation and/or enhancement of current ethics committee practices.

SUMMARY:

Investigation and adjudication of ethics complaints against psychiatrists drain financial and volunteer resources. Both accusers and accused report finding the processes and outcomes frustrating, unfair, and unsatisfactory: Psychiatrists under investigation complain of extensive disruptions in their lives and careers; victims report feeling angry and disempowered as they confront what they perceive to be the conflicts of interest inevitable when professionals are charged with investigating and punishing one of their own. Ethics committee procedures tend to be quasi-legal and may continue for months and even years. In addition, the involvement of insurance companies and multiple attorneys has intensified.

This workshop will be led by four individuals, each of whom views professional ethics committees from a vastly different point, i.e., two psychiatrists with extensive ethics committee experience, an attorney who represents victims of sexual abuse by medical and mental health professionals, and a consumer advocate who helped establish a victim's network that now numbers more than 700 in the Greater Boston area. Participants in this workshop will explore the rationale for ethics committees and whether investigation and punishment of members is an appropriate role. They will develop a new model, which may be organizational, governmental, communal, or some combination thereof.

REFERENCES:

1. Bisbing, et al: *Sexual Abuse by Professionals: A Legal Guide.* Charlottesville, Va: The Michie Company, 1995.
2. Md. Health Occupations Code Ann. @14-401, 1995.

Issue Workshop 23
PSYCHIATRISTS' INVOLVEMENT WITH GENOCIDE IN BOSNIA: EVIDENCE AND INTERPRETATION

Chairperson: Stevan M. Weine, M.D., *Department of Psychiatry, University of IL at Chicago, 1601 West Taylor Street, #423S, Chicago IL 60612*
Participants: Alma D. Kulenovic, M.D., Tvrtko Kulenovic, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should have an increased understanding of the roles that psychiatrists have fulfilled in relation to the recent genocide in Bosnia-Herzegovina and of some of the critical issues that arise in evaluating the relationship between psychiatric professionals and state-sponsored violence in general.

SUMMARY:

More speculation than evidence has come forth regarding the involvement of psychiatrists in the recent ethnic cleansing in Bosnia-Herzegovina. This workshop will present the evidence and set a framework for a meaningful group discussion on psychiatrists' involvement with genocide. We will specifically discuss Jovan Raskovic, the former leader of the Serbians in Croatia; Radovan Karadzic, the former leader of the self-proclaimed Bosnian Serb government; and psychiatrists at the Institute for Mental Health in Belgrade. *Tvrtko Kulenovic*, a literary scholar from Sarajevo (and former associate of Karadzic) and *Alma Dzubur*, a psychiatrist from Zagreb, will review selected writings: Raskovic's book, *The Mad Country*, Karadzic's poetry and public statements, and two books from the Institute of Mental Health, *The Stresses of War* and *The Stresses of Sanctions. Stevan Weine* will review his interviews with Karadzic's former psychiatric colleagues in Sarajevo and present an interpretation that centers on these psychiatrists' various public uses of survivors' stories so as to nurture nationalism, hatreds, violence, and denial. Ample time will be reserved for the group to discuss this material and to specifically address: (1) new forms of psychiatric abuse in the post-communist era, and (2) approaches to inquiry and investigation; and (3) Use of sanctions and other possible disciplinary actions.

REFERENCES:

1. Lifton RJ: *The Nazi Doctors: Medical Killing and the Psychology of Genocide.* New York, Basic Books, 1986.
2. Weine S: Genocide (letter to editor), *Psychiatric News,* Volume XXX, Number 7, April 7, 1995.

Issue Workshop 24
DO WE KNOW ENOUGH ABOUT OUR PATIENTS' SEXUAL LIVES?

Chairperson: Virginia A. Sadock, M.D., *Department of Psychiatry, NYU Medical Center, 550 First Avenue NB22N, New York NY 10016*
Participants: Waguih W. Ishak, M.D., Danni Michaeli, M.D., Laura McLaughlin, C.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participants should be able to recognize the importance of and the factors interfering with taking an adequate sexual history and should be able to use this practical knowledge in the evaluation and treatment of their own patients.

SUMMARY:

Taking a detailed history of past and present sexual behavior is an extremely valuable clinical practice that leads to learning about an important aspect of personal history, identifying sexual disorders, improving the quality of life of patients, addressing high-risk behavior, and treating sexual side effects of medications. Avoidance of discussing sexual issues is seen in clinical settings, and is often related to both clinician's and patient's anxiety about the topic. Taking a detailed sexual history sometimes is avoided by clinicians because of fear of increasing the distress of patients and/or feeling unqualified to deal with content in addition to personal barriers. Age of the patient, gender difference, sexual orientation, and cultural factors could also contribute to the reluctance of taking an adequate sexual history. Difficulties in taking sexual history from adolescents will be reviewed as an example. The participants will be able to share their own experience in taking sexual histories from patients and explore patient factors as well as clinician factors interfering with taking adequate sexual histories and how to address them.

REFERENCES:

1. Risen CB: A guide to taking a sexual history. *Psychiatr Clin North Am* 18:1, 39-53, 1995.
2. Sadock V: *Human Sexuality: Comprehensive Textbook of Psychiatry, 6th ed,* Kaplan HI and Sadock BJ, Baltimore, Williams and Wilkins, 1995.

Issue Workshop 25
FUNDING STRATEGIES IN CONSULTATION-LIAISON PSYCHIATRY: A NEW WORLD

Chairperson: Carol L. Alter, M.D., *Cancer Center, Temple University, 3322 North Broad Street, Philadelphia PA 19140*
Participants: Barbara A. Schindler, M.D., Philip R. Muskin, M.D., James L. Levenson, M.D., Theodore A. Stern, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to develop an increased understanding of how changes in public and private sector financing impact on CL services, what avenues are available for insuring funding sources, and assuring that appropriate levels and quality of CL service are provided.

SUMMARY:

Provision of psychiatric services to the medically ill has been significantly impacted by changes in mental health financing. Public sector financing is increasingly dependent on legislated managed care plans, which stipulate specific "covered services" for reimbursement. In most states psychiatric consultations have not been included in these plans. Private sector payment for consultation liaison (CL) services is somewhat better, but diligence is required on the part of providers to insure that psychiatric consultations remain a covered service whether they be integrated in the medical plan or included in part of a behavioral health carve out. Regionally and nationally CL psychiatrists are working for inclusion of CL services in public managed care plans. The Academy of Psychosomatic Medicine (APM), the national CL organization, is actively engaged in efforts to maximize funding opportunities and guarantee quality care in CL psychiatry. The multiple issues related to credentialing, training, and quality of care that are specific to CL psychiatry must be attended to in managed care agreements and are being incorporated in a set of practice guidelines written by the APM. The workshop will provide an interactive opportunity for attendees to develop strategies for addressing funding and practice concerns with CL psychiatrists who have been working to insure funding and practice quality strategies in the public and private sectors.

REFERENCES:

1. Koyangi C, Carty L: *Mental Health Managed Care: Survey of the States,* Washington, DC: Bazelton Center for Mental Health Law, 1986.

2. Goldberg RJ, Stoudemire A: The future of consultation-liaison psychiatry and medical-psychiatric units in the era of managed care. *General Hospital Psychiatry* 17:268-277, 1995.

Issue Workshop 26
NOVEL REMEDIES FOR DRUG-INDUCED SEXUAL DYSFUNCTION

Chairperson: Barbara D. Bartlik, M.D., *Department of Psychiatry, Cornell University Medical Col, 865 West End Avenue, New York NY 10025*
Participants: Alan J. Cohen, M.D., Peter M. Kaplan, M.D., Richard A. Friedman, M.D., James H. Kocsis, M.D.

EDUCATIONAL OBJECTIVES:

Participants will become familiar with the use of psychostimulants and gingko biloba for the treatment of drug-induced sexual dysfunction. Theoretical considerations and the mechanics of administration will be covered. The potential hazards of ginseng, often used by patients for this purpose, but without medical supervision, will also be addressed.

SUMMARY:

In an open trial, the psychostimulants dextroamphetamine, methylphenidate, and a combination of dextroamphetamine and amphetamine (Adderall) were 77% effective in treating sexual dysfunction caused by a variety of antidepressant medications, predominantly SSRIs (N=27). Small dosages of prn psychostimulants were generally found to augment all four phases of the sexual response cycle: desire, excitement (erection and lubrication), orgasm, and resolution (afterglow). Women were more responsive than men (91% versus 68%), which reflects differences in female responsivity to dopamine stimulation.

In a second open trial, ginkgo biloba, a cerebral enhancer derived from the bark of the Chinese maidenhair tree, was 84% effective in treating sexual dysfunction caused by antidepressant medications, predominantly SSRIs (N = 63). Again, women responded more vigorously than men (91% versus 76%). Presumed pharmacologic mechanisms will be described, including effects upon platelet activating factor, prostaglandins, peripheral vasodilatation, and central serotonin and norepinephrine receptor activity.

Thirdly potential hazards of ginseng will be discussed. Consumers are increasingly using over-the-counter ginseng for its presumed sexually and energy enhancing effects without medical supervision. Ginseng's estrogenic and testosterongenic action may be hazardous to some patients. Precautions will be described, as well as alternatives for patients seeking pharmacologic solutions to sexual problems, particularly drug-induced sexual dysfunction.

REFERENCES:

1. Cohen A: Treatment of antidepressant-induced sexual dysfunction. A new scientific study shows benefits of gingko biloba. *Healthwatch,* 5(1), January, 1996.
2. Bartlik B, Kaplan P, Kocsis J: Letter to the editor: Re: Balon R: Effects of antidepressants on sexuality. *Primary Psychiatry,* 2(10):13, Nov/Dec 1995.

Issue Workshop 27
MALINGERING PATIENT: SUICIDAL/HOMICIDAL DANGEROUSNESS

Chairperson: Cletus S. Carvalho, M.D., *Department of Psychiatry, St. Vincent's Hospital, 101 West 15th Street, #3-OS, New York NY 10011-6745*
Participants: Kenneth J. Tardiff, M.D., Andrew E. Slaby, M.D., Steven K. Hoge, M.D., Roger Dyer, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be able to recognize predictors of dangerousness to self and others in the malingering patient with suicidal or homicidal ideation and demonstrate an awareness of liability issues related to discharging such patients.

SUMMARY:

Every practicing psychiatrist is aware of the emergency room psychiatric patient in whom malingering is suspected. Many of these are patients with a history of mental illness who know how to "work the system," usually indicating that they suffer from suicidal or homicidal ideation. This is done in an attempt to obtain temporary shelter from homelessness, the law, potential criminals, etc. Unnecessarily admitting such patients is not always beneficial since this would only serve to reinforce such manipulative behavior, in addition to putting them at risk of exposure to unwanted diagnostic procedures or medications. Discharging them, however, may also prove problematic as they are not likely to comply with therapeutic suggestions. There is also the danger of such patients acting out their suicidal or homicidal ideation with subsequent legal liability implications for the psychiatrist initially involved in discharging the patient. Participants will benefit as speakers share their substantial expertise on the clinical and medico-legal aspects of this interesting but demanding group of patients. Issues discussed will surely invite active interaction between speakers and the audience.

REFERENCES:

1. Marcus EH: The dilemma of the malingering patient-litigant. *Am J Forensic Psychiatry* 7:3, 1987.
2. Resnick PJ: Malingering. *J Forensic Psychiatry* 5:1, 1994.

Issue Workshop 28
A CASE CONFERENCE ON HYSTERIA, INCEST AND TRAUMA: BOSTON, 1913

Chairperson: Bennett Simon, M.D., *170 Chestnut Street, West Newton MA 02165-2711*
Participants: Russell G. Vasile, M.D., Elizabeth Lunbeck, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should know more about the history of hysteria in early 20th century America, the mixed reception of psychoanalytic treatment, early ideas about rape and incest, and the use of archival material available in one's own geographical area.

SUMMARY:

The workshop will present the case of Rachel K., a young woman with severe hysterical symptoms, treated by a self-taught psychoanalyst, Louville E. Emerson, in Boston, from about 1912-1917. Emerson kept detailed notes of each session, both inpatient and outpatient, containing the unfolding of a history of rape, incest, and familial betrayal. We have the minutes of a case conference at the Boston Psychopathic Hospital, April 1913, where there was considerable controversy about Emerson's treatment. The structure of the workshop will be a case presentation, (Dr. Vasile), a presentation of the historical context of the case (Prof. Lunbeck), distribution to the participants of excerpts from several analytic sessions, and a discussion of how each workshop participant responds to the case history, to the mode(s) of treatment, to questions about diagnosis, and to the relationship between inpatient hospitalization and ongoing psychoanalytic treatment. We will then present a summary of the 1913 case conference to compare with the 1997 and 1913 discussions. A unique feature of this workshop is bringing together a historian and clinicians in order to enlarge the perspective of each profession about the case,

and to teach the workshop members some approaches to clinical archival material.

REFERENCES:

1. Lunbeck E: *The Psychiatric Persuasion: Knowledge, Gender and Power in Modern America,* Princeton, NJ; Princeton University Press, 1994.
2. Emerson LE: Psychoanalytic study of a severe case of hysteria. *Journal of Abnormal Psychology,* 7:385-406, 1912-13; 8:44-56; 180-207, 1913-14.

Issue Workshop 29
WHAT CLINICIANS CAN DO TO COMPETE WITH MANAGED CARE ORGANIZATIONS

Chairperson: Bruce J. Schwartz, M.D., *Department of Psychiatry, Montefiore Medical Center, 111 East 210th Street/Klau B, Bronx NY 10467*
Participants: Barton J. Blinder, M.D., Robert O. Friedel, M.D., Scott Wetzler, Ph.D.

EDUCATIONAL OBJECTIVES:

To formulate a strategy for developing a provider group to capitalize on local market conditions and compete with for-profit managed care organizations.

SUMMARY:

The provision of behavioral health services in organized delivery systems or to managed care enrollees has been dominated by for-profit managed care companies (MCO's). Clinicians around the country have begun to organize groups to compete with the profit-driven MCO's in order to ensure that the public has access to high-quality behavioral health care. These new organizations attempt to either recapture or maintain the centrality of providers in determining appropriate treatment and medical necessity. Several examples of such new provider-driven organizations and the market conditions to which they are responding will be presented so that the audience has an opportunity to react and learn about them. The following organizations will be discussed: University Behavioral Associates (NY), Bronx Behavioral Care IPA (NY), Integrated Behavioral Medical Group (CA), and UAB Mental Health System (AL).

REFERENCES:

1. Shore MG, Beige A: The challenges posed by managed behavioral health care. *New England Journal of Medicine* 334:116-118, 1996.
2. Iglehart JK: Managed care and mental health. *New England Journal of Medicine* 334:131-135, 1996.

Issue Workshop 30
IMPORTING INTERPERSONAL PSYCHOTHERAPY: AMERICAN THERAPY ABROAD IN EUROPE

Chairperson: John C. Markowitz, M.D., *Department of Psychiatry, Cornell University Medical Col, 445 East 68th Street, Ste 3N, New York NY 10021*
Participants: Erik Hoencamp, M.D., Giovanni De Girolamo, M.D., Roland Berg, M.D., Aviva Mayers, M.S.W. Theodore Hovaguimian, M.D.

EDUCATIONAL OBJECTIVES:

To recognize the challenges and opportunities involved in translating a focal psychotherapy from one culture to another. This workshop may have particular interest for psychiatrists from other countries who plan to learn and conduct research with IPT.

SUMMARY:

Interpersonal psychotherapy (IPT), a time-limited treatment developed by the late Gerald L. Klerman, M.D. and Myrna M. Weissman, Ph.D., has demonstrated efficacy for major depression and other disorders in controlled clinical trials. Unlike cognitive-behavioral therapy, which was clinically disseminated early in its development, IPT until recently remained largely a research intervention. In the last few years, IPT training of clinicians has increased both in the United States and abroad.

There has been interest in IPT in Austria, Germany, Iceland, Italy, the Netherlands, Norway, Spain, Switzerland, and Sweden. A controlled clinical trial of IPT is under way in the Netherlands. This workshop will describe the experience of European therapists in adapting to what has been perceived as an "American" therapy; the adjective connotes something optimistic, scientifically tested, and foreign. Differences and difficulties in adapting IPT on European terrain—including transnational supervision with English-speaking-only supervisors—will be discussed by an international panel.

REFERENCES:

1. Weissman MM, Markowitz JC: Interpersonal psychotherapy: current status. *Archives of General Psychiatry* 51:599-606, 1994.
2. Markowitz, JC: Teaching interpersonal psychotherapy to psychiatric residents. *Academic Psychiatry* 19:167-173, 1995.

Issue Workshop 31
COALITION BUILDING IN MENTAL HEALTH ADVOCACY

Chairperson: Elaine R. Brooks, M.S.W., *San Diego Coalition for Mtl Hl, 7021 Fay Avenue, La Jolla CA 92037*
Participants: Jim Gogek, M.A. Areta Crowell, Ph.D. Daniel B. Fisher, M.D., Michael Allen, J.D.

EDUCATIONAL OBJECTIVES:

The participant should be able to identify a few key issues that have a working consensus among mental health advocates, as well as understand the kind of effort necessary to achieve political efficacy.

SUMMARY:

Mental health advocacy is carried out by a small number of people with divergent interests. Except for a few advocates who have been patients at some time in their lives, most mental health advocacy comes from surrogates, including mental health professionals, family members, civil rights activists, disability advocates, and corporate entities such as the pharmaceutical industry and the emerging managed care companies. The collective strategy needed to be effective remains scattered over the policy landscape from local to national arenas. Political outcomes are discouraging as there continues to be a steady erosion of services, particularly to those who are among the sickest, people with severe and persistent mental illness.

In the past two years, with national health care reform, the need for well-organized advocacy is obvious, yet there has been little progress in putting this together. Individual organizations pursue their own narrow interests, but efforts to achieve a comprehensive approach remain difficult to sustain.

The workshop will explore coalition-building within mental health advocacy. Basic problems will be identified. The workshop will then develop a few key issues where a consensus may be possible. The resources necessary to develop effective advocacy around these issues will be delineated.

REFERENCES:

1. Brooks ER, Zuniga M, Penn NE: The decline of public mental health in the United States. In: Charles Willie, Patricia Reiker,

Bertram Brown and Bernard Kramer (Eds.) *Mental Health, Racism & Sexism.* University of Pittsburgh Press, 1995.
2. Hahn AJ: *The Politics of Caring.* Boulder: Westview Press, 1994.

Issue Workshop 32
CREATING AND USING ADDICTION TREATMENT GUIDELINES

Chairperson: Richard J. Frances, M.D., *Department of Psychiatry, Hackensack Medical Center, 60 Second Street, Hackensack NJ 07601*
Participants: Edward J. Khantzian, M.D., Sheldon I. Miller, M.D., Steven M. Mirin, M.D., Sheila B. Blume, M.D., Robert B. Millman, M.D., Lionel P. Solursh, M.D.

EDUCATIONAL OBJECTIVES:

To familiarize participants with the need for treatment guidelines, how they are developed, and how they are being applied.

SUMMARY:

This is the 31st year of the workshop dialog on alcohol and drug abuse originated by John Ewing, M.D., in which a panel of experts has an open forum with the APA meeting attendees. Active audience participation has always made this workshop an interesting learning experience. This year the topic will be "Creating and Using Addiction Treatment Guidelines." A number of guidelines for addiction treatment are being issued, including the American Psychiatric Association Treatment Guidelines, those developed by ASAM, and those of managed care companies. We are beginning to see the formulation of care maps and algorithms for addiction treatment. The panel of experts, who have been involved in developing and implementing treatment guidelines, will discuss the need for guidelines, ways in which they are developed, and how they can be applied. Usually based on reviews of empirical evidence, consensus opinions of experts, and the research literature, guidelines are increasingly being applied to improve the quality of care. There is the danger that treatment plans will follow a cookbook approach to psychiatry; therefore, individualized tailoring of treatment is still needed to ensure quality care.

REFERENCES:

1. Frances RJ, Miller SI, (eds): *Clinical Textbook of Addictive Disorders.* New York, Guilford Press; 1991.
2. American Psychiatric Association: Work Group on Substance Use Disorders (Mirin SM, Chair). Practice guidelines for the treatment of patients with substance use disorders: alcohol, cocaine, opioids. *Am J Psychiatry.* 152(suppl):11, 1995.

Issue Workshop 33
MALPRACTICE ISSUES IN A MANAGED CARE ENVIRONMENT

Chairperson: Nancy H. Halleck, J.D., *NYS Office of Mental Health, 44 Holland Avenue, Albany NY 12229*
Participants: C. Deborah Cross, M.D., Jay L. Zucker, J.D., Victoria Balkoski, M.D.

EDUCATIONAL OBJECTIVES:

The participant should be able to recognize malpractice issues unique to the practitioner working in a managed care setting. He or she should be aware of these issues and how they impact on professional practice standards. By the end of the presentation, some useful strategies for addressing these dilemmas should emerge.

SUMMARY:

The workshop will present information on trends in malpractice case law associated with managed care and how these cases impact on the way in which psychiatrists need to practice their specialty. A presentation of recent ERISA preemption cases will be included, which will bring up the question of whether or not managed care creates a shift in liability. We will also discuss how malpractice law in a managed care environment creates ethical dilemmas for the psychiatrist and how some of these issues can be addressed through the residency training process.

As managed care becomes more a part of the mental health practitioners' professional life, it raises a number of issues about the appropriate standard of care. Does the structure of managed care shift liability? Does it change the standard of care owed to the patient? By eliciting anecdotes from the audience that illustrate these problems, we hope to have the basis for a lively discussion.

REFERENCES:

1. *Dukes v. U.S. Healthcare, Inc.,* 57 F. 3d 350 (3rd Circuit, 1995).
2. Ethical issues in managed care, *JAMA* 273:330-335, 1995.

Issue Workshop 34
THE PSYCHIATRIC EMERGENCIES OF THE BATTERED WOMAN

Chairperson: Marjorie S. Braude, M.D., *11973 San Vicente Blvd, Ste 211, Los Angeles CA 90049-5098*
Participant: Carole L. Warshaw, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize, protect, treat, and refer domestic violence emergencies with presentations of psychiatric illness.

SUMMARY:

Both presenters served on the National Advisory Committee of the Family Violence Prevention Fund for the National Health Initiative on Domestic Violence. This initiative developed an intensive training program for hospital emergency rooms including a training manual, videos, and training materials for hospital emergency response to domestic violence. The purpose is to provide physicians and other personnel with the skills to recognize and respond appropriately to the current high incidence of domestic violence emergencies. One presenter, Carol Warshaw, was one of the principal authors.

This presentation will apply this knowledge to the psychiatric emergency room. Typical presentations and techniques for identification of cases, and the role of domestic violence in depression, suicidality, and anxiety disorders will be addressed. Treatment issues will be presented including considerations of the safety of the victim, the high risks of repeated emergencies, and the kinds of referrals that are necessary. The audience will be involved in role plays of typical situations.

REFERENCES:

1. Ganley A, Salber P, Warshaw C: *Improving Health Care Response to Domestic Violence,* Family Violence Prevention Fund, San Francisco, California 1995.
2. Stark C, Flitcraft A: Killing the beast within: woman battering and female suicidality *International Journal of Health Services,* 25:43-64, 1995.

Issue Workshop 35
MANAGEMENT OF AGGRESSION: PEARLS AND PITFALLS

Chairperson: William H. Campbell, M.D., *Department of Psychiatry, University of Florida, UFHSC/PO Box 100256, Gainesville FL 32610*
Participants: Josepha A. Cheong, M.D., Richard C. Christensen, M.D., Michael J. Tueth, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize potentially aggressive patients, evaluate them for

signs of impending aggression, and control their behavior using a combination of verbal techniques, physical restraints, and chemical restraints.

SUMMARY:

The management of aggression requires a well-organized management strategy to be safe and effective. A nonjudgmental, humane, and ethical approach to the patient is maintained while measures are implemented to control their aggressive behavior. The workshop format consists of an initial overview of aggression, including its causes, manifestations, and risks; presentation of an effective management strategy, including the use of verbal techniques (e.g., "the talk down"), physical restraints, and chemical restraints; and an interactive discussion of a series of brief clinical vignettes. As the cases unfold, the pros and cons of each decision will be reviewed to facilitate interaction between the audience and the faculty. The topic presentations will be interwoven with the clinical vignettes at each decision point in the case to reinforce essential concepts. The audience will have a vital role in the progression of the discussion. Emphasis will be placed on defining effective, humane, and ethical treatment measures that ensure the safety of the patient and the mental health professionals. The workshop will draw upon the knowledge and experience of both the faculty and the members of the audience.

REFERENCES:

1. Campbell WH: Uncontrolled violent behavior in a young man. *Case Studies Emerg Med* 4:7-12, 1988.
2. Corrigan PW, Yudofsky SC, Silver JM: Pharmacological and behavioral treatments for aggressive psychiatric inpatients. *Hospital Community Psychiatry* 44:125-130, 1993.

Issue Workshop 36
HOW TO WRITE AND PUBLISH IN PSYCHIATRY

Chairperson: Carol C. Nadelson, M.D., *American Psychiatric Press, Inc, 1400 K Street, NW #1101, Washington DC 20005*
Participants: Sydney Bloch, M.D., Nancy C. Andreasen, M.D.

SUMMARY:

Writing for publication can be a daunting task, with many obstacles. This workshop, presented by three editors, will consider organization of papers and chapters; journal and book policies; choice of journals and publishers; referencing; bibliography; the process of submission; and how to understand and address referee and editor comments. It is designed to facilitate and encourage writing and to provide feedback.

REFERENCES:

1. Day RA: *How to Write and Publish a Scientific Paper.* 4th ed. Oryx Press, 1994.
2. Huth E: *How to Write and Publish Papers in the Medical Sciences.* 2nd ed. Williams & Wilkins, 1990.
3. Goodman N, Edwards M: *Medical Writing; A Prescription for Clarity.* Cambridge University Press, 1991.

Issue Workshop 37
CONFIDENTIALITY VERSUS REPORTABILITY: INNER-CITY OUTPATIENT DEPARTMENT DILEMMAS

Chairperson: Susan Stabinsky, M.D., *Department of Psychiatry, Bronx-Lebanon Hospital, 15 Boulder Trail, Armonk NY 10504*
Participants: Harvey Bluestone, M.D., Harvey Stabinsky, M.D., Michael M. Scimeca, M.D., Richard Rosner, M.D., Marc Grossman, C.S.W.

EDUCATIONAL OBJECTIVES:

At the end of the presentation, the participant should be able to delineate those areas in which either confidentiality or reportability clearly apply and recognize special problems regarding impulsive and substance-abusing patients.

SUMMARY:

This workshop will explore the areas of potential conflict between the need to maintain confidentiality and the clinical decision to breach it.

After briefly reviewing state and local reporting requirements and Tarasoff-like obligations, the workshop will explore in an interactive fashion the more vague and problematic issues of how to clinically address the dangerousness of patients with impulse control problems and those who are both actively using and selling drug.

Clinical vignettes will be presented and encouraged from the audience to further explore the dilemmas we all encounter.

REFERENCES:

1. Beck C.J.: *Confidentiality Versus the Duty to Protect,* American Psychiatric Press, 1990.
2. Green FA: The ethical limits of confidentiality in the therapeutic relationship. *General Hospital Psychiatry,* 17(2):80-4, 1995.

Issue Workshop 38
LEADING ORGANIZATIONAL CHANGE: SKILLS FOR THE CHANGE AGENT

Chairperson: Margret I. Hanley, M.B.A., *4117 Couts Street, San Diego CA 92108*

EDUCATIONAL OBJECTIVES:

To summarize and employ key steps in a systematic change process model; to identify common signs of resistance to organizational change, and their remedies; and to recognize and engage key stakeholder groups in a change process.

SUMMARY:

This workshop is intended for medical service directors, administrators, elected members of professional organizations or medical staffs, and other clinician leaders required by the current health care environment to orchestrate radical change. Whether the task is reorienting clinicians to the demands of managed care, influencing powerful decision makers toward programmatic shifts, planning mergers of institutions or services, or attempting to alter community attitudes, understanding "change agent" skills and applying a systematic model of change are essential for successful outcomes. The workshop will include a self-assessment of participants' attitudes to organizational change. The clinical origins of modern organizational change theory will be reviewed. Participants will learn to identify recurring forms of resistance faced by those leading organization change efforts, as well as strategies for reducing, eliminating, or

utilizing this resistance. Based on a systematic model for planning and implementing complex organizational change, participants will describe the stage of their current change efforts and develop approaches to design or implement the desired outcome.

REFERENCES:

1. Strebel P: Why do employees resist change? *Harvard Business Review* 74:86-92, 1996.
2. Bridges W: *Managing Transitions.* Boston: Addison-Wesley, 1991.

Issue Workshop 39
REACTIONS AND ADAPTATIONS TO ORGANIZATIONAL CHANGE

Chairperson: Stewart Gabel, M.D., *Department of Psychiatry, Childrens Hospital, 1056 East 19th Avenue, Denver CO 80218*
Participant: Marshall R. Thomas, M.D.

EDUCATIONAL OBJECTIVES:

To demonstrate an awareness of adaptive and maladaptive reactions of psychiatrists and other mental health providers when confronting necessary organizational changes; to demonstrate an awareness of strategies to enhance adaptive reactions to necessary organizational change.

SUMMARY:

Under the influence of managed care and diminished funding, the mental health field is undergoing a major transformation. Existing mental health programs, departments, and agencies have been downsizing and restructuring in order to develop new types of service-delivery systems. In the current era, organizations must change to survive, yet change may be resisted in numerous ways by psychiatrists and other mental health providers whose actions may reduce the viability of their own programs and agencies.

This workshop will explore various characteristics and reactions of psychiatrists and other mental health care professionals as they face great stress, professional devaluation, and necessary organizational change and restructuring. Adaptive and maladaptive patterns in response to potential organizational changes will be explored. The role of the organization's leader in guiding and implementing programmatic changes and in dealing with denial and resistance will be highlighted. The workshop will be interactive in nature. It will rely in part on members' experiences in various organizational settings for illustrations of adaptive and maladaptive responses to change. From the experiences of the workshop leaders, as well as examples provided by participants, strategies will be generated to enhance the prospects for adaptive organizational change.

REFERENCES:

1. Bridges W: *Managing Transitions. Making the Most of Change.* New York, Addison-Wesley Publishing Co., Inc., 1991.
2. Thomas MR, House R, Shore JH: Adapting to the New Realities for Clinical Services and Residency Education in Managed Care, in *Proceedings of the AACDP/RTD Conference.* JA Talbott, et al. (Eds.) Baltimore, pp. 97-108, 1995.

Issue Workshop 40
CHILD PSYCHOPHARMACOLOGY: MEDICATION COMBINATIONS

Chairperson: Paul A. Andrulonis, M.D., *Department of Psychiatry, CT Children's Medical Center, 282 Washington Street, Hartford CT 06106*

EDUCATIONAL OBJECTIVES:

To understand the safe and efficacious use of combined pharmacotherapy, the benefits and concerns of polypharmacy, the development of clinical practice algorithms in psychopharmacology including augmentation strategies, and significant interactions between medications involving the cytochrome P450 system.

SUMMARY:

This workshop presents a current update of practical guidelines for the safe and efficacious use of medications. Following an overview of each medication class, including dosage schedule, side effects, laboratories, and maintenance, the workshop will focus on medication combinations, augmentation strategies, and clinical practice algorithms.

The author shares his 20-year experience in psychopharmacology and his development of specialty services. He will focus on the benefits and risks of combined pharmacotherapy including drug/drug interactions resulting in increased or decreased blood levels of other psychotropics. He will discuss significant interactions between inhibitors and substrates involving the P450 system. The clinician will have guidelines for medication combinations including ADHD with comorbid states, depression, aggression, and psychosis. Combinations of medications to avoid will be emphasized. Clinicians will learn from interactions with the author and other participants general guidelines to develop practice algorithms in pediatric psychopharmacology. The audience will also have the opportunity to present cases for consultation and discussion.

REFERENCES:

1. Wallup JT: Clinical decision-making in child and adolescent psychopharmacology. *Child and Adolescent Clinics of North America* 4:23-39, 1995.
2. Wilens TE, Spencer T, Brederman J, et al: Combined pharmacotherapy: an emerging trend in pediatric psychopharmacology *J Am Acad Child Adolesc Psychiatry* 34:110-112, 1995.

Issue Workshop 41
CULTURAL IDENTITY IN THE PSYCHOTHERAPEUTIC DYAD

Chairperson: Kamran Rahmani, M.D., *Department of Psychiatry, Montefiore Hospital, 111 East 210th Street, Bronx NY 10467*
Participants: Nelly Katsnelson, M.D., Galina Bass, M.D., Magdolna Saringer, M.D., Sulamit Rishik, C.S.W.

EDUCATIONAL OBJECTIVES:

To appreciate the impact of cross-cultural issues on the psychotherapeutic dyad when a patient and/or an analyst are from a nondominant culture.

SUMMARY:

Most of the current studies on cross-cultural issues in psychoanalysis have examined the therapeutic dyad when only the patient is from a nondominant culture. This workshop will expand the issue to explore the impact of cultural identification when either a patient or an analyst are from a nondominant culture. The workshop will study various combinations: an American analyst with a cross-cultural patient, an American patient with a cross-cultural analyst, and a cross-cultural analyst with a cross-cultural patient (the same or different cultures). Both patients' and therapists' perspectives will be represented. The issues of transference and countertransference will be explored. The audience will be able to participate with their experiences either as a patient or as a therapist.

REFERENCES:

1. Foster RMP: Psychoanalysis and the bilingual patient: some observations on the influence of language choice on the transference. *Psychoanalytic Psychology*, 9(1):61-76, 1992.

2. Zaphiropoulos ML: Transcultural parameters in the transference and countertransference. *Journal of the American Academy of Psychoanalysis,* 10:571-574, 1982.

Issue Workshop 42
PSYCHIATRIC WORKFORCE: CURRENT PERSPECTIVES

Chairperson: Roumen Nikolov, M.D., *Department of Psychiatry, St. Vincents Hospital, 144 West 12th Street, Room 173, New York NY 10011*
Participants: Jay Cutler, J.D., Sidney H. Weissman, M.D., Denny Cook, M.D., Albert J. Allen, M.D., Stanford W. Granberry, Ph.D.

EDUCATIONAL OBJECTIVES:

To recognize current determinants of supply and demand of psychiatrists; to express opinions on legislative decisions about the design of the health care system most likely to affect psychiatric workforce; to identify the role of the psychiatrist in new practice settings.

SUMMARY:

Health care reform has inflicted many changes on the field of psychiatry, including on psychiatric workforce. So far changes have mainly been in the forms and settings of practice, but changes in manpower needs are also to be expected. Estimates for these have been an issue of controversy for policy makers, and of concern for practicing and in-training psychiatrists. Some of the main factors that could affect demand for psychiatrists are: the pressure of managed care to redefine the scope of psychiatric practice and patient populations; the growing numbers of nonphysician providers in the field; the way society and its legislators determine the need for psychiatric services. This workshop will provide the audience with opportunities to discuss these issues with speakers whose expertise covers areas described as decisive determinants of future developments in psychiatric workforce. Participants will benefit from the discussion by increasing their awareness of current trends in the supply and demand of psychiatrists, and by developing an active stand on issues concerning their career and the future of the profession.

REFERENCES:

1. Weissman S: Recruitment and workforce issues in late 20th century American psychiatry, *Psychiatric Quarterly,* Vol. 67, No. 2, Summer 1996.
2. Scully JH, Weissman S: The Psychiatric Workforce in Transition, Section V, *Psychiatry in Transition.*

Issue Workshop 43
THE VILLAGE: A MODEL PUBLIC MANAGED CARE SYSTEM

Chairperson: Mark Ragins, M.D., *Village ISA, 456 Elm Avenue, Long Beach CA 90802*
Participant: Martha N. Long, B.A.

EDUCATIONAL OBJECTIVES:

To understand and describe a model managed care system for people with serious mental illness, a set of psychosocial rehabilitation principles, managed care principles, and the role of the psychiatrist.

SUMMARY:

As managed care moves into the public sector, it will have to make substantial alterations to address the large number of people with long-term, serious mental illness. The Village Integrated Services Agency in Long Beach is a model program that is a complete integrated system of care for people with long-term, severe mental illness within a capitated contract. We have some of the best outcomes across a range of life areas reported anywhere. In this workshop we will 1) describe the history, setup, and outcomes of our program, 2) describe the psychosocial rehabilitation philosophy and how we have used it as an umbrella under which to integrate our services, 3) describe the role of psychiatrists within this setting, and 4) describe our approach to managed care, "designed care," in contrast to the standard approach. Our objective is for our experience to give a hopeful framework from which to approach future public managed care. Martha Long and Mark Ragins, the presenters, were the 1995 cowinners of APA's Van AmeringenAward for their work at the Village.

REFERENCES:

1. *Journal of California Alliance for the Mentally Ill* Vol. 4 No. 2, 1993. (The entire journal is devoted to the Village.)
2. Hargreaves WA: A capitation model for providing mental health services in California *HCP* 43:3, 1992.

Issue Workshop 44
PICNIC FOR PARITY: CREATING A NATIONAL MOVEMENT

Chairperson: Molly T. Finnerty, M.D., *Department of Psychiatry, NYS Psychiatric Institute, 722 West 168th Street, Unit 92, New York NY 10032*
Participants: Wilfrid N. Raby, M.D., Nora Weinerth, Ph.D., David L. Schneider, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants will be informed about the history of the parity movement. They will understand how to participate in and how to initiate grassroots coalitions in their community to advance the cause of parity.

SUMMARY:

The Picnic for Parity became an annual event in Central Park in New York City in May 1995. Faced with large cutbacks in the state mental health budget, the threat of losing essential community-based services, and the lack of parity in insurance coverage of psychiatric illnesses, a coalition was formed. In one year the attendance at this event quadrupled, from 300 to over 1,500.

The participants will have an opportunity to hear the individual perspectives of organizers of this event, including representatives from local chapters of the Alliance For the Mentally Ill, National Stigma Clearing House, Consumer Information Network, New York City Depression Coalition, the local APA District Branches, and state committees. Throughout the workshop, a discussion between panelists and participants will focus on concrete advice and problem solving in the local application of the national concerns through coalition building and advocacy. Slides and a short video will illustrate how the picnic conveyed a "Serious Message Amid the Fun."

REFERENCES:

1. "Serious Message Amid The Fun." *Psychiatric News* 30(11):2-16, 1995.

2. Marchitello P: Picnic for parity unites NYC mental health community. *New York State Psychiatric Association Newsletter* Jul-Aug, p. 2, 1996.

Issue Workshop 45
PRIMARY CARE TRAINING IN PSYCHIATRY

Chairperson: Cletus S. Carvalho, M.D., *Department of Psychiatry, St. Vincent's Hospital, 101 West 15th Street, #3-OS, New York NY 10011-6745*
Participants: Nada L. Stotland, M.D., Donald A. Misch, M.D., Edward K. Silberman, M.D., Carlos Blanco-Jerez, M.D., Jeffrey Barton, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand 1) prevalent trends of primary care training and practice, 2) advantages, disadvantages, and legal liability implications of improving primary care training and practice, and 3) managed care's views on the psychiatrist as a primary care physician.

SUMMARY:

There is a growing debate among psychiatrists for and against their functioning as primary care physicians. It is, however, difficult to disregard current literature that demonstrates a higher occurrence of medical illness in psychiatric patients. In many, these are either misdiagnosed or not detected. Before consensus is formed, however, there are several concerns that need to be addressed.

At this workshop, speakers will provide input about the current level of primary care training in psychiatric residency programs and present primary care practice patterns among inpatient and outpatient psychiatrists. Pros and cons of improving the standard of primary care training in both groups of psychiatrists will be examined. Legal repercussions of psychiatrists attending to medical illness will also be discussed. Managed care's perspective on the psychiatrist as a primary care physician is an all-important factor, and this too will be looked at in detail. Issues raised during the discussion will affect psychiatrists in training and practice for years to come and active participation by the audience will be encouraged.

REFERENCES:

1. MacIntyre JS, Romano J: Is there a stethoscope in the house (and is it used?). *Arch Gen Psych* 34:1147-1151, 1977.
2. Koran LN, et al: Medical evaluation of psychiatric patients. *Arch Gen Psych* 46:733-740, 1989.

Issue Workshop 46
ACADEMIC PSYCHIATRY IN EASTERN AND SOUTHERN AFRICA

Chairperson: Lawson R. Wulsin, M.D., *Department of Psychiatry, University of Cincinnati, 231 Bethesda Avenue (ML 559), Cincinnati OH 45267-0559*
Participants: Fred Owiti, M.D., Sobbie Mulindi, Ph.D., Pius Kigamwa, M.D.

EDUCATIONAL OBJECTIVES:

To understand the resources and needs of academic psychiatry departments in eastern and southern Africa, and to identify opportunities for academic psychiatry to narrow the gaps between American and African psychiatry.

SUMMARY:

American psychiatrists know little about psychiatry in Africa. We rarely collaborate with African psychiatrists on research, education, clinical, or teaching projects. This workshop focuses on the current status of academic psychiatry departments in eastern and southern Africa. The aim is to generate ideas among American and African psychiatrists that will narrow the gaps of ignorance and prejudice and increase the chances for collaboration. We assume that academic departments of psychiatry on both continents offer promising places to begin these collaborations.

The chairperson will open with a review of the results of a survey of 16 academic psychiatry departments in eastern and southern Africa. The survey identifies department composition, current training programs, current research, clinical resources, and top priority needs. Each of the presenters will amplify with brief examples of current projects or problems. In the remaining 45 minutes the chairperson will invite brief presentations and suggestions from the participants, directing comments toward concrete proposals that can be implemented in the near future. We ask that participants share detailed information on funding sources, current collaborative projects, specific contacts, or any other information that may promote collaboration.

REFERENCES:

1. Odejide AO, Oyewami LK, Ohaeri JU: Psychiatry in Africa: an overview. *Am J Psychiatry,* 146:708-16, 1989.
2. German GA: Mental health in Africa: I. The extent of mental health problems in Africa today. an update of epidemiological knowledge. *Br J Psychiatry*, 151:435-39, 1987.

Issue Workshop 47
DEPARTMENT OF VETERANS AFFAIRS/ DEPARTMENT OF DEFENSE SHARING AGREEMENTS: PROMISES AND PROBLEMS

Chairperson: Jagannathan Srinivasaraghavan, M.D., *Department of Psychiatry, VA Medical Center, 400 Fort Hill Avenue, Canandaigua NY 14424*
Participants: Rena M. Nora, M.D., George W. Arana, M.D., David A. Graeber, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should be able to identify major strengths of VA/DoD sharing agreements and possible solutions for potential problems.

SUMMARY:

There has recently been increased emphasis on limiting federal spending and reducing health care costs. Department of Veterans Affairs medical centers and Department of Defense medical centers are finding it much more important to work together now than a decade ago. By 1995, 147 VA and 167 DoD facilities had sharing agreements, compared with 12 VA and 16 DoD facilities in 1983.

There are different models of sharing agreements, such as 1) VA physicians and personnel working in a DoD facility taking care of DoD patients, 2) both VA and DoD physicians and personnel working on a common unit taking care of both veterans and DoD patients, and 3) DoD patients admitted to a Veterans Affairs medical center where VA personnel provide the care (TriCare Role).

The sharing agreements can potentially save costs, increase efficiency, provide for cooperation between two government agencies, improve continuity of care, and provide for specialty services that may not be available otherwise. However, potential problems exist clinically and administratively. Clinically, critical issues include type of hospitalization, confidentiality, patient rights, and right to refuse treatment. Administrative critical issues include differing missions, work hours, grievance procedures, peer review, and military vs. civilian issues.

The panelists are all psychiatric administrators in clinical leadership positions in the VA. Audience participation with innovative ideas and solutions will be encouraged.

REFERENCES:
1. VA/DoD Sharing: TriCare role begins in Texas, *U.S. Medicine*, Vol. 31, Nos. 21 & 22, November 1995.
2. VA-DoD Sharing Update, Medical Sharing Office, April 9, 1996.

Issue Workshop 48
ABPN UPDATE: TRAINING REQUIREMENTS TO SIT FOR THE ABPN EXAMINATION AND CERTIFICATION PROCESS

Chairperson: Stephen C. Scheiber, M.D., *Amer Brd of Psych & Neuro, 500 Lake Cook Road, Suite 335, Deerfield IL 60015-5249*
Participants: Glenn C. Davis, M.D., William T. McKinney, Jr., M.D., Sheldon I. Miller, M.D., Pedro Ruiz, M.D., Roger Dyer, J.D., John E. Schowalter, M.D., Peter M. Silberfarb, M.D., Peter E. Tanguay, M.D., Elizabeth B. Weller, M.D.

EDUCATIONAL OBJECTIVES:

To inform the membership, particularly members in training and early career psychiatrists, regarding the necessary conditions to sit for the ABPN examination, the certification process, recertification, and subspecialization issues.

SUMMARY:

The American Board of Psychiatry and Neurology would like to focus its discussion regarding the necessary conditions for admission to its examination, the examination process, and plans for recertification and the current status of subspecialization with resident members and early career psychiatrists as the primary audience. Residents and early career psychiatrists will be encouraged to attend and answer questions about certification, recertification, and subspecialization. In addition to the Part I and Part II written and oral examinations for certification, the participants will be urged to discuss child and adolescent psychiatry, addiction psychiatry, geriatric psychiatry, forensic psychiatry, and clinical neurophysiology as well as participate in an update on plans for recertification.

REFERENCES:
1. Shore J, Scheiber S: *Certification, Recertification and Lifetime Learning*, APPI Press, Washington, DC 1994.
2. American Board of Medical Specialties: *Recertification for Medical Specialists*, ABMS, Evanston, IL 1987.

Issue Workshop 49
WOMEN IN PSYCHIATRY: BREAKING THE GLASS CEILING

Chairperson: Carolyn B. Robinowitz, M.D., *Assoc. Dean for Students, Georgetown University, 3900 Reservoir Road, N.W., Washington DC 20007-2197*
Participants: Carol C. Nadelson, M.D., Carol A. Bernstein, M.D., Ellen Leibenluft, M.D., Marian I. Butterfield, M.D.

EDUCATIONAL OBJECTIVES:

Participants will learn about the issues that affect professional opportunities for women psychiatrists and identify strategies for success.

SUMMARY:

Over the past two decades, there has been a great increase in the number of women in medicine. With this increase has come the expectation that the representation of women in more senior leadership positions in practice, academia, or organized medicine would increase proportionally. Yet data from all specialties, including psychiatry, do not support this expectation. Women residents tend to be involved and visible and receive recognition in proportion to that afforded their male colleagues. But critical mass does not seem to affect outcome, as soon after completion of training the gender gap is visible and increases over time. There have been many theories proposed to explain this process, as well as possible remedies.

The session, primarily aimed at residents and early to mid-career psychiatrists, will address issues for both men and women. The panelists, who represent "successful" women with a range of ages and career experiences, will identify issues and propose strategies to "level the playing field."

REFERENCES:
1. Leibenluft, et al: Sex differences in rank attainment and research activities among academic psychiatrists. *Arch Gen Psychiatry* 50:896-904, 1993.
2. Tesch BJ, et al: Promotion of women physicians in academic medicine; glass ceiling or sticky floor? *JAMA* 273:1022-5, 1995.
3. Fried LP et al: Career development for women in academic medicine. *JAMA* 276:898-905; 1996.

Issue Workshop 50
ESTROGEN, TESTOSTERONE, AND DYSPHORIA AT MID-LIFE

Co-Chairpersons: Barbara D. Bartlik, M.D., *Department of Psychiatry, Cornell University Medical Col, 865 West End Avenue, New York NY 10025,*
Susan Rako, M.D., *83 Walker Street, Newtonville MA 02160*

EDUCATIONAL OBJECTIVES:

The purpose of this workshop is to clarify the contribution of ovarian failure to dysphoric mood states in women. Ovarian failure may be secondary to natural menopause or to menopause induced by surgery or chemotherapy. The workshop will highlight the importance of estrogen and testosterone for healthy sexual functioning in women.

SUMMARY:

This workshop will present essential information regarding testosterone deficiency and testosterone supplementation in women. It will draw upon several hundred cases of women who have been diagnosed with and treated for major depression at midlife, who subsequently have been found to be deficient in estrogen and/or testosterone. The discussion will clarify the contribution of ovarian failure to dysphoric mood states. Ovarian failure may occur naturally or may be artificially induced through surgery or chemotherapy for breast or other cancers. The decline in estrogen and testosterone levels accompanying menopause appears to be causally related to the increased incidence of depression in the postmenopausal years. Estrogen and testosterone are now known to have positive effects on neurotransmitter systems involved in mood regulation, behavior, and cognition.

This workshop will also underscore the importance of testosterone for healthy libido and sexual functioning in women. In addition, the determination as to whether sexual dysfunction is secondary to depression or to testosterone deficiency will be covered. Finally, the workshop will include an open discussion regarding the administration of testosterone therapy via oral, sublingual, labial, intramuscular, or transdermal routes.

REFERENCES:
1. Rako S: *The Hormone of Desire: The Truth About Sexuality, Menopause, and Testosterone (Introduction by B. Bartlik and H.S. Kaplan).* Harmony Books, New York, NY, 1996.

2. Rako S: Testosterone deficiency and supplementation for women: what do we need to know? *Menopause Management*, 5(4), 1996.

Issue Workshop 51
MALPRACTICE SUITS: TURNING POINTS IN PHYSICIANS' LIVES

Chairperson: Miguel A. Leibovich, M.D., *Department of Psychiatry, Harvard Medical School, 83 Cambridge Park Way, #609W, Cambridge MA 02142*
Participants: Sara C. Charles, M.D. Maureen Mondor, R.N.

EDUCATIONAL OBJECTIVES:

At the end of the workshop, participants will be able to understand the various reactions that physicians experience when confronted with the emotional crisis of a malpractice suit and to learn about support programs that are helpful during those stressful events.

SUMMARY:

Physicians have been subject to a tremendous increase in malpractice litigation. The personal and professional impact of suits in their lives and those of their families often evolves in a state of emotional crisis. Being sued is one of the most debilitating life stresses for most medical people. At the same time, the occurrence of a suit can be effectively turned into an opportunity for salutory changes. Out of the crisis a fresh approach to medicine can be found that brings renewed interest in the profession and life in general. A structured support program for sued physicians can be the catalyst through which these crises can be changed into positive events. During the workshop, physicians' emotional reactions will be described, but more importantly, supportive interventions will be explored, specifically the effectiveness of support groups in alleviating the stress. The panelists will interact with the audience who will be invited to share their own experiences and concerns.

REFERENCES:

1. Charles SC, Kennedy EC: *Defendant: A Psychiatrist on Trial for Medical Malpractice*. Free Press, Mac Millan, New York, 1985.
2. Wiebert JR. Charles SC: Coping with the stress of malpractice litigation. *Illinois Medical Journal*, 171, 1987.

Issue Workshop 52
PUBLIC AND ACADEMIC LINKAGES IN SHIFTS TO MANAGED CARE

Chairperson: Joseph A. Flaherty, M.D., *Department of Psychiatry, University of Illinois, 912 South Wood Street, MC 913, Chicago IL 60612*
Participants: Boris M. Astrachan, M.D., Barbara Dickey, Ph.D., Susan Essock, Ph.D.

EDUCATIONAL OBJECTIVES:

To articulate creative and proactive roles for departments of psychiatry as state government and other public agencies make the transition from state operation to managed systems of behavioral health care.

SUMMARY:

Federal and local governments have long encouraged departments of psychiatry to enter into collaboration over education, training, and clinical work. Over the last decade, the recognized need for services research and the demand for public-sector mental health and substance abuse services has resulted in renewed interest in public-academic-linkages (PAL's). Over the last two years, the rapid growth of managed care, the widespread interest by state governments in using a managed care approach to the many governmental units responsible for mental health care, and the skepticism and political limitations of turning over all these services to a national managed care organization raise the prospects for new types of activities through PAL's. Many states are either planning or implementing a transition to managed mental health care in their departments of mental health, substance abuse, child welfare, and corrections. This panel will focus on the various options for collaboration between the state and university departments of psychiatry including: 1) consultation into the substance and process of converting to managed care; 2) designing treatment algorithms, critical decision points, and treatment protocols; 3) providing support and/or leadership in activities such as provider credentialing, utilization review and continuous quality improvement; 4) direct provision of services through traditional catchments, subspecialty services, or preferred providers; 5) collaborative services research that focuses on the most critical needs of the state as determined by both costs and disability; and 6) expansion of traditional training relationship beyond residents to a larger array of mental health workers and case managers. These PAL's may also benefit from the experience and technology of managed care companies, which can concurrently participate in these activities with clear delineation of duties and responsibilities of state, university, provider networks, and managed care companies.

Participants will be divided into four small groups according to interest: mental health, substance abuse, child welfare, and corrections. Groups will discuss methods and opportunities for PAL's unique to their interest and then return for a plenary discussion facilitated by the panel members.

REFERENCES:

1. Sullivan ME, Richardson CE, Spaulding WD: University-state hospital collaboration in an inpatient psychiatric rehabilitation program. *Community Mental Health J* 27:441-453, 1991.
2. Paulson RI: Addressing the public mental health personnel crisis through systemic reform and public-academic linkages. *Community Mental Health J* 27:393-409, 1991.

Issue Workshop 53
SWIMMING WITH SHARKS: ORGANIZATION POLITICS

Chairperson: Michelle Riba, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor MI 48109*
Participants: John S. McIntyre, M.D., Elissa P. Benedek, M.D., Marcia Slomowitz, M.D.

EDUCATIONAL OBJECTIVES:

To recognize systematic issues within organizations that promote or hinder advancement; to begin to understand personal goals versus organizational goals and how they may intersect or be at odds with one another; to listen to examples from workshop participants about experiences within organizations and how to learn from the mistakes or successes.

SUMMARY:

The ability of a psychiatrist to succeed within an organization depends on many factors—personal as well as institutional. There are multiple types of organizations in which we may want to participate and move ahead, but because of personnel or structural reasons, it may be difficult to do so. This workshop will offer participants an opportunity to hear various experiences that the panel has to offer and then time will be set aside to hear from the audience about what pitfalls, problems, or successes they have encountered. The panelists will help lead the audience in a discussion of the various issues that make succeeding and living in an organization so complex. (Note: This workshop was given last year and participants strongly recommended that it be repeated.)

REFERENCES:
1. Barton WE, Barton GM: *Mental Health Administration.* Human Sciences Press, New York, 1983.
2. Talbott JA, Kaplan SR: *Psychiatric Administration.* Grune and Stratton, New York, 1983.

Issue Workshop 54
INEPT LAWYER PLUS DISABLED LITIGANT EQUALS ROLE DILEMMA

Chairperson: Douglas Mossman, M.D., *Department of Psychiatry, Wright State University, PO Box 927, Dayton OH 45401-0927*
Participant: Michael L. Perlin, J.D.

EDUCATIONAL OBJECTIVES:

The participant will become familiar with (1) the empirical evidence concerning inadequate legal representation for mentally disabled persons, (2) the impact of poor representation on legal outcomes and the development of case law, (3) the practical and ethical issues faced by forensic psychiatrists who are asked to use their skills and knowledge in cases involving poorly represented, mentally disabled litigants.

SUMMARY:

Mentally disordered persons are disproportionately likely to be arrested, jailed, and imprisoned, and mental condition or psychiatric disability is increasingly a focus of civil cases involving personal injury, custody, workplace violence, and the Americans with Disabilities Act. Yet the legal profession's efforts to provide meaningful, skilled representation for mentally disabled litigants have been grossly inadequate. Skilled, experienced, well-structured legal advocacy is crucial to the outcome of mental disability litigation, but many persons with psychiatric problems are represented by counsel who are unmotivated, poorly paid, inexperienced, and ignorant of psychiatric issues.

This workshop will examine the ethical pitfalls, practical problems, and possible solutions for psychiatrists who become involved in criminal or civil legal matters where attorneys lack the ability, experience, knowledge, or willingness to vigorously pursue their clients' interests. The presenters will provide empirical information on inadequate lawyering and its impact on legal outcomes. They also will present case vignettes that highlight ethical and pragmatic questions about how clinicians should behave when a litigant's legal representation appears faulty. The presenters and audience will discuss the potential functions—neutral expert, consultant, advisor, or advocate—that clinicians can assume in adversarial proceedings and exchange views about the appropriateness, advantages, and drawbacks of these roles.

REFERENCES:

1. Perlin ML: Fatal assumption: a critical evaluation of the role of counsel in mental disability cases. *Law and Human Behavior* 16:39-59, 1992.
2. Mossman D: Is forensic testimony fundamentally immoral? *International Journal of Law and Psychiatry* 17:347-368, 1994.

Issue Workshop 55
TESTIMONY: THERAPY, STORY, AND HISTORY

Chairperson: Stevan M. Weine, M.D., *Department of Psychiatry, University of IL at Chicago, 1601 West Taylor Street, #423S, Chicago IL 60612*
Participants: Alma D. Kulenovic, M.D. Tvrtko Kulenovic, Ph.D.

EDUCATIONAL OBJECTIVES:

The participant should gain an increased understanding of the uses of the testimony method of psychotherapy in working with survivors of human rights violations, as well as some psychotherapeutic, literary, and historical conceptual views of testimony.

SUMMARY:

The testimony method of psychotherapy is an innovative way of working with survivors of human rights violations. The survivors tell the story of what happened when traumas shattered their lives, and the psychiatrist is the witness who records it. Together, they make a document of the survivor's trauma story and look for appropriate ways to make the survivor's story knowable to others. The clinical benefits of testimony for the survivor are often plain to see. However, as a narrative means of exploring phenomena on the boundaries between the self and history, and as a story that is shaped both by the survivor and also the witness, testimony narratives are not at all straightforward. Testimony and its narrative can be a type of psychotherapy, but it can also be considered autobiography, oral history, or even art. This workshop brings together an American psychiatrist, a Croatian psychiatrist, and a Bosnian literary scholar who have extensive experience doing testimony psychotherapy with Bosnians and doing clinical, narrative, and historical research and intellectual inquiry on the testimony. We shall share testimony material, then briefly present the concepts and an analysis of the testimony as seen from the perspectives of trauma psychotherapy, literary narrative, and oral history, and then facilitate a group discussion on the nature of testimony and its usefulness to psychiatrists as a means of working with survivors of human rights violations.

REFERENCES:

1. Weine SM, Laub D: Narrative constructions of historical realities in testimony with Bosnian Survivors of 'Ethnic Cleansing,' *Psychiatry*, 5:246-260, 1995.
2. Weine SM: Refugees' memories, witnessing, and history after Dayton, *World Refugee Survey*, U.S. Committee for Refugees, pp. 28-34, 1996.

Issue Workshop 56
PSYCHODYNAMIC PRINCIPLES IN PUBLIC PSYCHIATRY

Chairperson: James H. Scully, Jr., M.D., *Director, William S. Hall Psychiatric Institute, 1800 Colonial Drive, P.O. Box 202, Columbia, SC 29202*
Participants: Allan Tasman, M.D., David I. Joseph, M.D., Sandra C. Walker, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will be able to identify and make use of new opportunities for psychiatric education in psychodynamic psychiatry in public sector settings. These opportunities are closely related to enhanced patient care as well as to educational excellence.

SUMMARY:

The workshop will begin with a case presentation by a psychiatry resident illustrating her experience in the psychodynamic treatment of a suicidal young woman with symptoms of PTSD and a history of substance abuse, seen in a public sector setting. The presenter will describe the course of treatment in parallel with her own learning and development as a clinician. Her presentation will also illustrate the utility of a growing understanding of transference and countertransference feelings in managing the overall clinical care of an intelligent but self-destructive patient.

The two discussants, both distinguished psychiatric educators with extensive experience in public sector psychiatry, will respond to the presentation as a clinical case, as an illustration of important learning processes for psychiatry residents, and as a contribution to the care of public sector patients, who constitute an underserved population. Financial issues will be addressed, although they will not be the focus.

The chair, former director of the APA Office of Education, will discuss the case and related implications for psychiatric education. The chair will then engage the audience and presenters in a discussion of the special opportunities for psychiatric education in psychodynamic psychiatry in the public sector.

REFERENCES:

1. Sledge WH, Marcus K: The community clinic, *Psychodynamic Concepts in General Psychiatry*: ed. Schwartz HJ, Bleiberg E, Weissman SH. Washington, DC, American Psychiatric Press, Inc., 1995.
2. Tasman A: A recommended curriculum for psychodynamic psychiatry: *Psychodynamic Concepts in General Psychiatry*: ed. Schwartz HJ, Bleiberg E, Weissman SH: Washington, DC, American Psychiatric Press, Inc., 1995.

Issue Workshop 57
BEYOND MEDICAL SCHOOL: THE MBA ADVANTAGE

Chairperson: Arthur L. Lazarus, M.D., M.B.A, *Eastern PA Psychiatric Inst., 3200 Henry Avenue, Philadelphia PA 19129,*
Participants: Marie Zecca, John S. Lloyd, M.B.A., John S. Lloyd, M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant should be able to recognize the importance of graduate business education for aspiring physician executives and evaluate the advantages and disadvantages of an executive MBA program.

SUMMARY:

Medical management promises to be an area of growth and opportunity for many physicians, including psychiatrists. Although formal training beyond medical school and residency is not required for physicians to enter the ranks of management, physician executives are turning increasingly to graduate-level business training to learn effective management skills. Executive MBA programs, which can be completed in less than two years, offer physicians an opportunity to obtain an MBA degree without interrupting their career.

Workshop leaders will discuss a typical executive MBA curriculum, the MBA "lifecycle," and the resources needed to complete such a program. In addition, the careers of recent graduates from one executive MBA program (Temple University) will be profiled. Workshop participants will also have a chance to learn about the physician-executive marketplace. There will be ample time to ask questions and discuss personal experiences to help plan for a career in administrative psychiatry.

REFERENCES:

1. Lazarus A: From stethoscope to spreadsheet: the physician with an MBA. *The Pharos* 58:20-23, 1995.
2. Lazarus A: The psychiatrist-executive revisited: new role, new economics. *Psychiatric Annals* 25:494-499, 1995.

Issue Workshop 58
TELEPSYCHIATRY IN RURAL AMERICA: A KANSAS UNIVERSITY MEDICAL CENTER INITIATIVE

Chairperson: Charles L. Zaylor, D.O., *Department of Psychiatry, Kansas University Medical Ctr, 3901 Rainbow Boulevard, Kansas City KS 66160*
Participants: Jessica A. Hellings, M.D., Elizabeth C. Penick, Ph.D., David J. Ermer, M.D., Sunil Chhibber, M.D.

EDUCATIONAL OBJECTIVES:

To understand the recent technological advances that have been made in telemedicine, appreciate the enormous clinical potential of this method to provide comprehensive coverage and quality care in a highly professional manner to the psychiatrically ill in remote and rural areas, and understand how these services can be funded.

SUMMARY:

In 1991, the Kansas University Medical Center (KUMC) completed its first long-distance interactive TV examination of an identified patient. Relying primarily on private and local money, the KUMC telemedicine program has rapidly grown and now serves approximately 800 patients each year in 12 sites throughout Kansas. Psychiatry became a part of the KUMC telemedicine program in 1993. Extensive video vignettes will illustrate how we currently provide a wide array of mental health services to rural Kansans via interactive television. These include: (1) diagnostic assessment and medication clinics for adults, children, and adolescents; (2) follow-up medication clinics for chronic mentally ill adults including ongoing management of these patients in a rural partial hospital setting; (3) a behavioral and medication management program for the moderate-to-severe mentally retarded; (4) diagnosis-specific group psychotherapy for patients suffering from schizoaffective disorder. The clinicians involved in this, one of the most active telepsychiatry programs in North America, will discuss their work and welcome questions from the audience. Future applications and funding issues concerning telepsychiatry in Kansas and throughout the nation will be reviewed.

REFERENCES:

1. Preston J, Brown FW, Hartley B: Using telemedicine to improve health care in distant areas. *Hospital and Community Psychiatry*, 43:25-32, 1992.
2. Peredina DA, Allen A: Telemedicine technology and clinical applications. *JAMA* 273:483-488, 1995.

Issue Workshop 59
DEVELOPING AN AMBULATORY PRIMARY CARE LIAISON PSYCHIATRY PROGRAM

Chairperson: Philip A. Bialer, M.D., *Department of Psychiatry, Beth Israel Medical Center, 1st Avenue and 16th Street, New York NY 10003-2992*
Participants: Lowell D. Tong, M.D., Joseph S. Weiner, M.D., Wayne Ury, M.D.

EDUCATIONAL OBJECTIVES:

At the end of the workshop, the participant will gain a better understanding of a primary care clinic's needs concerning psychosocial assessment and treatment. The participant will also be able to discuss the components of a liaison psychiatry program that address these needs and how to develop such a program at their own institutions.

SUMMARY:

Health care reform has increasingly directed patient care into the ambulatory primary care setting. As the gatekeeper, the primary care provider is responsible for managing a variety of disorders including mental health problems. Epidemiologic and medical outcomes research has indicated that large numbers of patients attending primary care clinics suffer from psychiatric disorders that are not recognized or are improperly treated and thus affect overall health. Consultation-liaison (C-L) psychiatrists have traditionally worked along with primary care providers in evaluating and managing the psychosocial aspects of patients in the general hospital, and some C-L divisions have naturally extended this interaction into the outpatient setting. The panel will present the components that make up such ambulatory liaison programs, including methods of referral and consultation, precepting of primary care providers, curriculum development, and funding. Details of starting a new program will be presented. The audience will be encouraged to contribute their experiences with similar programs and thoughts regarding future development in this

area. Suggestions for improvements in existing programs will be solicited.

REFERENCES:

1. Wulsin LR: An agenda for primary care psychiatry. *Psychosomatics* 37:93-99, 1996.
2. Simon G, Ormel J, Von Korff, et al: Health care costs associated with depressive and anxiety orders in primary care. *Am J Psychiatry* 152:353-357, 1993.

Issue Workshop 60
PRACTICE AT THE LIMITS: LESSONS ABOUT BOUNDARIES

Chairperson: Simon L. Auster, M.D., *Department of Psychiatry, USUHS-School of Medicine, 4301 Jones Bridge Rd, Rm A1038, Bethesda MD 20814*
Participants: Jeffrey S. Akman, M.D., Paul S. Appelbaum, M.D., Marcia A. Meckler, M.D., Charles R. Privitera, Jr., M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should have a clear concept of the multileveled nature of boundaries in professional relationships, and should be able to recognize when and how boundary crossings can be used to facilitate the process of treatment without being disruptive.

SUMMARY:

The discovery that major ethical violations in the professional relationship between patient and physician are typically preceded by a series of seemingly benign "boundary crossings" has led to uneasiness about behaviors that might be interpreted as such crossings, even as many recognize that those behaviors may be essential to preserving the *human* relationship between the parties. Such negatively charged, legally tinged expressions as "slippery slope" and "risk management" applied in discussions of those behaviors are more intimidating than helpful to those whose circumstances or work place them "at the boundaries." The expansion of combined family practice/internal medicine and psychiatry residency programs will place more physicians in that position and makes the development of a broader perspective on this issue the more urgent. This workshop is a step in the effort to develop such a perspective.

In the practice of four of the presenters, a variety of boundary crossings inevitably occur: One of the panelists is a gay psychiatrist prominent in his local gay community; one is the only psychiatrist in an isolated island community of 3,000 Americans; one is a former military general and child psychiatrist with 21 years service; one is a full-time medical school teacher, family physician, and psychiatrist whose practice is limited to students, faculty, and their families. The fifth presenter is an expert on boundary issues in psychiatry. Attendees will be expected to join the presenters in examining their experiences of such boundary crossings for their short- and long-term treatment consequences and for their implications for the concept of boundaries itself.

REFERENCES:

1. Frick DE: Nonsexual boundary violations in psychiatric treatment. In: Oldham JM, Reba MB, eds. *American Psychiatric Press Review of Psychiatry* 13:415-432, 1994.
2. Gutheil TG, Gabbard GO: The concept of boundaries in clinical practice: theoretical and risk-management dimensions. *Am J Psychiatry* 150:188-196, 1993.

Issue Workshop 61
PSYCHIATRIC PSYCHOSOCIAL REHABILITATION SETTINGS

Chairperson: Mark Ragins, M.D., *Village ISA, 456 Elm Avenue, Long Beach CA 90802*
Participant: Karl S. Burgoyne, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand principles of psychosocial rehabilitation, working as a psychiatrist integrated into these settings and training residents in them.

SUMMARY:

As managed care moves into the public sector it will be expected to include a variety of nonclinical services, like clubhouses, drop-in centers, social centers, and rehabilitation programs. These services can be efficiently and effectively integrated with clinical services, but very few psychiatrists have sufficient familiarity with or training in the psychosocial rehabilitation philosophy and practice, and yet this approach can be a far more rewarding and appealing way of working through the standard CMHC. Psychiatrists who have become very experienced working with and training others in sophisticated psychosocial rehabilitation settings will (1) give an overview of the psychosocial rehabilitation philosophy, (2) describe adaptions we have made to construct our present roles in these programs, (3) describe our affiliation with several psychiatric residency programs and the lessons we've learned in training residents in this approach. Dr. Ragins is the 1995 winner of the APA award for psychiatric rehabilitation and Dr. Burgoyne won the HGH-UCLA 1995 residents' teacher award.

REFERENCES:

1. Links PL, Kirkpatrick H, Whelton C: *Psychosocial Rehabilitation and the Role of Psychiatrist.*
2. Harris M, Bergman H, Greenwood V: Integrating hospital and community systems for treating revolving door patients. *Hosp Comm Psychiatry.* 33:225-227, 1982.

Issue Workshop 62
PATIENT SELECTION IN THE BRIEF PSYCHOTHERAPIES

Chairperson: James E. Groves, M.D., *Department of Psychiatry, Harvard Medical School, 8 Hawthorne Place, Suite 102, Boston MA 02114-2383*
Participant: Miguel A. Leibovich, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should (1) be able to distinguish types of patients unsuitable for short-term therapy from patients likely to respond, and (2) know how to match various forms of brief treatment with specific categories of patients and their presenting foci in order to tailor treatment to the particular individual.

SUMMARY:

With growing economic pressures on clinicians to offer short-term therapy, increasingly greater numbers of individuals are likely to be treated briefly, including some Axis I and Axis II patients previously thought unsuitable for short-term dynamic treatment. Patient selection in this context assumes an even more important role than in the past. We view "short-term dynamic therapy" as not a

single entity but, rather, as a group of related treatments, each with its own indications, strengths, therapeutic effects, and limitations. These various submodalities within brief therapy have four essential similarities (brevity, focus, therapist activity, and patient selectivity), but critical differences exist among them. Patient selection, then, becomes a two-stage process—excluding patients unsuitable for any brief modality, and, next, matching a given patient and focus with the particular type of short-term therapy that patient is most likely to respond to. Participants will be invited to take part in case discussions and enact, direct, or critique "blind role plays" designed to illustrate matches and mismatches of patient and modality.

REFERENCES:

1. Groves JE (ed): *Introduction. Essential Papers on Short-Term Dynamic Therapy.* New York, New York University Press, 1-25, 1996.
2. Leibovich MA: Why short-term psychotherapy for borderlines? *Psychother Psychosom* 39:1-9, 1983.

Issue Workshop 63
FEMINIST PERSPECTIVES ON SEXUAL HARASSMENT CLAIMS

Chairperson: Patricia R. Recupero, M.D., J.D., *Department of Psychiatry, St. Elizabeth Medical Center, 736 Cambridge Street, Boston MA 02135*
Participants: Alison M. Heru, M.D., Terry Halbert, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop the participants will be familiar with the general principles of feminist legal theory and female psychosexual development and their application in a sexual harassment case. Participants will develop an ability to describe the psychological and legal sequelae of harassment.

SUMMARY:

Workplace sexual harassment complaints are an ever-increasing problem for industry, the legal profession, and the clinician. Both the forensic psychiatrist and the practicing clinician can benefit from an understanding of the legal elements of a sexual harassment case as well as some of the current theories of women's psychosexual development. A case of workplace sexual harassment will be presented. The legal elements of a sexual harassment case will be examined utilizing the legal context of the complaint. Theories of recovery, including hostile environment, will be reviewed. The feminist legal theories in support of and in opposition to such a legal claim will be reviewed. Particular emphasis will be given to female psychosexual developmental issues and the utility of feminist legal thought in developing a legal theory of recovery and damages.

Participants will be invited to comment on the theories presented as well as to present issues from workplace sexual harassment cases.

REFERENCES:

1. Halbert T, Inguli E: *Law and Ethics in the Business Environment*; New York, West Publishing Co., 1990.
2. Long BL: *Psychiatric Diagnoses in Sexual Harassment Cases*, 22; 195-203, 1994.

Issue Workshop 64
VIDEO CASE STUDIES OF COUPLES IN TREATMENT

Chairperson: Ian E. Alger, M.D., *Department of Psychiatry, New York Hospital-Cornell, 500 East 77th Street, New York NY 10162-0025*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: (a) identify critical stages of couples therapy; and, b) have an increased awareness and understanding of his/her style as a couples therapist.

SUMMARY:

Video segments of several actual clinical situations from the practice of the workshop leader will be used to focus on issues of impasse and stress during different stages of couples treatment, including issues of engagement, problem identification, change facilitation, and termination.

Workshop participants will join in discussion and comparison of their own clinical experiences around problems related to dual careers, struggles during separation and divorce, second marriages, sexuality and intimacy, and issues involving children as well as extended family members and peer and friendship networks.

REFERENCES:

1. Alger Ian: Marital therapy with dual-career couples, *Psychiatric Annals.* Vol. 21, No. 8, 1991.
2. Alger Ian: Marital Crises, *Psychiatric Therapies,* 20th Edition, Grune & Stratton, 1981.

Issue Workshop 65
UNDERSTANDING THE DYNAMICS OF ABUSIVE RELATIONSHIPS

Chairperson: Gary J. Maier, M.D., *Mendota Mental Health Institute, 301 Troy Drive, Madison WI 53704-1521*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) identify the need to diagnose couples involved in an abusive relationship. (2) identify a model that will differentiate an abusive fight from a fair fight. (3) identify control tactics used by an abuser to maintain power and control over a victim. (4) be able to counsel an abused woman on the need to seek professional, therapeutic, and legal help to break the cycle of abuse and as necessary, end an abusive relationship. (5) counsel an abuser on the need to seek professional help to identify and change the habit of abuse.

SUMMARY:

The goal of this workshop is to raise the consciousness of clinicians of the need for better diagnosis and treatment of battering men and battered women. Using a model that defines the stages of a fair fight so it can be contrasted with the stages of an abusive fight, the workshop leader will present examples of the differences so the participants can discuss the factors that must be considered when making the "diagnosis of abuse" (30 minutes).

In small groups, the participants will then discuss three cases of abuse and formulate a management plan, which will then be discussed with all participants. The cases will involve "couples" at different stages of abusive relationships. The treatment issues will range from no intervention through building a support group to legal remedies including the use of restraining orders and divorce (30 minutes).

Finally, the workshop leader will present a protocol for managing abusive relationships, enriched by the participant discussion. The participants will then discuss the practical implementation of the protocol as it applies to real abusive relationships in the context of the support system in their communities (30 minutes).

REFERENCES:

1. Maier FJ: Understanding the dynamics of abusive relationships, *The Psychiatric Times,* September, 1996.

2. Jones A, Schechter S: *When Love Goes Wrong.* Harper Perennial, New York, N.Y. 1992.

Issue Workshop 66
TREATMENT OF DISABILITY: HOW MUCH IS ENOUGH?
Joint Session with the Academy of Organizational and Occupational Psychiatry

Chairperson: C. Donald Williams, M.D., *402 East Yakima Avenue, Ste330, Yakima WA 98901-1143*
Participants: Brian L. Grant, M.D., Robert A. Haines, M.D.

EDUCATIONAL OBJECTIVES:

Controversies abound regarding what constitutes appropriate treatment for disabled workers. Disagreements as to whether the conditions predate the injury, are aggravated by it, or are causally related are common. At the conclusion of this presentation, the participant should be able to identify and address potential areas of dispute.

SUMMARY:

Patients with workplace injuries frequently develop psychiatric disorders, with major depression, pain disorders, and anxiety disorders being most prevalent. Upwards of 90% of such patients have comorbid disorders, with pre-existing Axis II conditions occurring in 60% to 80% of all cases. Such patients are clinically challenging. Because issues of causality influence whether treatment will be paid for, complex assessments are required to evaluate the degree of causal relationship to the workplace injury. The patient's interests, the treating psychiatrist's interests, and the insurance carrier's interests may frequently conflict. The treating psychiatrist's responsibility is to put the health and well being of the patient first. An independent psychiatrist, and not the treating psychiatrist, should be used to evaluate the claim with respect to forensic matters.

One written case example will be presented to the workshop participants to illustrate common examples of challenging diagnostic and administrative issues. The participants will be asked to render diagnoses, to state an opinion with respect to causality, and to make treatment recommendations. Structured choices will be presented and the results tabulated, with immediate report to the participants. Issues of agency and advocacy as well as the ethical pitfalls potentially present for all parties will be discussed.

REFERENCES:

1. Grant BL, Robbins DB: Disability, workers compensation, and fitness for duty, *Mental Health in the Workplace: A Practical Psychiatric Guide*, Kahn JP (ed), Van Nostrand Reinhold, New York, 1993.
2. Oldham, JM, et al: Comorbidity of Axis I and Axis II disorders, *Am J Psychiatry* 152:4, pp. 571-578, 1995.

Issue Workshop 67
CONCEPTUALIZATION AND BOUNDARIES OF TRAUMA

Chairperson: Malkah T. Notman, M.D., *Department of Psychiatry, Cambridge Hospital, 54 Clark Road, Brookline MA 02146*
Participants: Carl P. Malmquist, M.D., Elissa P. Benedek, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation participants should be able to have a clearer knowledge of criteria for judging trauma vs. stress, PTSD and its long-term course, and a more comprehensive understanding of the process.

SUMMARY:

The term trauma has been used increasingly widely. DSM-IV has broadened the definition of trauma to include individuals who have learned from someone else about an event that "involves death, injury or a threat to the physical integrity of another person," not only those that have the direct personal experience of such an event. This has brought recognition of the victims of secondary trauma, such as therapists of traumatized individuals. However, it also contributes to a blurring of the concept of trauma and of PTSD. When is an experience traumatic and when is it a stressful event in the course of life? What are the criteria? How does one judge and when should it be considered as a cause for PTSD? How long can one expect the PTSD to last? These experiences raise clinical issues as well as philosophical and legal ones. Internship, childbirth, the loss of an important person, hostile remarks as well as witnessing violence, rape, or experiences of the magnitude of the Holocaust have been considered traumatic. Without minimizing the seriousness of these experiences and their effects, it is important to discuss and clarify criteria for assessing them. This workshop will address these questions from a theoretical, clinical, and forensic perspective. Dr. Benedek will present a videotape of a patient who had a past traumatic experience for discussion by presenters and participants.

REFERENCES:

1. Herman J: *Trauma and Recovery*, Basic Books, 1992.
2. Speigel D, Classen C: Acute stress disorder. In: *Treatment of Psychiatric Disorders.* Gabbard G (ed.) Vol 2, APPI, pp 1521-1535.

Issue Workshop 68
PSYCHOLOGICAL FOSTER PARENTS: DEVELOPMENT OF IDENTITY

Chairperson: Robert L. Tyson, M.D., *Department of Psychiatry, University of CA at San Diego, 3252 Holiday Court, La Jolla CA 92037-1807*
Participants: Jodi H. Brown, M.D. Anne J. Adelman, Ph.D. Guari Agnzhotri, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to use developmental and psychodynamic understanding of identity formation to: (1) assess potential trauma to children who are placed in foster care, adopted, or reunified with biological families; (2) guide therapeutic interventions with these children, their biological and psychological families, and social, legislative, and judicial agencies responsible for their best interests.

SUMMARY:

Developmental and psychodynamic perspectives will be presented to demonstrate how identity formation is affected in children placed in custody situations (foster or adopted). These children reexperience trauma based on repeated disruption in attachments to initial caretakers and/or psychological parents. Disruption is related to not only object loss but also to differences between biological, foster, and adoptive parents: for these children attempt to integrate external differences (phenotypic features, socioeconomic status, education, ethnic, cultural, and spiritual values) and incorporate new information about "real parents" and other siblings, alien to their self-image. They frame behaviors and feelings as "old and new me," "real, foster, or adopted me," "bad and good me." Limited cognitive and emotional capacities lead to compartmentalization in reworking earlier representations of "self-schemas."

Three brief presentations highlighting developing self-image and fantasy formation in children in custody situations will be presented by Jodi Brown, M.D., Guari Agnihotri, M.D., and Anne Adelman, Ph.D. Dr. Robert Tyson will then discuss the case material. To

enlarge understanding, participants will be encouraged to contribute their experiences (1) with this group of children in great need of psychiatric intervention, and (2) with the multiple systems (family, social services, legislative, and judicial) responsible for protecting these children's interests.

REFERENCES:

1. Foster children in acute crisis: assessing critical aspects of attachment. Pilowsky D, Kates W. *J. Am. Acad. Child. Adolesc. Psychiatry,* 35:8 August 1996. Bowlby J: *Loss* New York: Basic Books, 1980.

Issue Workshop 69
PSYCHODYNAMIC PSYCHOTHERAPY AND MANAGED CARE: TRAINING AND PRACTICE

Chairperson: Carlos Blanco-Jerez, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, Box 81, New York NY 10032*
Participants: Michael E. Doyle, M.D. Sheila H. Gray, M.D., Allan Tasman, M.D., George M. Wohlreich, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able (1) to understand and evaluate the changes that managed care is bringing to the practice and training in psychodynamic psychotherapy; (2) to recognize the value and limitations of other treatment options in the current health care environment.

SUMMARY:

The increasing influence of managed care in psychiatry has made it imperative to consider its impact on the prescription and practice of different therapies. While managed care has fostered a heightened interest in outcomes, quality of care, and cost-effectiveness of interventions, it has also raised concerns regarding issues of confidentiality and rationing of care. Many fear that managed care organizations may be encouraging pharmacotherapy and short-term therapies in cases where psychodynamic therapy could be more appropriate. In an attempt to adapt to the new environment, some training programs are decreasing the amount of training in psychodynamic psychotherapy in favor of other treatment modalities, further increasing the risk that psychodynamic psychotherapy may become a lost art. This workshop will present the views of academicians, private practitioners, residents, and psychiatrist-administrators with experience in managed care in different parts of the country on the advantages and disadvantages of the current trends in training and practice of psychodynamic psychotherapy. Supporting and critical views will be presented. The workshop will encourage the exchange of opinions and experiences between presenters and attendees in order to learn how best to adapt to (or improve) this new environment.

REFERENCES:

1. Tasman A: The future of residency training in psychiatry. *Bull Menninger Clinic* 58:475-485, 1994.
2. Gabbard GO, Takahashi T, Davidson J, et al: A psychodynamic perspective on the clinical impact of insurance review.

Issue Workshop 70
COMPASSION FATIGUE: PSYCHIATRISTS AT RISK

Chairperson: Lyn Williams-Keeler, M.A., *Schizophrenia Service, Royal Ottawa Hospital, 1145 Carling Avenue, Ottawa ON K1Z 7K4, Canada*
Participant: Gail Beck, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should be able to recognize their own levels of compassion stress and compassion fatigue and to understand the differences between these forms of stress that are an inherent risk to the practice of psychotherapy. In addition, participants should be able to evaluate the efficacy of their own prevention and treatment strategies.

SUMMARY:

This workshop will be highly interactive. Workshop participants will be invited to complete three different questionnaires that have been studied for their efficacy in measuring the development of compassion stress and compassion fatigue in psychotherapists. One of these questionnaires is specifically designed to consider shifts in belief systems of psychiatrists who are exposed to narratives of trauma survivors. Workshop participants will score these self-report assessments, and the resultant discussion about the significance of symptom levels will also include the reactions and opinions of the workshop participants.

The differences between compassion stress and compassion fatigue will also be outlined and illustrated with specific clinical examples of therapists' responses to clients and patients exposed to significant traumatic events, such as combat veterans, peace-keepers, sexual abuse survivors, and police officers. In addition, an overview of the contributions of psychiatrists to the field of compassion stress and compassion fatigue during this century will be provided. Although research and clinical practice in this field has been dominated by American researchers and clinicians such as Figley and Pearlman, Canadian clinicians are now recognizing the significance of compassion stress and compassion fatigue for their clinical practices, research endeavors, and the training of future psychiatrists. Therefore, this workshop will conclude with a final interactive discussion of formal and informal intervention strategies to address the universal signs and symptoms of compassion stress and compassion fatigue for psychiatrists.

REFERENCES:

1. Figley CR (ed): Compassion Fatigue Coping With Secondary Traumatic Stress Disorder in *Those Who Treat The Traumatized.* Brunner/Mazel, NY, 1995.
2. Pearlman LA, Saakvitne KW: Trauma and the Therapist Countertransference & Vicarious Traumatization in *Psychotherapy with Incest Survivors.* W.W. Norton, NY, 1995.

Issue Workshop 71
BRIEF COGNITIVE BEHAVIOR THERAPY OF SUICIDAL YOUTH

Chairperson: John Piacentini, Ph.D., *Department of Psychiatry, UCLA/LA County DMH, 760 Westwood Plaza, Rm 68-251A, Los Angeles CA 90024*
Participants: M. Steven Sager, M.D., Lisa Song, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be able to understand the cognitive-behavioral formulation of adolescent suicidality, conduct an imminent danger assessment of acutely suicidal adolescents, demonstrate the key treatment techniques of reframing, creating a family problem hierarchy, role-playing, problem-solving, and negotiation, and demonstrate the use of tokens, the feeling thermometer, and coping cards.

SUMMARY:

Adolescent suicidality is increasing in prevalence and associated with significant morbidity including repeat attempts and completion, and-long term behavioral, emotional, and psychosocial disturbance. In spite of this, few treatments have been developed specifically for this group.

This workshop will present a detailed overview of Successful Negotiation Acting Positively (or SNAP). SNAP is a manualized six-session cognitive-behavioral treatment program for adolescent

suicide attempters and their families (Rotheram-Borus, Piacentini, et al., 1994). In SNAP, a series of structured activities are used to create a positive family atmosphere, enhance affect recognition and regulation, teach problem-solving and coping skills, and shift the family's attribution of their problems from difficult individuals to troublesome situations, thereby reducing conditions associated with future attempts. SNAP addresses a number of issues critical to successful interventions with suicidal adolescents including their historically poor treatment compliance, the need for family involvement in treatment, and an emphasis on coping and problem-solving strategies. Moreover, the brief, manualized format of SNAP is consistent with the growing trend toward standardized, empirically tested, and cost-efficient interventions.

The workshop will consist of didactic presentation, presenter demonstration of techniques, and audience participation in role-plays and mock therapy sessions.

REFERENCES:

1. Piacenthini J, Rotheram-Borus MJ, Cantwell C: Brief cognitive-behavioral family therapy for suicidal adolescents, In Vande-Creek L, et al: (eds), *Innovations in Clinical Practice: A Sourcebook,* Sarasota, FL: Professional Resource Press, 151-168, 1995.
2. Rotheram-Borus MJ, Piacentini J, et al: Brief cognitive-behavioral treatment for adolescent suicide aatempters and their families. *J Am Acad Child Adol Psychiatry* 33:508-517, 1994.

Issue Workshop 72
IMPLEMENTING SHARED MENTAL HEALTH CARE

Chairperson: Nick S. Kates, M.B., *Department of Psychiatry, McMaster University, 43 Charleton Avenue East, Hamilton ON L8N 1Y3, Canada*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) understand the role of the family physician in delivering community mental health care and the principles underlying shared care, and 2) work collaboratively and effectively with primary care physicians.

SUMMARY:

Although psychiatry is now placing greater emphasis on collaboration with primary care practitioners, relatively few mental health programs have succeeded in developing strong collaborative partnerships with referring family physicians. This workshop explores ways in which psychiatrists and other mental health workers can work more closely with primary care physicians. It covers the following five areas: (1) problems that currently exist in the relationship between psychiatry and primary care, (2) what family physicians are looking for from psychiatric services, (3) principles that should underlie shared (collaborative) mental health care, (4) strategies that can bring about shared mental health care, and (5) ways to implement these ideas in any community. The workshop will be interactive. Discussions of each of these five areas will begin with an introductory overview, after which workshop participants will be invited to contribute their own experiences.

REFERENCES:

1. Royal College of Psychiatrists and Royal College of General Practitioners. *Shared Care of Patients with Mental Health Problems.* London, 1993.
2. Strathdee G, Fisher N, McDonald E: Establishing psychiatric attachments to general practice: a six stage plan. *Psychiatric Bull* 16:284-286, 1992.

Issue Workshop 73
PHARMACOTHERAPY OF ADDICTIVE DISORDERS

Chairperson: Norman S. Miller, M.D., *Department of Psychiatry, University of IL at Chicago, 912 South Wood Street/MC 913, Chicago IL 60612*
Participant: Raye Z. Litten, Ph.D.

EDUCATIONAL OBJECTIVES:

To educate and discuss with the psychiatrist the pharmacotherapy of addictive disorders. The workshop will feature standard pharmacotherapies as well as newer research. Guidelines for use of pharmacotherapies in comorbid psychiatric disorders will be discussed.

SUMMARY:

The audience will understand the current standards of practice for the use of pharmacological therapies in addictive disorders. The pharmacological agents contained in the pharmacotherapies for alcoholism (and other drug addictions) can be classified according to the following major categories: (1) intoxication - agents that reverse the pharmacological effects of alcohol; (2) withdrawal - agents that suppress the pharmacological withdrawal from alcohol; (3) desire and compulsion - agents that block the preoccupation with acquiring alcohol and the desire to use, or to continue to use, alcohol; (4) psychiatric complications - agents that treat or ameliorate the psychiatric symptoms induced by alcohol and other drugs; (5) psychiatric disorders - agents that are used in patients who have addictional independent psychiatric disorders; and (6) concurrent drug addiction - agents used in drug addictions in addition to alcoholism. Conclusions for clinical practice and directions for research will be presented to, and discussed with, the audience.

REFERENCES:

1. Miller NS: Pharmacotherapy in alcoholics. *Directions in Psychiatry* 13(20):1-7, 1993.
2. Gorelick DA: Overview of pharmacological treatment approaches for alcohol and other drug addictions. *Psychiatric Clinics of North America* 16(1):141-156, 1993.

Issue Workshop 74
BALANCING PARENTHOOD AND PSYCHIATRY

Chairperson: Linda S. Godleski, M.D., *Department of Psychiatry, VA Medical Center, 800 Zorn Avenue, 116A, Louisville KY 40206*
Participants: Mary A. Haering, D.O., Steven B. Burton, M.D.

EDUCATIONAL OBJECTIVES:

The purpose of this workshop is to discuss the parenthood experience and strategies for balancing the impact of family with professional demands at various stages of psychiatrists' careers.

SUMMARY:

Clinicians face ongoing challenges in combining their professional roles with parenthood. From the onset of the pregnancy process throughout the developmental stages of their children, clinicians must negotiate their priorities and balance the impact of family and psychiatry. This workshop will provide an opportunity to discuss the experience of motherhood and fatherhood at all levels of psychiatric careers.

The pregnancy process begins with decisions about whether or when to start a family, and continues from fertility issues to delivery leave. Maternity/paternity policies and attitudes will be presented as

they relate to male and female psychiatric trainees and clinicians. The discussion will address conflicting demands, practical realities of time limitations, flexible job scheduling, and recommendations for improving administrative and collegial support. Unique aspects of a psychiatric career as it relates to parenthood will be highlighted.

REFERENCES:

1. Stotland NL (ed) Psychiatric Aspects of Reproductive Technology. *American Psychiatric Press, Inc.*, Washington 1990.
2. Watson W, Watson L, Wetzel W, et al: Transition to parenthood: What about fathers? *Canadian Family Physician* 41:807-812, May 1995.

Issue Workshop 75
EVALUATION OF PSYCHIATRIC CLERKS: THE ORAL EXAMINATION

Chairperson: Catherine S. Brennan, M.D., *Department of Psychiatry, University of CA/Davis Med Ctr, 2315 Stockton Boulevard, Sacramento CA 95817*
Participants: Paul D. Cox, M.D., Donald M. Hilty, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) understand the role of the oral exam in the evaluation and experience of medical students on psychiatric rotation; (2) formulate and implement an oral examination.

SUMMARY:

The grading of students during the psychiatric clerkship is multifactorial. Commonly used approaches include the evaluation by preceptors and the NBME Part II Psychiatry Subject Examination (NBME-PSE). Preceptors' evaluations are criticized for poor inter-rater reliability and multiple choice-type examinations for limited capacity to measure critical thinking and problem-solving abilities. Other specialty clerkships use an oral examination as part of the evaluation process. A review of the literature reveals that an oral examination is used for psychiatry clerkships in England and Canada, but only rarely in the United States. This type of examination serves as an opportunity to integrate problem-based learning into the evaluation process. We piloted an oral examination for the psychiatry clerkship with attention to inter-rater reliability, then instituted an oral examination for the clerkship, now administered to 75 students. Correlations between the oral exam score, NBME-PSE score, and clinical evaluations were made. In this workshop, we will review the literature on oral examinations and discuss a format for the exam, controls for inter-rater reliability, and correlates between the oral exam and other methods of grading. Participants will have an opportunity to develop an oral examination for implementation.

REFERENCES:

1. Miller DA, Sadler JZ, Mohl PC: Critical thinking in preclinical course examinations. *Academic Medicine*, 68(4):303-5, Apr 1993.
2. Allison R, Katona C: Audit of oral examination in psychiatry. *Medical Teacher*, 14:383-9, 1992.

Issue Workshop 76
TEACHING SOLUTION-ORIENTED THERAPY TO RESIDENTS

Chairperson: Thomas E. Steele, M.D., *Department of Psychiatry, Medical University of SC, 171 Ashley Avenue, Charleston SC 29425*
Participants: Stephen A. McLeod-Bryant, M.D., Lorraine R. Dustan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe how the growth of managed care complicates teaching psychotherapy; identify problems in teaching time-sensitive treatments to residents; list technical principles and attitudes basic to solution-oriented therapy; and identify patients for whom solution-oriented techniques are appropriate.

SUMMARY:

Training oriented primarily toward today's job market may not prepare residents for professional growth throughout their careers. Residents must learn to provide "customer-friendly," time-sensitive, cost-effective services, but they must also learn psychodynamics, which remains the best foundation for understanding doctor-patient interactions across the diagnostic spectrum. Yet learning short-term *dynamic* therapy is difficult for novices, who must respond trenchantly to the most salient dynamic issue of the moment while still struggling to recognize those issues.

We approach this dilemma by teaching solution-oriented treatment, a time-sensitive, focused approach which, because it is quite distinct from dynamic therapy, seems to interfere less with teaching psychodynamics. Solution-oriented treatment emphasizes the importance of language, the therapist's role in co-creating the patient's reality, and utilization of latent patient strengths. Challenges in teaching this approach include ensuring that residents do not use time-sensitive treatment to avoid patients who need prolonged therapy or who stimulate unpleasant countertransferences. Most practitioners of this approach are nonphysicians, so psychiatrists are in a unique position to apply elements of it to patients with psychiatric illnesses as well as "problems in living." The audience will be encouraged to share their experiences with teaching and practicing time-sensitive treatments, and to learn how solution-oriented techniques may be useful.

REFERENCES:

1. O'Hanlon WH, Weiner-Davis M: *In Search of Solutions: A New Direction In Psychotherapy*. WW Norton, New York, 1989.
2. Hoyt MF: *Brief Therapy and Managed Care: Readings For Contemporary Practice*. Jossey-Bass, San Francisco, 1995.

Issue Workshop 77
PSYCHIATRIC TRAINING IN PRIMARY CARE SETTINGS

Chairperson: Linda B. Andrews, M.D., *Department of Psychiatry, Baylor College of Medicine, One Baylor Plaza, Rm 625D, Houston TX 77030*
Participants: Lucy J. Puryear, M.D., James W. Lomax II, M.D., Mary Van Sickle, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) identify advantage/disadvantages and barriers to establishing psychiatry residency training experiences in nonpsychiatric settings. (2) identify reasons for psychiatric consultations and diagnostic assessments/treatment recommendations made by psychiatrists working in these nonpsychiatric settings. (3) understand nonpsychiatric physicians' perspectives of benefits to residency training and patient care of providing these psychiatric services.

SUMMARY:

This workshop will address the training of psychiatry residents in nonpsychiatric settings (OB/GYN and internal medicine), including Baylor's reasons for and methods of pursuing these training experiences, the benefits to resident education and patient care that have resulted from these training assignments, and possible barriers to establishing training experiences in nonpsychiatric settings.

A Baylor PGY-III resident has provided psychiatric consultation/liaison services to a public hospital high-risk OB/GYN clinic and community OB/GYN clinic since July 1995, and to a public hospital internal medicine clinic and a private hospital geriatric medicine

clinic since July 1996. Presenters will discuss the most frequent reasons for psychiatric consultations and the most frequent psychiatric diagnostic assessments and treatment recommendations made in these settings.

Almost no literature exists to compare and contrast similar models of education, so the presenters will encourage audience participation to assess if others are experimenting with training psychiatric residents in nonpsychiatry settings. Since these are novel training experiences, sharing data and experiences is important to foster innovative program expansions, especially given the national trend toward primary care specialties and the ever shrinking financial resources available to residency training programs.

REFERENCES:

1. Kates N: Training psychiatric residents to work with primary care physicians: results of a national survey, *Canadian Journal of Psychiatry - Revue Canadienne de Psychiatrie* 38(2):79-82, March 1993.
2. Epstein SA, Gonzales JJ: Outpatient consultation liaison psychiatry: a valuable addition to the training of advanced psychiatry residents, *General Hospital Psychiatry,* 15(6):369-74, November 1993.

Issue Workshop 78
PSYCHIATRISTS AND ETHICS COMMITTEES

Chairperson: Tia P. Powell, M.D., *Department of Psychiatry, Columbia University, 500 West End Avenue, Ste GR-J, New York NY 10024*
Participants: Stewart B. Fleishman, M.D., Marguerite S. Lederberg, M.D.

EDUCATIONAL OBJECTIVES:

Participants will gain both practical and theoretical information on the increasingly common and important relationship of psychiatrists to ethics consultation and ethics committees.

SUMMARY:

This interactive workshop will include brief presentations on three different aspects of the psychiatrist's role on the hospital ethics committee. Dr. Tia Powell will discuss the process of clinical ethics consultation, and in particular how psychiatric expertise may come into play in assessing these cases. Issues of capacity evaluations, the interplay of capacity and depression, and problems with countertransference will be addressed. Dr. Stewart Fleishman will review his role as ethics committee chair, with a focus on consensus building, education, and policy formation. Dr. Marguerite Lederberg will analyze the interface between psychiatry and ethics with a view to recognizing pseudo-psychiatry, pseudo-ethics, and mixed psychiatry-ethics consultation. Dr. Lederberg will also discuss ethics education for mental health professionals. After the three brief presentations, the speakers will allow ample time for audience discussion.

REFERENCES:

1. LaPuma J, Schiedermayer D: Ethics consultation: skills roles and training *Annals of Internal Medicine.* 114(2):155-160, 1991.
2. Powell T, Lowenstein B: Refusing life-sustaining treatment after catastrophic injury: ethical implications. *The Journal of Law, Medicine and Ethics.* 24(1):54-61, 1996.

Issue Workshop 79
MEDICATION IN THE FIELD: TO TREAT OR NOT TO TREAT?

Chairperson: David C. Lindy, M.D., *CMHS, Visiting Nurse Services, 1250 Broadway, 3rd Floor, New York NY 10001*
Participants: Neil Pessin, Ph.D., Lawrence B. Jacobsberg, M.D., Madeline O'Brien, M.D., Leila B. Laitman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the issues regarding the decision to medicate psychiatric patients in the field.

SUMMARY:

As psychiatric care moves increasingly into the community, the use of psychiatric medications in "nontraditional" settings has also increased. Clinicians practicing "in the field" often encounter the dilemma of treatment in suboptimal conditions vs. no treatment at all. The Visiting Nurse Service of New York (VNS) provides community-based, psychiatric outreach services to over 5,000 patients per year in New York City. We have presented preliminary data regarding the use of medication in the field by psychiatrists working in nine different VNS programs. Aggregate demographic and descriptive data (N = 265) showed a heterogeneous group from which it was difficult to draw specific conclusions. In this workshop, we will present subsequent analyses of a larger sample of the study cases (N = 390) with more specific delineation of medication patterns in terms of patient diagnosis, symptomatology, demographic factors, and program, including issues of program staffing and goal. Since our data are uncontrolled and reflect practice only within our own mental health "ecology," we will use the workshop as an opportunity to share views and experiences with interested colleagues working in their respective settings. With our data providing a starting point, panelists and audience members will form a study group to make specific recommendations regarding the optimal use of medication in the field.

REFERENCES:

1. Cohen NI: *Psychiatry Takes to the Streets: Outreach and Crisis Intervention for the Mentally Ill.* New York: The Guilford Press, 1990.
2. Simpson CJ, Seager CP, Robertson JA: Home-based care and standard hospital care for patients with severe mental illness: A randomised controlled study. *Br J Psychiatry* February: 2:239-243, 1993.

Issue Workshop 80
TREATING OFFSPRING OF HOLOCAUST SURVIVORS: AN UPDATE

Chairperson: Andrei Novac, M.D., *Department of Psychiatry, University of California, 400 Newport Center Dr, Ste 309, Newport Beach CA 92660-7604*
Participants: Rita R. Newman, M.D., Rachel Yehuda, Ph.D., Yael Danieli, Ph.D., Cecilia Schulberg, M.F.C.C., Aaron Hass, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation the participants should: (1) become familiar with the latest concepts concerning treatment of offspring of Holocaust survivors; (2) understand the necessity of an eclectic, multidisciplinary approach in their treatment; and (3) comprehend the concept of intergenerational issues of trauma.

SUMMARY:

Renewed interest in the psychological sequelae of Holocaust survivors and their offspring among psychiatrists, psychologists, clinicians, and social scientists has triggered additional research into the identity and levels of functioning of Holocaust survivors, their children, and grandchildren. The definition of a Holocaust survivor has been updated. The numbers in the Holocaust community have reached an all time high currently including not only the aging survivors but also offspring and grandchildren who have been born since the end of World War II. The passage of time has loosened the defenses against the disturbing feelings associated with "revis-

iting" the Holocaust. A preoccupation persists with problems of identity, family history, and the fate of relatives during World War II among offspring of aging survivors. Significant research has suggested common neurobiological alterations in Holocaust survivors and their offspring, and a specific clinical vulnerability in individuals who grew up with traumatized parents. These intergenerational aspects of trauma as currently reflected by recently published data will be examined. This year's workshop reflects the joint effort of clinicians and researchers to develop guidelines for the treatment of offspring of Holocaust survivors, with specific recommendations for medical treatment. Different psychotherapeutic parameters, including trauma-focused group therapy and self-help will be discussed. Two newer techniques ("reconciliation" and "GIM techniques") will be examined. Participation from the audience will be encouraged.

REFERENCES:

1. Danieli Y: *An International Handbook of Multigenerational Legacies of Trauma,* Plenum (in press).
2. Hass A: *The Aftermath: Living with the Holocaust,* Cambridge University Press, 1995.
3. Yehuda R, Elkins A, Binder-Brynes K: Dissociation in aging Holocaust survivors, *Am J Psychiatry* 153:935-940, 1996.
4. Merritt S, Schulberg C: GIM and collective grief: facing the shadow of the Holocaust, *J Ass Music and Imagery* 4:103-120, 1995.

Issue Workshop 81
COMPREHENSIVE APPROACH TO SMALL-GROUP TEACHING

Chairperson: Richard G. Tiberius, Ph.D., *Department of Psychiatry, University of Toronto, 399 Bathurst Street, Toronto ON M4X 1B3, Canada*
Participants: Ivan Silver, M.D., Brian D. Hodges, M.D., Mark Hanson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop participants should appreciate the importance of the major components of small group teaching and be able to identify appropriate training methods for each component. This framework should enable them to direct their future training in small group teaching toward a comprehensive plan.

SUMMARY:

The comprehensive approach to small group teaching was inspired by an all too common occurrence—teachers who suffer from poor student evaluations despite their having participated in many workshops on this topic. We are convinced that the problem lies in the narrow focus of the typical workshop on small group teaching. Typically, they are designed to teach one or two essential components of small group teaching but fall short of the comprehensive program needed to achieve expertise in such a multifaceted activity.

Ironically, the various types of knowledge, skills, and attitudes that constitute expertise in leading small groups have been known since 1959 (Miles). These include (a) knowledge about small groups; (b) sensitivity, attitudes, feelings, and self-awareness; and (c) skills, both heuristic (the so-called "tricks of the trade") and diagnostic (knowing which strategy to use for each situation). Training methods for all the competencies will be provided in a full set of detailed handouts. Participants will engage in exercises demonstrating some of these competencies (not all of the competencies can be demonstrated in a brief workshop), and in discussions about others. This workshop can be viewed as a "sampler" to be followed by a series of focused training sessions targeted to specific competencies.

REFERENCES:

1. Barrows HS: *practice-based learning: problem-based learning applied to medical education.* Springfield, Ill: Southern Illinois University School of Medicine, 1994.
2. Tiberius, R. G. (1995). *Small group teaching: a trouble-shooting guide.* Toronto, Ontario: OISE Press.

Issue Workshop 82
TONING AND CHANTING FOR DISSOCIATIVE AND DEPRESSED PATIENTS

Chairperson: Leah J. Dickstein, M.D., *Department of Psychiatry, University of Louisville, 323 East Chestnut Street, Louisville KY 40292*
Participant: Alice Cash, Ph.D.

SUMMARY:

Toning and chanting, known as vibrational medicine, are ancient forms of healing. These techniques are regaining acceptance by the medical community.

Two patients in treatment with a psychiatrist (Dr. Dickstein) were referred to Dr. Cash for music therapy. The first was being treated for major depressive disorder with comorbid anxiety symptoms. She verbalized a constant wish to scream. The second patient with a dissociative identity disorder is an accomplished musician and has been an instrumentalist all her life.

While continuing in psychodynamic psychotherapy and pharmacotherapy these patients were in ongoing music therapy. Their structured music therapy programs and current positive outcomes will be presented. There will be sufficient time for discussion. Demonstration of toning and chanting involving workshop participants will also be included.

REFERENCES:

1. *Music Therapy Perspectives,* V. 10, #1, National Association of Music Therapy, 1992.
2. *Music Therapy in the Treatment of Adults with Mental Disorders,* Robert F. Unkefer RF (ed): Schermer Books, 1990.

Issue Workshop 83
PSYCHOTHERAPY IN THE 21ST CENTURY

Chairperson: Malkah T. Notman, M.D., *Department of Psychiatry, Cambridge Hospital, 54 Clark Road, Brookline MA 02146*
Participants: Martha J. Kirkpatrick, M.D., Glen O. Gabbard, M.D., Susan G. Lazar, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be able to assess the role of psychotherapy in the current range of options and constraints regarding treatments and recognize where and when it is appropriate.

SUMMARY:

Major changes are occurring in the structure of the support for psychotherapy. Reimbursement within managed care, constraints on psychotherapy by HMO's economic pressure for even briefer therapy, and a reliance on psychopharmacology have undermined the importance of psychotherapy. Nevertheless, psychotherapy remains one of the most effective treatments for many conditions and is attracting new interest as an important component of comprehensive treatment. How do we understand its value as the end of the century approaches? This workshop will discuss some key aspects of psychotherapy in this context. The following topics will be addressed: effectiveness and cost effectiveness of psychotherapy by Glen Gabbard and Susan Lazar, psychotherapy training by Malkah Notman,

and psychotherapy and feminism by Martha Kirkpatrick. Audience participation will be encouraged.

REFERENCES:

1. Nadelson C, Notman M: Gender Issues in Psychiatric Treatment in Gabbard G (ed): *Treatments of Psychiatric Disorders* 2nd *Edition,* Vol 1 pp35-53, APPI, 1995.
2. Gabbard G: Psychodynamic Psychotherapies. In Gabbard G (ed): *Treatments of Psychiatric Disorders* 2nd *edition,* pp1205-1220 Vol 1, APPI, 1995.

Issue Workshop 84
HCFA, HMO'S, AND INPATIENT PSYCHIATRIC EDUCATION

Chairperson: Kenneth R. Silk, M.D., *Department of Psychiatry, University of Michigan, B2919 CFOB/Box 0704, Ann Arbor MI 48109*
Participants: Allan Tasman, M.D., Oladapo T. Tomori, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, participants will appreciate how the changes that are occurring on inpatient psychiatry units directly affect psychiatric education. Participants will develop a better appreciation of how to adapt and modify the psychiatric training of residents and medical students to these changes.

SUMMARY:

As managed care has dramatically shortened lengths of stay and as federal regulations have threatened the independent clinical practice by residents on inpatient units, the question is raised as to whether residents and medical students should continue to be trained on psychiatry inpatient units. This workshop discusses this issue with panelists who include a senior resident, an associate chair of psychiatry, and a current chair of psychiatry who has been a director of residency training. The audience is encouraged to bring their own ideas and clinical experience to the workshop, which will provide an opportunity for a free exchange between the panel and the audience. Issues to be discussed include: Should training and education continue on inpatient units? If training is to continue, is there the time or the need to teach anything beyond diagnosis and pharmacologic intervention in crisis situations and in chronic treatment-resistant conditions? Is there a continuing need to teach the evaluation of the variety of psychosocial and other environmental stresses that could lead to illness exacerbation and eventual hospitalization, or should these concepts be taught in outpatient or other settings? Inpatient settings demand that we evaluate, diagnose, and institute treatment in a very short time while developing a reasonable, comprehensive discharge plan for very ill patients. Is it necessary, then, to teach residents and medical students to work in multidisciplinary teams, and is the inpatient unit the best place for such experiential training? Finally, are inpatient units the ideal setting in which to teach integration of biological, diagnostic, environmental, and interpersonal system principles in psychiatry, or are the patients too ill and the third party payers too demanding for any broad teaching to take place beyond diagnosis and rapid institution of pharmacologic treatment?

REFERENCES:

1. Silk KR, Eisner W, Allport C, et al: Focused time-limited inpatient treatment of borderline personality disorder. *Journal Personality Disorders* 8:268-278, 1994.
2. Summergrad P, Herman JB, Weilburg JB, et al: Wagons ho: forward on the managed care trail. *Gen Hosp Psychiatry* 17:251-259, 1995.
3. Tasman A: The future of residency training in psychiatry. *Bull Menninger Clin* 58:475-85, 1994.

Issue Workshop 85
MEN-ONLY GROUPS: AN EASY WAY TO GET THEM INTO PSYCHOTHERAPY

Chairperson: Miguel A. Leibovich, M.D., *Department of Psychiatry, Harvard Medical School, 83 Cambridge Park Way, #609W, Cambridge MA 02142*
Participants: Max Day, M.D., Peter Feldman, Ph.D., Scott Reinhardt, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop participants should be able to develop techniques (a) to motivate men to enter the psychotherapeutic process via the group psychotherapy modality, (b) to organize men-only groups, and (c) to learn about men's particular ways of approaching conflict resolutions.

SUMMARY:

Women still outnumber men as psychotherapy patients. However, in the last few years there has been a noticeable increase in the interest by men for embarking on psychotherapeutic treatment. Still it is very difficult for many of them to accept the value of the "talking cure." These men are frequently dragged into therapy by women who want them to be "changed" or when they find themselves isolated and lonely due to their inability to develop satisfying relationships. Men in general are not used to looking inside and avoid self-exploration and self-understanding. Fears of humiliation or of weakening their image prevent them from exposing themselves to their emotional, sensitive side. Group psychotherapy is a therapeutic mode that often appeals to men as being less threatening. The intimacy of the individual psychotherapeutic relationship is often found to be too anxiety provoking. The workshop will demonstrate how men-only psychotherapy groups offer a "safe-comfortable" environment that facilitates the entry as well as the retention of male patients in the psychotherapy process. The workshop will involve the audience in an interactional atmosphere and participants, men and women, will have the opportunity of experiencing themselves in a "mock" group therapy session.

REFERENCES:

1. Levant RF: Psychological services designed for men: a psychoeducational approach, *Psychotherapy,* Vol. 27, pp. 309-315 Fall, 1990.
2. Pollack WS: Men's development and psychotherapy: a psychoanalytic perspective, *Psychotherapy,* Vol. 27, pp. 316-321, 1990.

Issue Workshop 86
INTEGRATING COGNITIVE-BEHAVIOR THERAPY STRATEGIES INTO LONG-TERM TREATMENT

Chairperson: Ari E. Zaretsky, M.D., *Department of Psychiatry, Mount Sinai Hospital, 600 University Avenue, #941A, Toronto ON M5G 1X5, Canada*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should acquire basic skills in integrating a cognitive conceptualization as well as various basic cognitive strategies into the long-term psychotherapy treatment of difficult or resistant patients.

SUMMARY:

In clinical psychotherapy practice many patients have comorbid personality or characterological issues that even if not the primary problem being treated, play a crucial role in complicating treatment.

Although the psychodynamic tradition has a rich literature on the conceptualization of resistance and characterological defense mechanisms, the cognitive approach may also have something useful and unique to offer clinicians when working with patient resistance and impasses in therapy.

In this workshop, participants will learn how a sophisticated cognitive conceptualization may augment their psychodynamic formulation. Participants will then learn how specific cognitive strategies such as agenda/goal setting, Socratic questioning, the downward arrow techniques, automatic thought recording, and core belief worksheets, can help to facilitate and accelerate the long-term working through process and can also help to overcome impasses in ongoing therapy with difficult patients.

The workshop will utilize actual clinical case material, videotaped psychotherapy sessions, and experiential techniques such as dyadic role playing to enhance the learning and skill acquisition of the workshop participants.

REFERENCES:

1. Beck AT, Freeman A, et al: *Cognitive Therapy of Personality Disorders.* New York, Guilford Press, 1990.
2. Beck JS: *Cognitive Therapy: Basics and Beyond.* New York, Guilford Press, 1995.

Issue Workshop 87
QUALITY MANAGEMENT AND THE JOINT COMMISSION SURVEY

Chairperson: Roger L. Coleman, M.D., *Department of Psychiatry, University of Connecticut, c/o 8 Salem Road, Woodbridge CT 06525*
Participants: Leo E. Kirven, Jr., M.D., Richard L. Elliott, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should be able to develop, implement, monitor, and evaluate quality management programs at their facilities with specific reference to the standards of the Joint Commission on Accreditation of Healthcare Organizations; to understand the relationship between clinical management and performance improvement; and to implement programs that integrate both.

SUMMARY:

This workshop is an updated version of one given previously. The presentation will provide educational and practical experience in developing quality management programs and in preparing these programs to meet the standards of the Joint Commission on Accreditation of Healthcare Organizations. The presenters, who are surveyors for the Joint Commission and facility medical directors, will provide information from both perspectives. This session, which is designed to give practical, hands-on experience, will explain both the content of the survey and the process of implementing quality management standards within psychiatric and substance abuse departments and facilities. Topics relating to the Joint Commission standards include credentialing and appointment requirements, medical staff organization, peer review, bylaws, and performance improvement. The implementation of quality management programs, including development of clinical indicators, problem solving, and leadership will be addressed. The workshop will deal with the Joint Commission's emphasis on performance improvement and will promote discussion of issues relating to the emphasis and other issues including the use of functional, in contrast to discipline-specific, standards, and the role of the medical staff in facility leadership.

REFERENCES:

1. Elliott R: Applying quality improvement principles and techniques in public mental health systems. *H&CP* 45:439-444, 1994.
2. Coleman R, Hunter D: Contemporary quality management in mental health. *American Journal of Medical Quality,* 1994.

Issue Workshop 88
IT DOESN'T NEED TO BE PRIVATE PRACTICE VERSUS LIFE

Chairperson: Eve A. Hershberger, M.D., *Department of Psychiatry, University of Florida, 1203 NW 12th Avenue, Gainesville FL 32601*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant will have an explicit concept of the interactive context of financial, temporal, and emotional overhead implicit in private practice designs. Participants will develop an increased understanding of how the type of practice they create will influence their overall life patterns.

SUMMARY:

From paper clips to computers, from a one-person office to a group negotiating for managed care contracts, each participant will be invited to design his/her own private practice setting. In the course of the workshop experienced practitioners may share their expertise with those just starting out. Fantasies of money to be made with minimum time and effort while providing excellent patient care could be the starting point of this workship directed toward integrating practice style with overall life goals. The first step is to know the overhead structure of the chosen practice design. The participants will be guided to create detailed overhead projections for their practices. Items omitted, over- or under-valued will be highlighted for discussion by the leader or by other participants. The effect of managed care will be included. After clear definition of the financial overhead, the concepts of temporal and emotional overhead needed to meet the financial requirements will be explored. The group will then be encouraged to return to their life fantasies and goals—now viewed within the context of financial, temporal, and emotional overhead of their practices. Creative but practical interactions of private practice style with life goals will be sought.

REFERENCES:

1. Nissen R: Successfully solo. *Minnesota Medicine* 77(3): 10-15, 1994.
2. Schreter RK: Earning a living: a blueprint for psychiatrists. *Psychiatric Services* 46(12):1233-35, 1995.

Issue Workshop 89
HOSPITAL PHYSICIAN HEALTH COMMITTEES: INNOVATIVE MODELS

Chairperson: Patti Tighe, M.D., *Department of Psychiatry, Northwestern University, 676 North St. Clair, #1785, Chicago IL 60611*
Participants: Marsha W. Snyder, M.D., Robert P. Schwartz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will understand the magnitude of the problem of physicians' failure to obtain proper medical care for themselves. They will be acquainted with several models for hospital-based physician health committees and how to establish an effective committee in their own hospital and learn techniques to best insure success.

SUMMARY:

A large and rapidly growing literature documents the problem of physicians' reluctance to acknowledge the presence of and seek appropriate treatment for illness in themselves, particularly major

depressive disorder and alcohol and drug abuse and dependence. Consequences include the unnecessary development of late stage illness, destruction of family and personal life, developmental damage to children, and practicing medicine while impaired.

Conscious and unconscious resistance and lack of understanding of the problem contribute to maintaining the status quo. While medical schools and residencies largely ignore this issue, interest is developing in hospitals across the country to create local physician health, assistance, and wellness committees. Numbers are few, however, and extant committees tend to be ad hoc with an exclusive attention to late-stage alcohol dependence.

This workshop will present three innovative models (representing three very different hospital organizational structures) for hospital-based physician health committees. Background, organization, administrative obstacles, successful and unsuccessful strategies, and solutions to predictable problems will be described.

Participants will be encouraged to present the experiences, difficulties, impediments, and solutions they have encountered or anticipate in organizing a committee in their own hospital.

REFERENCES:

1. Lang DA: *The Disabled Physician. Problem-Solving Strategies for the Medical Staff.* Chicago, American Hospital Publishing, 1989.
2. Samkoff JS, McDermott RW: Structure of a hospital's impaired physician committee. *Pa Med.* 34-39, 1990.

Issue Workshop 90
SECONDARY TRAUMATIC RESPONSES AND COMPASSION FATIGUE IN CLINICIANS TREATING TRAUMA SURVIVORS

Chairperson: Patricia L. Paddison, M.D., *CWH-C8, Virginia Mason Medical Center, PO Box 900, Seattle WA 98111*
Participant: Jennifer D. Bolen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize signs and symptoms of secondary trauma responses in a treating clinician. Avoiding the occurrence of this as well as ways to heal secondary trauma responses will be discussed.

SUMMARY:

There is little written about secondary traumatic responses in clinicians treating trauma survivors, such as an acute stress disorder or an adjustment disorder. The purpose of this workshop is to discuss secondary traumatic responses that occur in clinicians treating trauma survivors such as sexual abuse victims or physical abuse victims. This secondary trauma response may manifest itself in behaviors such as compassion fatigue, stopping therapy with survivors, or avoiding the discussion of painful material. Clinicians may also experience sleep disturbance, nightmares, or increased fears for their own personal safety and that of their families.

These patients often evoke strong responses (countertransference) in their caregivers. Demands placed on the caregiver and the treatment may lead to boundary problems such as overinvolvement. Treatment gains may be slow or illusory leading the clinician to feel helpless or to try alternative treatment modalities that may not be beneficial to the patient. Sometimes the therapist may assume more responsibility for the patient's gains or lack thereof than the patient. Honest discussion of these issues will hopefully shed light on ways to heal ourselves and thus continue to heal our patients. The audience will discuss these issues and offer suggestions for healing.

REFERENCES:

1. Gladding ST: Counselor self-abuse. *J of Mental Health Counseling.* 13: 414-419, 1991.
2. Hartman CR: The nurse-patient relationship and victims of violence. *Scholarly Inquiry for Nursing Practice.* 9(2): 175-192, 1995.

Issue Workshop 91
DYNAMIC THERAPY WITH SELF-DESTRUCTIVE PATIENTS WITH BPD

Chairperson: Eric M. Plakun, M.D., *Admissions, The Austen Riggs Center, PO Box 962/25 Main Street, Stockbridge MA 01262*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to enumerate principles in the dynamic psychotherapy of self-destructive borderline patients, recognize the importance of the establishment and maintenance of a therapeutic alliance with such patients, and be familiar with the countertransference problems inherent in work with these patients.

SUMMARY:

Psychotherapy with self-destructive borderline patients is a formidable psychotherapeutic challenge. Although much has been written about metapsychological and dynamic issues with these patients, little has been written that helps clinicians focus on technique. This workshop begins with a 20- to 25-minute presentation of seven principles crucial to the establishment and maintenance of the therapeutic alliance in the psychodynamic psychotherapy of self-destructive borderline patients. The principles are: (1) inclusion of the self-destructive behavior in the initial therapeutic contract; (2) metabolism of the countertransference; (3) engagement of affect; (4) nonpunitive interpretation of the patient's aggression; (5) assignment of responsibility for the preservation of the treatment to the patient; (6) a search for the perceived injury from the therapist that may have precipitated the self-destructive behavior; and (7) provision of an opportunity for reparation. After the presentation, the remaining hour will be used for an interactive discussion of case material. Although the workshop organizer will offer cases to initiate discussion, workshop participants will be encouraged to offer case examples from their own practices. The result should be a highly interactive opportunity to discuss this challenging treatment problem.

REFERENCES:

1. Plakun EM: Prediction of outcome in borderline personality disorder. *Journal of Personality Disorders:* 5:93-101, 1991.
2. Plakun EM: Principles in the psychotherapy of self-destructive borderline patients, *Journal of Psychotherapy Practice and Research* 3:138-148, 1994.

Issue Workshop 92
GENESIS OF A MANAGED BEHAVIORAL HEALTH CARE FELLOWSHIP

Chairperson: Steven J. Schleifer, M.D., *Department of Psychiatry, New Jersey Medical School, 185 South Orange Avenue, Newark NJ 07103*
Participants: Michael A. Silver, M.D., Beverly R. Delaney, M.D., Pamela Y. Williams, M.D., Jonathan D. Book, M.D.

EDUCATIONAL OBJECTIVES:

The participant will gain an increased awareness of issues germane to the interaction between managed care and psychiatric training, as well as an appreciation of potential models of collaboration among managed care organizations, academic medical centers, trainees, and practitioners.

SUMMARY:

Managed behavioral health care has challenged traditional vehicles of mental health care delivery. With increasing patient contacts under managed care oversight, it becomes essential to train future psychiatrists (and other behavioral health practitioners) to participate effectively within this system. Further, psychiatrists' managerial and reviewer roles in managed care organizations (MCO's) are likely to expand. UMDNJ-New Jersey Medical School, in collaboration with Green Spring Health Services, a managed behavioral health care company, has developed a unique one-year fellowship, providing training in both provider and reviewer roles and exposure to administration and relevant research. A senior resident elective, completed June, 1996, piloted this program. Additionally, Green Spring and the University of Maryland department of psychiatry have conducted a successful senior resident elective for five years. These collaborations require novel approaches for both the academic organization and MCO, posing challenges in curriculum definition, the melding of corporate and academic cultures, and funding. The workshop will expand on our experiences from a variety of perspectives and describe implications for psychiatric education. These perspectives include the residency training director; MCO medical director; academic chair; trainees; other MCO and academic leadership; and funding agencies. Panel-audience discussion will consider training program development, MCO-department of psychiatry collaborations, and the role of psychiatrists in managed behavioral health care.

REFERENCES:

1. Lazarus A: Opportunities for psychiatrists in managed care organizations. *Hospital and Community Psychiatry.* 45:1206-1210, 1994.
2. Meyer RE, Sotsky SM: Managed care and the role of and training of psychiatrists. *Health Affairs* 14(3):65-77, 1995.

Issue Workshop 93
SUCCESSFUL MANAGEMENT OF A CONSULTATION-LIAISON PSYCHIATRY SERVICE

Chairperson: Daniel A. Monti, M.D., *Department of Psychiatry, Jefferson Medical College, 1020 Sansom St. Ste 1652 Thomp, Philadelphia PA 19107*
Participants: Troy L. Thompson II, M.D., Mitchell J.M. Cohen, M.D., Howard L. Field, M.D., Elisabeth J.S. Kunkel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to appreciate the necessary fiscal, administrative, and clinical components of a successfully and efficiently managed consultation-liaison (C-L) psychiatry service.

SUMMARY:

The consultation-liaison (C-L) psychiatrist offers an important, specialized service. In these days of managed care, consultations to patients on specific medical and surgical services is often one of the few "out-of-network" psychiatric evaluations and interventions that insurance companies will approve. To provide this service efficiently, competently, and cost-effectively, requires administrative and clinical skills that are not always taught in psychiatry residency programs. One of the members of our panel is a C-L administrative authority and will discuss proper organization and structure of a C-L service. The other presenters have subspecialized interests in particular aspects of C-L psychiatry, including pain management, organ transplantation evaluation, terminal illness, and management of disruptive patients on medical/surgical units. The last topic will include a discussion of competency, the use of constant (1:1) observation, restraints, and transfer to more appropriate units (e.g., medical-psychiatric units). These topics will be discussed with particular emphasis on initial interventions and appropriate follow-up treatments, documentation and billing issues, and other economic and administrative considerations. Participants will be encouraged to present problem cases and pose questions for discussion by the panel.

REFERENCES:

1. Holtz JL: Making a consultation service work: an organizational commentary. *Psychosomatics* 33:324-328, 1992.
2. Shakin-Kunkel EJ, Thompson TL, II: The process of consultation and organization of a consultation-liaison psychiatry service. *Textbook of Consultation-Liaison Psychiatry,* American Psychiatric Press, Washington, DC, pp. 12-23, 1996.

Issue Workshop 94
INTEGRATING INTENSE SPIRITUAL EXPERIENCES

Chairperson: Robert P. Turner, M.D., *1719 Union Street, San Francisco CA 94123*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: (1) identify common types of spiritual problems; (2) differentiate between spiritual problems and psychopathology; (3) apply the new DSM-IV V Code for spiritual problems; (4) choose more effective treatment modalities for spiritual problems; and (5) recognize phases of the integration process.

SUMMARY:

Increasing numbers of people are having intense spiritual experiences with life-changing consequences. These experiences may occur spontaneously, arise from spiritual practice, or emerge in the context of grief, dying, illness, or in recovery from substance or sexual abuse. The consequences of such spiritual experiences are usually positive. For example, persons who have had mystical and near-death experiences consistently report aftereffects such as increased appreciation for life, self-acceptance, concern for others, and sense of purpose. However, many persons encounter problems integrating such experiences and require clinical attention.

This workshop will review the common types of spiritual problems that may arise in the course of integrating an intense spiritual experience. Specific topics include the assessment of spiritual problems, guidelines for differentiating spiritual problems from mental disorders, models for understanding the integration process, and various treatment approaches. Excerpts from the film "Fearless" will be shown to stimulate discussion and highlight the phases of the integration process.

REFERENCES:

1. Turner RP, Lukoff D, Barnhouse RT, Lu F: Religious or spiritual problem: a culturally sensitive diagnostic category in the DSM-IV. *J Nerv Ment Dis* 183(7):435-444, 1995.
2. Assagioli R: Self-realization and psychological disturbances. In Grof S, Grof C (Eds), *Spiritual Emergency: When Personal Transformation Becomes a Crisis.* Los Angeles, Jeremy Tarcher, Inc., 1989.

Issue Workshop 95
ADVOCACY: REACHING THE MEDIA ON MENTAL HEALTH

Chairperson: Edward B. Gogek, M.D., *5501 North 7th Avenue, Ste 430, Phoenix AZ 85013*
Participant: Jim Gogek, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should have a stronger belief in the value and necessity of media advocacy. They

should know how to write an opinion piece or letter that will be printed, how to talk to journalists, and how to emphasize the link between psychiatric issues and important news stories.

SUMMARY:

This workshop will promote and teach the skills of media advocacy. Our profession needs frontline psychiatrists to speak out on national problems that are affecting our patients. Psychiatric knowledge should be a significant part of many news stories. But it's not happening because journalists don't understand the link and we're not explaining it to them. The presenters, a journalist and a psychiatrist, write a column on mental illness as a minority issue for the New America News Service, a branch of the New York Times Syndicate. They will review important news stories in which the mental health angle was missed or underreported. These include legislation on crime and Social Security, psychotherapy and managed care, parity, children and violence, and, most of all, stigma. Participants will learn how to educate the public about socially significant psychiatric issues both by writing about them and by contact with journalists. The workshop will also provide an inside look at how newspapers work. Suggested guidelines for writing mental health editorials will be covered. The format will be partly lecture, but mostly discussion based on participants' ideas and experiences with advocacy in the print media.

REFERENCES:

1. Gogek J, Gogek E: Alcoholism and responsibility. *St Louis Post-Dispatch,* Jan 5 1996: 7B.
2. Gogek E: "Schizophrenic" shouldn't be used as a term of derision. *Dallas Morning News,* Mar 7 1995: 13A.
3. Gogek J, Gogek E: Suicide is not the way out. *Lexington Herald-Leader,* May 27 1996: A11.
4. Gogek J, Gogek E: Using public stigma to limit health care. *San Diego Union-Tribune,* May 3 1996: B9.

Issue Workshop 96
BECOMING A FATHER

Chairperson: Martin Greenberg, M.D., *1940 Soledad Avenue, La Jolla CA 92037-3901*
Participants: Jerrold L. Shapiro, Ph.D., Michael J. Diamond, Ph.D.

EDUCATIONAL OBJECTIVES:

To understand the experience of fathering through contemporary, social, developmental, and clinical perspectives.

SUMMARY:

Dr. Greenberg describes a concept of engrossment that fathers experience when first seeing their newborns. Dr. J. Shapiro elaborates on experiences of fathers during pregnancy. Also, being rejected during pregnancy and other concerns will be discussed. Dr. M. Diamond's work describes father as watchful protector who creates a sense of security.

REFERENCES:

1. Greenberg, M: *The Birth of a Father* Continuum 1985.
2. *Becoming A Father,* eds., Shapiro JL; Diamond MJ; Greenberg M, Springer 1995.

Issue Workshop 97
VICTIMIZATION AS A PSYCHIATRIC ISSUE: THE BLAME GAME

Chairperson: Landy F. Sparr, M.D., *Department of Psychiatry, Oregon Health Sciences Univ, PO Box 1034/VA Med Ctr, 116A, Portland OR 97207*
Participants: Irwin Savodnik, M.D., John F. Fergueson, M.Div.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize that victimization can be a two-edged sword. While there are legitimate victims who may benefit from mental health intervention, victimization has also developed a separate sociopolitical identity far removed from traditional medical-therapeutic formulations.

SUMMARY:

Psychiatrists may find themselves in the middle of victimization debates, asked to endorse victims' symptoms, uphold victims' rights, and/or give legitimacy to victims' claims (e.g., syndrome evidence, stress disability) in a variety of forums, legal and otherwise. At times, these issues may be more political than psychological. While there are many legitimate victims who undoubtedly benefit from mental health intervention, victimization has also developed a separate sociopolitical identity far removed from traditional medical-therapeutic formulations. For example, if individuals can establish that they have been treated unfairly (e.g., "stressed"), they then seek to establish victimhood and, by logical (or illogical) extension, claim psychiatric or "mental" sequelae. Such inverse reasoning neglects the fact that stress is a physiological fact of life and dissatisfaction is not a psychiatric condition. In truth, these issues are seen on a larger scale by social observers who have decried a national desire to seemingly blame everyone else for everything. Recently, in his book The Culture of Complaint, Robert Hughes asked whether or not Americans were becoming obsessed with a "blame game" (e.g. Afrocentrism, gender feminism) that decrees that only victims should be heroes. Further, says Hughes, the lack of individual responsibility in modern America and the tendency to frame nearly every social controversy in terms of a clash of rights (a woman's right to her own body vs. a fetus's right to life) impedes compromise, understanding, and discovery of common grounds. In fact, a society cannot operate if everyone has rights, and no one has responsibility. This workshop will examine victimization malformations and roles of mental health evaluators who are often asked to make judgments about authenticity as reluctant participants in the "blame game."

REFERENCES:

1. Savodnik I: The concept of stress in psychiatry. *Western State University Law Review* 19:175-189, 1991.
2. Hughes R: *The Culture of Complaint: The Fraying of America.* New York: Oxford University Press, 1993.

Issue Workshop 98
USING PSYCHOTHERAPEUTIC SKILLS IN BRIEF INPATIENT WORK

Chairperson: Howard D. Kibel, M.D., *Department of Psychiatry, New York Medical College, Valhalla NY 10595*
Participants: C. Deborah Cross, M.D., Walter N. Stone, M.D., Saul Scheidlinger, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize how psychotherapeutic scrutiny of processes enhances diagnosis and that work on the treatment alliance enhances patient compliance with aftercare treatment.

SUMMARY:

In recent years, inpatient hospitalizations have become progressively shorter. This change has been accompanied by an increased emphasis on pharmacotherapy with a corresponding decreased emphasis on psychotherapeutic interventions. Yet psychotherapeutic techniques have traditionally been an integral part of the work of the inpatient psychiatrist. These techniques have been used to effect a comprehensive understanding of the patient and to enhance treatment

compliance. There is a danger, given the current trend toward brief inpatient stays, that psychiatrists will neglect their psychotherapeutic skills and that those in training will not learn them. This workshop will discuss the importance of using psychotherapeutic skills in brief hospital treatment.

Diagnosis is not limited to descriptive elements. A good clinician uses his/her own countertransference to tease out essential elements of psychopathology. Inferences that are drawn from a psychiatric evaluation can provide significant information about prognosis and planning for aftercare. Understanding the defensive and adaptive functions of psychotic symptoms can help a clinician work with the patient in the hospital and enable him/her to make a thoughtful consultation to the outpatient clinician.

Clinical vignettes will be used to demonstrate these issues and the audience will be invited to share their own experiences.

REFERENCES:

1. Leibenluft E, Tasman A, Green SA: *Less Time To Do More: Psychotherapy on the Short-Term Inpatient Unit.* Washington, DC, American Psychiatric Press, 1993.
2. Lieberman PB, Von Rehn S, Dickie E, et al: Therapeutic effects of brief hospitalization: the role of the therapeutic alliance. *J Psychotherapy Practice and Research* 1:56-63, 1992.

Issue Workshop 99
UNMASKING DELIRIUM IN THE ELDERLY

Chairperson: Michael J. Tueth, M.D., *Department of Psychiatry, University of Florida, PO Box 100256/College of Med, Gainesville FL 32610*
Participants: Josepha A. Cheong, M.D., William H. Campbell, M.D.

EDUCATIONAL OBJECTIVES:

To recognize the common behavioral presentations of delirium in the elderly patient; to become familiar with the most common causes of delirium in the elderly; to accurately identify the cause of delirium in clinical situations; to select a proper treatment setting for the patient.

SUMMARY:

Following a review of the diagnostic criteria for delirium, the major behavioral presentations and physical causes will be discussed. Types of presenting disturbances will include cognitive, mood, anxiety, and psychotic, emphasizing brief duration and fluctuation of symptoms. Medical illness, medication/substance abuse, and brain structure change will be emphasized as potential causes. The audience will then be introducted to a medical screening algorithm useful for identifying the probable cause of each case. History, physical exam, and ancillary testing will be emphasized, highlighting key questions to ask, examinations to perform, and tests to order. During the remaining 30 minutes the audience will be involved in a discussion utilizing four interactive vignettes consisting of four behavioral disturbances brought on by four different physical causes occuring in four separate clinical settings. Audience participants will be encouraged to apply diagnostic criteria, arrive at probable causes, and refer patients to appropriate treatment settings.

Presenters include a physician board certified in emergency medicine, a geriatric psychiatry fellow, and a psychiatrist with added qualifications in geriatric psychiatry. Handouts will include listings of common behavioral presentations and causes as well as a diagnostic algorithm. Question/answer opportunities will follow each of the three sections.

REFERENCES:

1. Lipowski ZJ: Delirium in the elderly patient. *N Engl J Med* 320:578-582, 1989.
2. Tueth MJ, Cheong JA: Delirium: diagnosis and treatment in the older patient. *Geriatrics* 48:75-80, 1993.

Issue Workshop 100
UPDATE ON MENTAL HEALTH IN THE OREGON HEALTH PLAN

Chairperson: David A. Pollack, M.D., *Mental Health Services, West Inc., 710 SW 2nd Street, Portland OR 97204-3112*
Participants: Bentson H. McFarland, M.D., Robert A. George, M.D., Richard H. Angell, M.D., Magnus Lakovics, M.D.

EDUCATIONAL OBJECTIVES:

Participants will become familiar with issues pertaining to the integration of mental health services into an overall health care reform plan. Persons who participate in this workshop will have a foretaste of political and economic questions to be addressed in their own states as health reform proceeds.

SUMMARY:

In its first three years of operation, the Oregon Health Plan has increased access to health care by providing services according to a prioritized list of conditions and their treatments. Chemical dependency services are now integrated, and mental health services are still being phased into this innovative system. The integration of mental health and chemical dependency services mandated by the Oregon Health Plan has led to a dramatic restructuring of public and private behavioral health programs in Oregon. This workshop will briefly review the development of an integrated statewide program that addresses mental illness and chemical dependency on a basis of parity with physical conditions. Discussion will then address the political, organizational, and financial aspects of the movement away from fragmented, fee-for-service systems and towards integrated, prepaid programs. The workshop will also consider other aspects of the Oregon Health Plan including mental health and chemical dependency preventive services, the interface with primary care providers, practice guidelines, and the development of managed care systems designed to deliver integrated services. Participants in the workshop will be able to utilize this information as their own states and the nation struggle with health care reform.

REFERENCES:

1. Pollack DA, McFarland BH, George R, Angell R: Prioritization of mental health services in Oregon. *Milbank Quarterly.* 72(3), 1994.
2. Minkoff K, Pollack D (Eds): *Managed Mental Health Care in the Public Sector: A Survival Manual.* Newark, Gordon & Breach, 1997.

Issue Workshop 101
SEXUAL HARASSMENT/DISCRIMINATION: TARGETING SYMPTOMS OF ANXIETY, DEPRESSION, PSYCHOSOMATIC DISORDERS AND PTSD

Chairperson: Rita R. Newman, M.D., *Department of Psychiatry, St. Barnabas Medical Center, 1046 South Orange Avenue, Short Hills NJ 07078-3131*
Participants: Angela M. Hegarty, M.D., Andrei Novac, M.D.

EDUCATIONAL OBJECTIVES:

This workshop is designed to provide a forum and 1997 update for clinicians to present problems and master the latest methods of assessment and treatment of sexual harassment/discrimination, targeting symptoms of anxiety, depression, psychosomatic and post-traumatic stress disorders.

SUMMARY:

Increasing numbers of women from all levels of employment are coming forth to confront their employers and to seek professional consultations and therapy for sexual harassment and discrimination issues. Reports in the media about victims of harassment and discrimination and legal suits and settlements have encouraged women to focus on their own negative experiences at work much earlier than they would have just one to two decades ago.

Sexual harassment, like rape, is an offense where sexual behavior is used as a means to express aggression. Parallels can easily be drawn: both offenses are associated with threats for noncompliance, with demands that the "secret" be kept, and with further threats if the offense is revealed. In sexual harassment, as in rape, power is exercised in a sexual manner. The only obvious difference is the severity of the physical assault and the form of threat used to ensure the compliance of the victim and her silence. These profiling techniques, useful in the investigation of both single and serial rapists, may provide useful clues in assessing the alleged perpetrator of sexual harassment, either for the purposes of forensic evaluation or clinical management.

The guide for interviewing victims of sexual harassment prepared by the Committee on Women of the New Jersey Psychiatric Association will be explained during the workshop. Current legal positions on issues of harassment/discrimination will be explored, along with the advantages of settlement so that the individual can move on to another work position with greater ease. This workshop will be addressed by several psychiatrists and an attorney with special expertise in employment issues.

REFERENCES:

1. Shrier D (ed.): *Sexual Harassment in the Workplace and Academia - Psychiatric Issues,* American Psychiatric Press, Inc., 1995.
2. Lenhart SA, Evans C: Sexual harassment and gender discrimination: a primer for women physicians, *Journal of American Medical Women's Association,* 40:77-82, 1991.

Issue Workshop 102
GROUP PSYCHOTHERAPY FOR ADOLESCENT SUBSTANCE ABUSE
Joint Session with the American Group Psychotherapy Association

Chairperson: David W. Brook, M.D., *Community Medical, Mt. Sinai School of Medicine, One Gustave Levy Place, New York NY 10029*
Participants: Mary A. Pressman, M.D., Pavlos I. Kymissis, M.D.

EDUCATIONAL OBJECTIVES:

To understand the developmental, neurobiological, and psychosocial bases for the use of group psychotherapeutic approaches in the treatment of adolescent substance abusers; to evaluate which group approaches are most appropriate; and to treat adolescent substance abusers using a variety of group psychotherapeutic techniques.

SUMMARY:

Group psychotherapeutic approaches form a major method of treatment for adolescent substance abusers, and this topic is of critical importance for the future well-being of youth at risk for substance abuse. Theoretical and technical issues will be presented that are relevant to both the evaluation and treatment of adolescent substance abusers using a variety of group approaches.

Group approaches discussed will include multiple family groups, groups combined with psychopharmacological agents, medication groups, behavioral-educational groups, relapse-prevention groups, substances-abuse groups, self-help groups, and others. A broad overview of the current literature will be presented. A developmental approach will be used to look at risk and protective factors and their relationship to group treatment approaches. Issues involving comorbidity will be addressed, as will the uses of group approaches in a variety of settings, including inpatient, outpatient, and partial hospitalization. The presenters will utilize specific clinical examples and material from group sessions as illustrations.

Audience participation about specific or general theoretical or treatment issues will be encouraged. Participants will be asked to present specific clinical examples or problems for discussion. This issue workshop is cosponsored by the American Group Psychotherapy Association.

REFERENCES:

1. Brook DW: Group approaches in the treatment of adolescent substance abusers. In P. Kymissis & D. Halperin (eds.) *Working with Children and Adolescents: New Perspectives in Group Therapy for Children and Adolescents.* Washington, DC: American Psychiatric Press, 1995.
2. Spitz HI, Spitz SP: An overview of group therapy with adolescent substances abusers. In P. Kymissis & D. Halperin (Eds.) *Working with Children and Adolescents: New Perspectives in Group Therapy for Children and Adolescents,* 1995.

Issue Workshop 103
HYPERSEXUALITY: ADDICTION OR COMPULSION?

Chairperson: Virginia A. Sadock, M.D., *Department of Psychiatry, NYU Medical Center, 550 First Avenue NB22N, New York NY 10016*
Participants: Victor B. Rodack, M.D., Waguih W. Ishak, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participants should be able to recognize the manifestations, models of understanding, and treatment implications of hypersexual behavior.

SUMMARY:

Hypersexuality is occasionally discovered during the course of treating patients and is a chief complaint at times. There is curiously little in the literature on this controversial and little-understood topic. While DSM-IV does not carry it as a diagnosis, many models have been applied in the literature to conceptualize hypersexuality. The most widely used models are the addiction model and the sexual compulsivity model. Bipolar disorder, dysthymia, and anxiety disorders need to be considered when evaluating hypersexual behavior. Treatment modalities that have been attempted with these patients include both psychopharmacological interventions (SSRIs, TCAs) and behavioral therapy, in addition to self-help groups modeled after other 12-step programs (SAA). Other psychodynamic and behavioral models will be explored. The participants will be able to present cases they have seen using the above described models to learn more about hypersexual behavior and its underlying etiology.

REFERENCES:

1. Travin S: Compulsive sexual behaviors. *Psychitr Clin North Am* 18:1, 155-169, 1995.
2. Stan DJ, et al: Serotonergic medications for sexual obsessions, sexual addictions, and paraphilias. *J Clin Psych* 53:8, 1992.

Issue Workshop 104
DEALING WITH THE DIFFICULT EMPLOYEE

Chairperson: Stephen M. Soltys, M.D., CPS, *Department of Mental Health, 1706 East Elm Street, Jefferson City MO 65101*
Participants: Roberta Gardine, James Impey, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to utilize the strategies presented to effectively motivate mental health employees and successfully resolve conflicts with employees while avoiding potential legal pitfalls.

SUMMARY:

In order for mental health organizations to run effectively, employees from a range of disciplines must work together as a team. Yet in any large group of employees, there are individuals, ranging from psychiatric aides to psychiatrists, who may function in a manner that is disruptive to the organization. Clinicians in administrative positions quickly find that successfully motivating individuals to work with their coworkers requires personnel management skills that are significantly different from the interpersonal clinical skills they have developed. This workshop is designed to familiarize clinicians with effective supervision skills.

In this interactive workshop, a psychiatrist, hospital administrator, and department of mental health attorney will share their experience in successfully dealing with difficult employees, with an emphasis on situations that commonly occur in mental health settings. Approaches toward motivating both professional and nonprofessional employees will be explored, as will the effects of managed care and public sector privatization on employee work attitudes. Techniques of effective supervision, discipline, and termination will be described, with attention to decreasing the risk of potential legal actions.

Each brief presentation will be followed by time for questions. Members of the audience will be encouraged to share situations they have encountered.

REFERENCES:

1. Light D, Levine S: The changing character of the medical profession: a theoretical overview. *Milbank Quarterly* 66 (Suppl. 2):10-32, 1988.
2. Shamir B: Calculations, values and identities: the sources of collectivistic work motivation. *Human Relations* 43:313-332, 1990.

Issue Workshop 105
POETRY THERAPY: THE ANNE SEXTON CASE

Chairperson: Owen E. Heninger, M.D., *Department of Mtl Hlth, 14030 Marsha Lane, Whittier CA 90602*
Participants: Kenneth P. Gorelick, M.D., Jeffrey L. Geller, M.D., Margaret C. Keenan, M.D., Laura Emery, Ph.D., Dawn Skorczewski, Ph.D.

EDUCATIONAL OBJECTIVES:

At the end of this workshop, participants will have learned how Anne Sexton was able to use her poetry to help herself and others; they will also begin to appreciate how they might use poetry in their own practice.

SUMMARY:

This innovative workshop brings together a distinctive group of educators who are Sexton scholars. They will give lively presentations of topical and unusual material from different points of view. They represent both coasts, several disciplines, and diverse institutions. The format will be unique, with a special reading of Anne Sexton's poetry. The workshop will deal with the rationale for and the use of poetry in the psychotherapy of Anne Sexton. It will explore the special materials collected by Anne Sexton's selected biographer. It will delineate how writing/publishing poetry can be cathartic, channel unconscious process into artistic form, gain mastery over trauma, and contribute to generativity. This workshop will convey how Anne Sexton was able to release her creativity, fight off suicidal impulses, save her own life, and help others with her poetry. It will delineate how, by focusing on her strengths, Anne Sexton's therapist helped her develop wellness in spite of a childhood of abuse and tension.

Following a discussion by the faculty, there will be substantial time given to discussion with the audience so participants can learn how they too might use poetry in their practice.

REFERENCES:

1. Heninger OE: Poetry therapy in private practice: an odyssey into the healing power of poetry, *Poetry in the Therapeutic Experience.* Ed. Arthur Lerner, 2nd ed., St. Louis, MO, MMB Music, 1994.
2. Middlebrook DW: *Anne Sexton: A Biography.* Boston, Houghton Mifflin Co., 1991.

Issue Workshop 106
COGNITIVE THERAPY FOR AXIS II DISORDERS

Chairperson: Judith S. Beck, Ph.D., *Cognitive Therapy & Research, The Beck Institute, 1 Belmont Avenue, Suite 700, Bala Cynwyd PA 19004,*

EDUCATIONAL OBJECTIVES:

To conceptualize personality disorder patients according to the cognitive model; to recognize therapeutic alliance issues in the treatment of personality disorder patients; to set goals and plan treatment for patients with characterological disturbance; to learn to combine pharmacotherapy and cognitive therapy for personality disorder patients; to describe and implement cognitive techniques.

SUMMARY:

Cognitive therapy, a short-term, structured, problem-solving-oriented psychotherapy, has been shown in more than 120 trials to be effective in treating Axis I disorders. In the past 10 years cognitive therapy methods have been developed for Axis II disorders, and outcome research has verified the utility of this treatment approach. Cognitive therapy for personality disorders requires substantial variation from that for Axis I treatment. A far greater emphasis is placed on developing and maintaining a therapeutic alliance, modifying dysfunctional beliefs and behavioral strategies, and restructuring the meaning of developmental events.

In this workshop, a variety of case examples of patients with personality disorders will illustrate the principles of cognitive therapy, conceptualization of individual patients, developing the therapeutic relationship, planning treatment, and the adjunctive use of medication. Role plays will provide clinicians with demonstrations of how cognitive and behavioral techniques are used. Questions and clinical material from participants will be encouraged, and a final segment will instruct participants in the steps they can take to learn more about this empirically validated approach for a difficult patient population.

REFERENCES:

1. Beck AT, Freeman A: *Cognitive Therapy of Personality Disorders.* New York: Guilford, 1983.
2. Beck JS: Cognitive approaches to personality disorders. In Dickstein, L.J., Riba, M.B., Oldham, J.M. (Eds.) *American Psychiatric Press Review of Psychiatry,* Vol. 16, Washington, DC: American Psychiatric Press (in press).

Issue Workshop 107
BIOPSYCHOSOCIAL MODEL AND MANAGED CARE: IS COEXISTENCE POSSIBLE?

Chairperson: Hoyle Leigh, M.D., *Department of Psychiatry, University of California, 2615 East Clinton Avenue, Fresno CA 93703-2223*
Participants: Craig Van Dyke, M.D., Don R. Lipsitt, M.D., Seth M. Powsner, M.D., Avak A. Howsepian, M.D.

EDUCATIONAL OBJECTIVES:

To recognize theoretical and practical aspects of the biopsychosocial model and its areas of conflict with managed care; to discuss its long-term advantages in managed care and the means of educating the public and managed care providers about its value.

SUMMARY:

The biopsychosocial approach that forms the theoretical underpinning of modern psychiatry faces challenges from both within and without. By distinguishing the disease and the illness, and emphasizing both treatment of disease and management of illness, it plays an important role in education. The multiaxial approach of DSM-III and DSM-IV usefully incorporates this model. Nevertheless, genetic engineering, receptor pharmacology, and other breakthroughs in medicine promise to provide effective cure and prevention of disease through unidimensional intervention. The greatest challenge to the biopsychosocial model comes from managed care. Short-sighted managed care, driven by short-term profits, encourages (coerces) physicians to increase productivity at the expense of time spent with patients and to provide brief and focused care at the expense of a comprehensive approach. The reality of this environment and the compelling nature of a comprehensive approach to patients induces a dilemma for both students and teachers. The panel will discuss, with active audience participation, how to educate the public and managed care providers about the advantages of this model and how to participate in legislative efforts to humanize and control the quality of managed care.

REFERENCES:

1. Engel GL: The need for a new medical model: a challenge for biomedicine. *Science* 196:129-136, 1977.
2. Leigh H, Reiser MF: *The Patient: Biological, Psychological, and Social Dimensions of Medical Practice, 3rd Edition.* Plenum Publishing Co. New York, 1992.

Issue Workshop 108
COLLABORATIVE PRIMARY PREVENTION FOR ADOLESCENTS

Chairperson: Thomas L. Reynolds, M.D., *21 Church Street, Dedham MA 02026-4315*
Participant: Nancy Rappaport, M.D., C. Alec Pollard, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe how psychodynamically informed, school-based support groups can modify peer culture and foster adolescent development. Participants should be able to identify common adolescent behaviors in peer groups and suggest adult responses.

SUMMARY:

Adolescents' strong affiliation with school is critical for preventing future emotional problems as substantiated by multiple studies in the prevention of mental illness. As community psychiatrists we designed a large-scale collaborative primary prevention program to increase school engagement and social support in a developmentally appropriate manner. All 2000 Cambridge, Massachusetts public school adolescents participated in 159 weekly support groups for six months led by 192 school adults (teachers, principals, custodians, security guards). Student-to-adult ratio was approximately 13:1. Presenters will describe the structure of the program. We will explore the training of school adults, which emphasized key psychotherapeutic techniques to modify adolescent peer culture. Quantitative results from two surveys of students will be presented (n of students = 1386 and 1273).

The data indicate that overall students and advisors appreciate this format of structured interaction (e.g. 80.1% of students rated groups as working excellent, well, or OK). Presenters will discuss subgroup differences and analyze how adolescents categorized their group as a way of understanding adolescent group process. This workshop will encourage audience participation in discussing implications of the program and results. Presenters will invite audience members to consider how psychiatric principles can help communities develop effective strategies for promoting positive adolescent behavior.

REFERENCES:

1. Schofield J: Promoting positive intergroup relations in school settings. In Hawley WD, Jackson AW (eds.). *Toward a Common Destiny: Improving Race and Ethnic Relations in America.* San Francisco: Jossey-Bass, pp. 257-91, 1995.
2. Steinberg L, Brown B, Dombusch S: *Beyond the Classroom: Why School Reform Has Failed and What Parents Need to Do.* New York: Simon and Schuster, 1996.

Issue Workshop 109
PSYCHOTHERAPY AND MARTIN BUBER'S PHILOSOPHY

Chairperson: Tony Stern, M.D., *Department of Psychiatry, Westchester County Medical Ctr, Ravine Drive, Hastings-on-Hudson NY 10706*
Participants: Patricia L. Speier, M.D., Maurice Friedman, Ph.D., Judith Grunebaum, C.S.W.

EDUCATIONAL OBJECTIVES:

To recognize subtler aspects of the empathic process; to appreciate the relationship between therapy and dialogue more fully; and to demonstrate greater understanding of philosophical and spiritual dimensions of therapy.

SUMMARY:

Martin Buber's thought can contribute richly to the theory and practice of psychotherapy. This workshop provides an opportunity to explore implications of his philosophy with his main translator and interpreter, Maurice Friedman, who is also a cofounder and supervisor at the Institute for Dialogical Psychotherapy in San Diego.

In the 1957 William Alanson White lectures at the Washington School of Psychiatry, Buber spoke in depth about dialogue, empathy, guilt, and the unconscious. Over the years he debated and shared reflections with Carl Rogers, C.G. Jung, and other leaders of the field. With far-reaching scholarship and insight, he pointed the way to a vision of "healing through meeting" and an image of what it means to be human that embraces psychological and spiritual dimensions.

In order to maximize participation, the workshop will focus on a hand-out of several short passages from Buber's writings as a starting point for discussion with the audience.

REFERENCES:

1. Friedman M: *The Healing Dialogue in Psychotherapy* NY: Jason Aronson, 1985.
2. Friedman M: *Dialogue and the Human Image: Beyond Humanistic Psychology* Newbury Park CA: Sage Publications, 1992.

Issue Workshop 110
DISCUSSION GROUP FOR YOUNG CAREER PSYCHIATRISTS: AMERICAN AND JAPANESE EMPLOYEE ASSISTANCE PROGRAMS

Chairperson: Marcia Scott, M.D., *Disability, Prudential Insurance, 6 Campus Drive, Parsippany NJ 07054*
Participants: Osamu Fujita, M.D., Karen A. Miotto, M.D., David Batson, Satoru Shima, M.D., Stephen H. Heidel, M.D.

EDUCATIONAL OBJECTIVES:

To define urgent needs, opportunities, skills, and training necessary for psychiatric practice in employee assistance programs.

SUMMARY:

The nonprofessional course of employee assistance program (EAP) development in the U.S., the recent changes in EAP delivery systems, and their integration with managed behavioral health makes the EAP an uncharted area for most of American psychiatry and contrasts with the Japanese system. In the U.S. EAP's were fostered by unions to deal with alcohol abuse. Structure and staffing have not kept pace with increasingly complex demands, problems, and treatments. Many are now telephone referral services or simply gatekeepers. Often, paraprofessionals, HR, and business trainers set goals and do the work. There is acute need for sophisticated assessment and medication, specific evaluation, and maintenance of function in the face of illness or medication side effects, and training/consultation to EAP professionals on prevention, prevention of recurrence, referral, case management, and strategies to maintain employment of workers with serious mental disorders. There is also the need to educate industry about improved treatments and resulting subtler illness that still affects worker performance.

Japan's EAP's developed with psychiatrists, social workers, and community workers (hoken-fu) taking the lead. It is a work-focused mental health system fostering behavioral health, prevention, and productivity. EAP's lead wellness and prevention programs and are integrated with the country's mental health system. They take an active role, working with management and employees to deal with recent changes in jobs and employment systems.

REFERENCES:

1. APA Committee on Occupational Psychiatry: Employee assistance program and the role of the psychiatrist. *American Journal of Psychiatry,* 146:690-695, 1989.
2. Sonnenstuhl W, Trice HM: *Strategies for Employee Assistance Program-The Crucial Balance.* Cornell University, School of Industrial and Labor Relations, Ithaca, NY, 1990.

Issue Workshop 111
PSYCHIATRY AND HUMAN RIGHTS: A TEACHING APPROACH

Chairperson: Roberta J. Apfel, M.D., *Department of Psychiatry, Cambridge Hospital, 1493 Cambridge Street, Cambridge MA 02139*
Participants: Bennett Simon, M.D., Amanda Sims, M.D., David J. Geltman, M.D.

EDUCATIONAL OBJECTIVES:

To demonstrate greater awareness of human rights issues in psychiatry; to generate ideas on how to transmit this awareness to colleagues and students; and to recognize the importance of taking a political history as part of a psychiatric evaluation.

SUMMARY:

Many people come into psychiatry with an interest in human rights and social justice and a belief that the professional and the political can be mutually enhancing. Yet medical education and psychiatric residency are usually silent on the relationship between medicine and human rights. Indeed, the professional principles of scientific objectivity and neutrality often are taught in ways that deny the interweaving of political and professional life. This leads to disillusionment for some and poses problems for psychiatry as a whole. The topic of this workshop will be how to avoid the silencing of interest in human rights and how to amplify it during psychiatric residency. The problem of integrating psychiatric tools and concepts with action for social justice will be addressed. Specifically, we will offer our experience in conducting a seminar on psychiatry and politics as a way of providing a forum within residency training where these interests can be aired. Workshop participants will be invited to discuss a specific clinical situation presented by the leaders, as well as to compare other educational initiatives and to suggest situations where the roles of clinician, researcher, and advocate may be in conflict.

REFERENCES:

1. Martin-Baro I: *Writings for a Liberation Psychology,* A. Aron and S. Corne, eds. Cambridge, Mass: Harvard University Press, 1994.
2. Eth S: Ethical challenges in the treatment of traumatized refugees. *Journal of Traumatic Stress* 5:103-110, 1992.

ADVANCES IN PRACTICE GUIDELINES RESEARCH ADVANCES IN GERIATRIC PSYCHIATRY: APA PRACTICE GUIDELINES

Chairperson: John S. McIntyre, M.D.
Participants: Deborah L. Blacker, M.D., Dilip V. Jeste, M.D., Paula T. Trzepacz, M.D., Peter Rabins, M.D.

EDUCATIONAL OBJECTIVES:

To provide an update concerning the development of APA practice guidelines for geriatric care, Alzheimer's Disease, and delirium and obtain feedback/answer questions on a variety of issues relating to the practice guideline project in general and these guidelines in particular.

SUMMARY:

The APA practice guidelines project has moved forward according to a previously approved process designed to result in documents which are both scientifically sound and clinically useful to practicing psychiatrists. On the basis of nationally-recognized standards for the development of practice guidelines (sometimes termed "practice parameters"), APA guidelines reflect: 1) comprehensive literature reviews; 2) classifications of supporting evidence and the nature of recommendations; and 3) a series of revisions based on input from the Steering Committee, Work Group, Assembly, Board of Trustees, Joint Reference Committee, related APA components, and from psychiatric consultants, non-psychiatrist experts, and representatives from related organizations.

The geriatric series being developed reflects a review of evidence supporting treatment strategies, as well as a framework for clinical decision making in these areas. We expect that these guidelines will form the basis for the recertification exam for geriatric psychiatry, the first of which will be administered in 2000.

Copies of the guidelines will be available for study, and members of the work groups will be available to respond to comments and questions regarding these guidelines of great importance to psychiatry.

REFERENCES:

1. Zarin DA, Pincus HA, McIntyre JS: Editorial on Practice Guidelines. *Am J Psychiatry* 150:2, 1993.
2. American Psychiatric Association: Practice Guideline for Treatment of Patients with Bipolar Disorder. *Am J Psychiatry* 151:12 (suppl) 1994.

AIDS PROGRAM PART I

No. 1A
AIDS AND HIV DISEASE: A MEDICAL UPDATE

Christopher Matthews, M.D., *Medical Director, Owen Clinic UCSD Medical Center, 200 West Arbor Dr., San Diego, CA 92103-8681*

EDUCATIONAL OBJECTIVES:

To review the medical, epidemiologic, and treatment issues associated with AIDS and HIV infection.

SUMMARY:

At the time of this writing, more than one million people in the United States are thought to be infected with HIV, over 400,000 diagnosed with AIDS, and 250,000 people have died of AIDS-related conditions. To meet the challenges presented by this epidemic, psychiatrists need to understand the biomedical aspects of AIDS as well as patterns of HIV infection in special patient populations including women, children, ethnic minority groups, and the chronically mentally ill. This session is designed as an update on basic virology and immunology, epidemiology, clinical course and manifestations, opportunistic diseases resulting from HIV infection, and new treatment regimens, including protease inhibitors. The session will include a lecture and question and answer period allowing participants a forum for discussion of individual clinical problems.

REFERENCES:

1. Karon JM et al, Prevalence of HIV infection in the United States, 1984 to 1992, *JAMA*, July 10, 1996, 276(2): 126-31.
2. Bartlett, J. Protease inhibitors for HIV infection. *Annals of Internal Medicine*, Vol 124, No. 12, p 1086-1087, June 1996.
3. Moyle G., Gazzard, B. Current knowledge and future prospects for the use of HIV protease inhibitors. *Drugs* 1996 May: 51(5):701-712.

No. 1B
NEUROPSYCHIATRIC MANIFESTATIONS AND THEIR TREATMENTS: A REVIEW

Francisco Fernandez, M.D., *10710 Cranbrook, Houston, TX 77042;* Karl Goodkin, M.D., Stephen McDaniels, M.D., Marshall Forstein, M.D.

EDUCATIONAL OBJECTIVES:

To review the spectrum of neuropsychiatric conditions that often exist with HIV infection and the range of effective psychopharmacological treatment approaches.

SUMMARY:

Clinical experience and current research have yielded increasing evidence that HIV directly infects the brain, resulting in central nervous system (CNS) impairment and neuropsychiatric complications, including dementia, myelopathy, and delirium. Current studies estimate that as many as 65% of all AIDS patients present with symptomatic CNS consequences. During this presentation, panelists will discuss primary infection the central and peripheral nervous systems, cognitive-motor impairment, HIV-1 associated dementia, delirium and psychosis, and review effective psychopharmacologic interventions and palliative treatments. Panelists will also review the diagnosis and treatment of various clinical psychiatric conditions that often exist with HIV infection including anxiety, and depression, and highlight pharmacotherapy, psychotherapies, and other nonpharmacological interventions. The session will provide an open forum for discussion of individual clinical problems.

REFERENCES:

1. Goodkin K, Fernandez, F, McDaniel, S, et al. *HIV-Related Neuropsychiatric Complications and Treatments.* Commission on AIDS, American Psychiatric Association, Washington, DC, 1996.
2. Kalichman, S. *Understanding AIDS: A Guide for Mental Health Professionals.* American Psychological Association, Washington, DC, 1995.

AIDS PROGRAM PART II

No. 2A
NEW HORIZONS IN HIV CARE AND TREATMENT

Francine Cournos, M.D., *5355 Henry Hudson Parkway, #9F, Bronx, NY 10471-2839;* Robert Stasko, M.D., Eric Bing, M.D.

OBJECTIVE:

Participants will understand the clinical implications of new HIV treatments and the psychological impact of treatment for the HIV patient population.

ABSTRACT:

There is great optimism shared by many in the clinical community that for the first time we have a real chance to transform HIV disease from a inexorably fatal condition to a chronic, manageable viral infection. Protease inhibitors, in particular, have generated renewed hope for the treatment of HIV infection, resulting in rapid and dramatic changes in available treatment options. The advent of these new drugs, however, has raised a number of questions for psychiatrists as little information exists on possible neuropsychiatric side effects, their efficacy in the treatment of HIV-related neuropsychiatric complications (e.g., HIV-associated dementia), or drug-drug interactions.

Along with the clinical implications psychiatrists must also consider the impact on the mental health of the HIV-positive individual, ranging from renewed optimism to survivor guilt for those individuals who respond to therapy, and profound pessimism and depression for those individuals who do not respond or cannot tolerate treatment. In addition, complex psychosocial issues such as access to care, treatment costs, and complicated medication regimens may require psychiatrists to advocate newer therapies such as protease inhibitors for their patients who may be viewed as poor candidates for treatment as a result of their mental illness.

During this session, panelists will present current information on (1) new treatments and their clinical significance, including a discussion of the pharmacokinetics and pharmacodynamics of these agents, and their impact on the central nervous system; (2) the medical impact of new treatments, including a discussion of medical compliance, eligibility, maternal testing and treatment; and (3) the significant psychological aspects of treatment and how hope and despair over treatment failure continue to be important issues for psychiatrists.

REFERENCES:

1. Carpenter CJ et al. Antiretroviral therapy for HIV infection in 1996: Consensus statement and recommendations of an international panel. *JAMA*, July 10, 1996; 276: 146-154.
2. Markowitz M: Protease Inhibitors: A New Family of Drugs for the treatment of HIV Infection. International Association of Physicians in AIDS Care, 1996, Chicago, Illinois.

CLINICAL CASE CONFERENCES

1. PSYCHOTHERAPY WITH WOMEN AT HIGH RISK FOR BREAST CANCER

Mary Jane Massie, M.D., *Memorial-Sloan Kettering Institute, Department of Psychiatry, 1275 York Avenue, New York, NY 10021*
Philip R. Muskin, M.D., Donna E. Stewart, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will: 1) be able to describe common therapeutic issues in psychotherapy with women at risk for breast cancer; 2) know the factors which place a woman at high risk of developing breast cancer, and 3) be able to describe the essential components of the psychiatric evaluation of a woman who is considering bilateral mastectomy as risk-reducing surgery.

SUMMARY:

One in eight American women will develop breast cancer in her lifetime. In 1996 approximately 46,000 American women will die of the disease. Genetic testing for certain mutations of the BRCA1 and BRCA2 tumor suppressor genes are now available within research protocols and through commercial laboratories. Increasing numbers of women are being referred for psychiatric consultation for consideration of genetic testing and of bilateral total "prophylactic" mastectomy (PM) as risk-reducing surgery for mutation carriers. The psychotherapy of these women is intense, variable in length and is often perceived by the patient as "emergency" in nature. In this case presentation, the psychotherapy with a woman at high risk who was advised to consider PM as her sister was dying of breast cancer will be described, as will her psychological and social adaptation to PM and breast reconstruction. In addition, factors which place a woman at "high risk" and the essential components of the psychiatric evaluation (*i.e.*, understanding of the usefulness and limitations of both genetic testing and risk-reducing surgery, history of surgery and reconstructive procedures, desire for more children, timing of PM in relationship to future pregnancies, anticipated changes in body and self-image post PM, partner and family concerns, decision-making process, defense mechanisms, *etc.*) of the woman at high risk of developing breast cancer will be described.

REFERENCES:

1. Burke W, Kahn MJE, Garber JE, Collins FS: "First do no harm" also applies to cancer susceptibility testing. *The Cancer Journal*: 250-252, 1996.
2. Lerman C, Narod S, Schulman K et al.: BRCA1 testing in families with hereditary breast-ovarian cancer. *JAMA* (275):1885-1892, 1996.

2. PSYCHOTHERAPY OF A CAREGIVER WHO HAS EXPERIENCED THE SAME TRAUMAS AS HER PATIENTS

June Pagaduan Lopez, M.D., *Cardinal Santos medical Center, Suite 233 Wilson Street Greenhills, San Juan Metro Manila, the Philippines*, Howard E. Book, M.D.

EDUCATIONAL OBJECTIVE:

To elucidate the issues attendant to the psychotherapy of a traumatized caregiver and demonstrate the use of a culturally sensitive analytic and treatment framework

SUMMARY:

The presentation revolves around the case of a 45 year old female social worker and university faculty member, M.C., first seen as a volunteer respondent in a case study project involving women survivors of military torture during the years of dictatorship in the Philippines. On the advise of the research team, MC sought consultation for psychotherapy for lingering emotional and behavioral problems which resurfaced after an interview conducted in connection with the research.

Presenting complaints were a depressed mood, inability to sleep, poor concentration and uncontrollable crying spells experienced for the past two weeks immediately after the completion of her research interview. Mental status examination revealed a fairly nourished, well-groomed, highly motivated and insightful woman in her mid-forties. While her subjective assessment places her as "depressed" she exhibited a spontaneous and animated demeanor throughout her interviews.

Her history reveals a string of traumatic life events which includes incestuous rape at age 17, physical, psychological and sexual torture at age 31 and spousal infidelity and abandonment at 42. She has been working as a community organizer prior to her arrest and detention 14 years ago and as a faculty member and social worker for the past five years. Over-all performance has been evaluated as below expectation. MC has been known to be a "roving rebel" with a record of transferring from one job to another. She claims that she easily "burns out" with her tendency to overdo her caregiving job and encourage client dependency.

Psychotherapy was brief (8 weekly sessions) and focused. It utilized a cognitive model called the "Circles of Life" which aimed at helping her attach a new sense of positive meaning to her traumatic experiences as well as providing her with some skills in doing a self-inventory of depleted as well as intact resources. This model was developed by proponents of the use of psychological tools indigenous to Filipino psychology. It was finally applied as a counseling tool for political prisoners and torture survivors by a Filipino priest and torture survivor himself.

REFERENCES:

1. Lopez J, Marcelino E, et al: *Torture Survivors and Caregivers: Proceedings of an International Workshop on Therapy and Research Issues.* University of the Philippines Press, 1995.
2. Herman J: *Trauma and Recovery.* Basic Books, New York, 1992.

3. ANATOMY AS DESTINY? PSYCHOTHERAPY OF A WOMAN WITH AMBIGUOUS GENITALIA

Howard Devore, Ph.D., *4328 18th Street, San Francisco, CA 94114*
Jennifer I. Downey, M.D.

EDUCATIONAL OBJECTIVE:

To demonstrate a health and adaptive adjustment to an intersexed identity after a childhood, adolescence and young adulthood of reclusive and depressed reaction to childhood surgery and genital trauma as well as stigmatization both within family and community.

SUMMARY:

An overview will be provided of the therapeutic process of an adult intersexed individual with a social identification as female. Important therapeutic accomplishments are: 1) integration of the intersexed history and identity, affirming and embracing the intersexed identity; 2) ending the impossible task of pretending to be fully female when the psychological identity is neither female nor male; and 3) adjustment to anorgasmia and sexual dysfunction consequent to genital surgery in conjunction with female sex assignment.

REFERENCES:

1. Fausto-Sterling A: *The Five Sexes:* Why Male and Female Are Not Enough. *The Sciences,* March/April:20-25, 1993.
2. Kessler S: The Medical Construction of Gender: Case Management of Intersexual Infants. *Signs* 16(1):3-26, 1990.

4. PSYCHOTHERAPY WITH THE HIV POSITIVE PHYSICIAN

Joseph Weiner, M.D., *115 East 34th Street, New York, NY 10016* John O'Donnell, M.D., Bert Schaffner, M.D.

EDUCATIONAL OBJECTIVES:

To examine the psychological, social, and professional impact of HIV on the life of an infected physician and to review selected psychotherapeutic treatments among the many valid ones that could be used.

SUMMARY:

HIV-positive patients represent a highly diverse population with a wide array of mental health challenges. Patients often seek services for the emotional turmoil of facing HIV and AIDS to deal with loneliness and isolation, stigmatization and shame, or to cope with fears of illness and death. This is no less true for the HIV-positive patient who is also a physician. The shock of the diagnosis may give way rather quickly to avoidance, isolation, and denial. When faced with the implacability of escalating illness, the clinician can often struggle with issues of control, abandonment, hopeliness, anger, humiliation, material loss, and the surrendering of a valued career.

During this session, panelists will present a case of an HIV-infected physician that illustrates many common and difficult issues that arise for the physician as patient. It is presented as an evaluation of a couple to more clearly illustrate the multiple psychologic levels on which HIV touches people's lives. It is the panel's intention to examine various therapeutic interventions that could be used in treatment, including individual therapies and their particular theoretical orientations and couples therapy. Issues of countertransference and the challenge of treatment will also be explored. Participant interaction will be strongly encouraged.

REFERENCES:

1. Burnham R, Cadwell S, Forstein M: *Therapists on the Front Line: Psychotherapy with Gay Men in the Age of AIDS.* American Psychiatric Press, Inc., Washington, DC, 1994.
2. Counselman EF, Alonso A: The ill therapist: therapists' reaction to personal illness. Am J Psychotherapy 47(4):591-602.

5. CONTINUOUS CLINICAL CASE CONFERENCE PART I AND II

Steven E. Hyler, M.D., *NY Psychiatric Institute, WHCS, Unit 112, 21 Springdale Road, Scarsdale, NY 10583*, Norman E. Alessi, *University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109*, Jerrold Block, M.D., Tal Burt, M.D., Howard Feinstein, M.D., David Forrest, M.D., Stuart Gitlow, M.D., Susan Vaughan, M.D., Paul Quinlan, M.D.

EDUCATIONAL OBJECTIVES:

Day one will focus on the impact of technology on the practice of psychiatry. How the machine and software can be used, and does that add or detract from the clinical situation. It will include a presentation on how the information available on the Worldwide Web can provide a potential problem for some patients. Day two will focus on issues of the patient/physician relationship and how it will change with increased access to information concerning patient care through the Web and through Chat rooms. It will also deal with the issue of the danger the Web presents to patients and the vulnerability that a patient might experience.

SUMMARY:

Day one will include presentations from Dr. Ken Silk on using e-mail with patients with BPD and will allow participants to have some appreciation as to how e-mail can be used as a transitional object to decrease the borderline patient's feeling of disconnection and separation between sessions. Dr. Jerrold Block will focus on pathologic computer use which is best described as a behavioral addiction or impulse disorder. A proposed set of criteria for the syndrome, based upon the current criteria for substance dependence, and a case are presented. Finally, on day one, Dr. Howard Feinstein will talk about using computers to take notes while conducting therapy with patients. On day two, Dr. Paul Quinlan will talk about the impact of patient self education through the Internet. Dr. Stuart Gitlow will focus on group therapy in the online environment and will educate participants on the availability of simultaneous group access to discussions, audio/video availabilities within the online environment and potential group therapy, including issues of privacy, licensure and regulations. Finally, Dr. Tal Burt will discuss the stalking of a patient on the Internet.

REFERENCES:

1. Gunderson JG: The Borderline Patient's Intolerance of Aloneness: Insecure Attachments and Therapist Availability. *Am J Psychiatry* 153:752-758, 1996.
2. Keepers GA: Case Study: Pathological Preoccupation with Video Games. *J of the American Academy of Child and Adolescent Psychiatry* 29:49-50, 1990.
3. Miller MJ, Hammond KW, Hile MG: *Mental Health Computing.* Springer Press, 1996.

DEBATE

RESOLVED: IS IT ETHICALLY PERMISSIBLE FOR PSYCHIATRISTS TO PARTICIPATE IN THE COMPETENCY EVALUATION OF A PRISONER TO BE EXECUTED?

Moderator: Jeremy A. Lazarus, M.D.
Affirmative: Paul S. Appelbaum, M.D., and Steven K. Hoge, M.D.
Negative: Alfred M. Freedman, M.D., and Lawrence Hartmann, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant will be able to explore the ethical justification for psychiatrists to participate in the criminal justice system, including the assessment of competence for execution in capital defendants. Be aware that traditional and current ethical principles are being challenged in their role in the criminal justice system which will have implications in other areas of psychiatric practice such as managed care.

SUMMARY:

Affirmative:

Our system of justice has established procedures for the differential treatment of the mentally disordered. The mentally disordered may have special claims for non-responsibility for their actions, criminal adjudication may not proceed against the incompetent defendant, and the incompetent inmate may not be executed. In the name of justice for persons with mental illness, psychiatry has supported these rules. In order for these rules to be applied with integrity and to be recognized as legitimate, they must be applied reliably. To be applied accurately, psychiatrists must be part of the process. For psychiatrist to withdraw from the process, as would be required if an activity were ethically proscribed, would jeopardize the interest of persons with mental illness. Given the constitutional prohibition against execution of incompetent prisoners, psychiatrists' participation in evaluating competence is necessary to vindicate prisoner's rights and their interest in justice. Moreover, psychiatrists may be placed in an untenable ethical bind if they are proscribed from testifying about the competence for execution of prisoners whom they know or suspect to suffer serious impairments that may lead to a finding of incompetence.

Negative:

The issue has raised two aspects: first, the examination of disturbed death-row inmates to determine if they are competent to be executed; and, second, whether to treat such individuals so that they may be restored to competence to be executed.

It is surprising that the issue has been raised for debate, since over the past 50 years numerous national and international societies have reaffirmed resolutions that physicians', including psychiatrists', perspectives of their views in regard to capital punishment should abstain from any participation in legal executions. Most recently, on August 25, 1996, the Declaration of Madrid, adopted by the World Psychiatric Association, concluded in unequivocal language that "Under no circumstances should psychiatrists participate in legally authorized executions or participate in assessment of competency to be executed." Similar but less specific language is found in the 1995 edition of the APA "Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry."

This position has been challenged in the June 1995 report of the AMA Committee on Ethics and Judicial Action (CEJA). This resolution, which received input from APA members, has as its rationale a theory that the forensic psychiatrist acting in the criminal justice system is not bound by the accepted principles of ethics for psychiatrists. The implications of that statement constitutes a superimposition of legal ethics on medical ethics; principles which can lead to disastrous consequences as demonstration historically and in recent legislation in Illinois.

REFERENCES:

1. Council on Ethical and Judicial Affairs: *Physician Participation in Capital Punishment: Evaluations of a Prisoner Competence to be Executed; Treatment to Restore Competence to be Executed.* AMA, Chicago. June, 1995.
2. Appelbaum PS: The parable of the forensic psychiatrist: ethics and the problem of doing harm. *Int J Law and Psychiatry* 13:249-259, 1990.
3. Bloche MG: Psychiatry, Capital Punishment and the Purposes of Medicine. *Int J Law and Psychiatry* 18:301-357, 1993.
4. The American College of Physicians: *Breach of Trust: Physician Participation in Execution in the United States.* March, 1994.

FORUMS

1. DSM FORUM: ASSESSMENT IN CLINICAL PRACTICE: THE HANDBOOK OF PSYCHIATRIC MEASURES

Co-Chairperson: A. John Rush, M.D., Harold Alan Pincus, M.D.
Participants: Deborah L. Blacker, M.D., Neal D. Ryan, M.D., Ming T. Tsuang, M.D., Norman Sartorius, M.D., Deborah A. Zarin, M.D.

EDUCATIONAL OBJECTIVES:

At the session's conclusion, participants will know the ICD-9-CM code changes affecting DSM-IV for 1997, proposed code changes and other classification issues. Participants should be able to choose, use, and interpret psychiatric measures in clinical settings. They will also be familiar with issues in selecting and applying outcomes and other psychiatric measures.

SUMMARY:

The presentation will focus on updating the attendees of ongoing coding issues and future plans to revise codes in DSM-IV in preparation for the implementation of ICD-10-CM. The majority of the session will focus on the *Handbook of Psychiatric Measures and Outcomes* and will address issues in the selection, use and interpretation of psychiatric measures for use in clinical settings. Issues in the evaluation of measures for their components, reliability, validity, strengths, weaknesses and clinical utility will also be presented.

REFERENCES:

1. Kazis LE: Health Outcomes Assessments in Medicine: History, Applications, and New Directions. *Advances in Internal Medicine* 36:109-130, 1991.
2. Smith GR, Rost KM, Fischer EP, Burnam MA, Burns BJ: *Assessing the Effectiveness of Mental Health Care in Routine Clinical Practice: Critical Components, Administration and Application of Outcomes Modules.* (in press).

2. THE AMERICAN PSYCHIATRIC ASSOCIATION MEETS THE AMERICAN PSYCHOLOGICAL ASSOCIATION: THE COMMON GROUND FOR PSYCHIATRY AND PSYCHOLOGY

Chairperson: Harold I. Eist, M.D.
Participants: Herbert S. Sacks, M.D., Dorothy W. Cantor, Psy.D., Norman Abeles, Ph.D., Marty P. Seligman, Ph.D.

EDUCATIONAL OBJECTIVES:

To promote mutual understanding and cooperation between The American Psychiatric Association and the American Psychological Association.

SUMMARY:

Each panelist will briefly describe critical areas of mutual interest in patient care and how our working together can improve care for the mentally ill. The panel will discuss joint efforts to obtain parity, joint efforts to educate corporate America to the benefits of equal care for mentally ill individuals, and, where necessary, joint litigation efforts against the depredations of managed care. Ample time will be available for discussion with the audience.

REFERENCES:

1. Lazar SG: Epidemiology of Mental Illness in the United States: An Overview of the Cost-Effectiveness of Psychotherapy for Certain Patient Populations. In: Lazar SC (ed). Psychoanalytic Inquiry, 1997 Supplement: *Extended Dynamic Psychotherapy, Making the Case in an Era of Managed Care,* pp. 4-17, 1997. Analytic Press, NJ, 1997.
2. Eist HI: Managed Care: Where Did it Come From? What Does it Do/ How does it Survive? What Can Be Done About It? In: Lazar DG (ed). Psychoanalytic Inquiry, 1997 Supplement: *Extended Dynamic Psychotherapy, Making the Case in an Era of Managed Care,* pp. 162-182. Analytic Press, NJ, 1997.

3. NOTABLE WOMEN PSYCHIATRISTS IN THE 19TH AND 20TH CENTURIES

Chairperson: Leah J. Dickstein, M.D.
Participants: Lucy D. Ozarin, M.D., Martha J. Kirkpatrick, M.D.

EDUCATIONAL OBJECTIVE:

Participants will learn of the major contributions of many notable, and often unknown or unrecognized women to the fields of psychiatry during the past 150 years.

SUMMARY:

Women psychiatrists, in increasing numbers, have made many notable contributions to the many diverse areas of psychiatric research, treatment and education during the past 150 years. However, many of these notable women have been unrecognized, and therefore, their outstanding and major contributions have remained hidden.

This forum will enable the knowledgeable presenters to bring to light these many notable women leaders in the history of psychiatry and those currently contributing as well.

REFERENCES:

1. Dickstein LJ, Nadelson C (eds): *Women Physicians in Leadership Roles.* American Psychiatric Press, Inc., Washington, DC, 1986.

4. THE 50TH ANNIVERSARY OF THE NIMH: FIVE DECADES OF CONTRIBUTION TO PSYCHIATRIC PRACTICE

Chairperson: Lewis L. Judd, M.D.
Participant: Bertram S. Brown, M.D., Herbert Pardes, M.D., Shervert H. Frazier, M.D., Frederick K. Goodwin, M.D., Steven E. Hyman, M.D.

SUMMARY:

Every former and the current NIMH Director will speak on the contributions of NIMH to the practice of psychiatry during their tenure as NIMH director. With NIMH having played a central and critical role in the growth and expansion of post World War II American Psychiatry, this forum will trace NIMH's contributions from its founding to the present. Finally, it will offer a glimpse of how current research will impact on psychiatric practice in the 21st Century.

5. PSYCHOTHERAPY WORKS: THE DATA EVERY PSYCHIATRIST SHOULD KNOW APA Commission on Psychotherapy

Chairperson: Norman A. Clemens, M.D.
Participants: Susan G. Lazar, M.D., Glen O. Gabbard, M.D., David Spiegel, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation the participants should be able to demonstrate data on the cost-effectiveness of psychotherapy for a number of different patient populations including those with borderline personality disorder, schizophrenia, depression, as well as child patients and medical and surgical patients with concomitant psychiatric disorders. In addition, data from actuarial studies will be

presented to illustrate the cost-effectiveness of psychotherapy for mixed diagnostic groups of patients.

SUMMARY:

This forum will examine the concept and present data relevant to the cost-effectiveness of psychotherapy. Cost-effectiveness is a standard that is more appropriate than the older one of cost-offset, which examined whether providing psychotherapy led to savings in subsequent medical, surgical and psychiatric expenses. The concept of cost-effectiveness does not necessarily mean "cheap," nor does it imply money saved only in future medical expenses, but also takes into account lost work days saved, improved efficiency at work and the decrease in suffering provided by psychotherapy.

Data will be presented to demonstrate the cost-effectiveness of psychotherapy for patients with borderline personality disorder, schizophrenia, depression, medical and surgical patients with psychiatric disorders and child patients. Relevant epidemiological and actuarial studies will also be presented.

REFERENCES:

1. Gabbard G. Lazar S, Hornberger J, Spiegel D: The Economic Impact of Psychotherapy: A Review. *Am J Psychiatry* 154, No. 2:147-153 1997.
2. Tarrier N, Lowson K, Barrowclough C: Some Aspects of Family Interventions in Schizophrenia. II: Financial Considerations. *Br J Psychiatry* 159:481-484, 1991.

6. ASIAN CULTURES AND PSYCHOTHERAPY

Chairperson: Chang H. Lee, M.D.
Presenter: Luke I.C. Kim, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation the participant should be able to recognize the practices and issues related to psychotherapy with Asian–Pacific immigrants.

SUMMARY:

Euro-American cultural values stress the centrality of individualism, self-independence, autonomy and equality. Many Asian–Pacific Islanders may embrace these American values superficially, but in their daily life and practice, their world view is one of family and group orientation with interdependency. Asian countries strive toward modernization. However, modernization is not necessarily synonymous with Westernization in cultural values.

There are still problems with conceptual and technical issues in doing psychotherapy with Asians. If the implicit or explicit goal of psychotherapy is to foster further individuation/separation and self-actualization, the goal may be in conflict with the values the Asian client may hold. To express feelings freely and openly is something many Asians have been taught to avoid. In fact, they have been encouraged to control morbid thoughts, to suppress "unhealthy" emotions, and to practice the principle of moderation, etc. Theoretically this approach appears to be more in line with cognitive-behavior therapy. However, psychotherapy outcome studies with Asian clients are few.

What are the psychotherapeutic approaches more culturally relevant to Asian-Pacific immigrants? How well does the Western psychotherapy work with Asians or Asian-Pacific immigrants? The presentation will discuss and explore issues on different concepts and psychotherapy as related to Asian-Pacific immigrants, and will include literature review with regard to the clinical experiences and efficacy of various forms of psychotherapy with Asians or Asian-Pacific immigrants.

REFERENCE:

1. Gaw A (ed): *Culture, Ethnicity and Mental Illness.* American Psychiatric Press, Washington, DC, 1992.

7. CELEBRATING NARSAD'S 10TH ANNIVERSARY: WHAT THE NEW BRAIN SCIENCE MEANS FOR PSYCHIATRISTS, PATIENTS AND FAMILIES

Co-Chairpersons: Harold Alan Pincus, M.D., Herbert Pardes, M.D., Constance Leiber
Participants: Floyd E. Bloom, M.D., Steven E. Hyman, M.D., Judith H.L. Rapoport, M.D., John Kane, M.D., Martin S. Willick, M.D.

EDUCATIONAL OBJECTIVE:

To present an overview of new developments in neuroscience, molecular biology and brain imaging as it might impact on the diagnosis and treatment of mental illness. In addition, a description of the critical role that NARSAD has had in expanding research on psychiatric disorders will be presented.

SUMMARY:

Over the past several decades there has been tremendous expansion in research on mental disorders that has had an enormous impact on the diagnosis and treatment. More recently, new technologies, molecular biology, brain imaging, and other areas related to neuroscience have even further expanded opportunities in research and hold the promise for true revolutions in the care of the mentally ill. In this forum, designed to honor the tenth anniversary of the National Alliance for Research on Schizophrenia and Depression (NARSAD) leading investigators who have been involved with NARSAD, either as part of the scientific advisory council, as awardees, or as funded investigators will participate in a discussion of the implications of these new research opportunities for clinicians, patients, and families. Dr. Pardes, chair of the NARSAD Scientific Council, will present an overview of the critical role that NARSAD has played over the past ten years in supporting research, particularly focusing on young investigators. Dr. Bloom, vice–chair of the NARSAD Scientific Council and editor of *Science* magazine, will present an overview on the new technologies and opportunities in brain science. A panel of leading scientists as well as clinicians and family members will respond with regard to how these opportunities can be translated in a way that brightens the clinical practical reality of patients and families for the future.

REFERENCES:

1. Hyman SE, Nestler EJ: Initiation and Adaption: A Paradigm for Understanding Psychotropic Drug Action. *Am J Psychiatry* 153(2):151-162, 1996.
2. Bloom FE: Advancing a Neurodevelopmental Origin for Schizophrenia. *Arch Gen Psychiatry* 50(3):224-227, 1993.

8. TOWN HALL MEETING ON REASSERTING PSYCHIATRY'S CONTROL OF ITS FUTURE: THE CONTAINMENT OF MANAGED CARE

Chairperson: Harold I. Eist, M.D.
Participants: Karen Shore, Ph.D., Mike M. Faenza, M.S.W.

EDUCATIONAL OBJECTIVES:

To learn about approaches to reasserting professional control of health care, the right and responsibility of professionals to define themselves, alternating approaches to financing health care which include attention to protecting the doctor/patient relationship and confidentiality for all sectors of the population, including the poor, minorities and the seriously mentally ill.

SUMMARY:

The panelists will discuss approaches to attaining professional autonomy, protecting confidentiality and eliminating the profit-tak-

ing middle man from the treatment occasion. Approaches such as managed cooperation and MSAs will be described.

REFERENCES:

1. Eist HI: Managed Care: Where Did it Come From? What Does it Do? How does it Survive? What Can Be Done About It? In: Lazar DG (ed). Psychoanalytic Inquiry, 1997 Supplement: *Extended Dynamic Psychotherapy, Making the Case in an Era of Managed Care,* pp. 162-182. Analytic Press, NJ, 1997.
2. Ackley DC: *Breaking Free of Managed Care.* Guilford Press, New York, 1997.

9. MELVIN SABSHIN, M.D.: HIS LIFE AND CONTRIBUTIONS TO PSYCHIATRY

Co-Chairperson: Sidney H. Weissman, M.D.
Participants: James H. Scully, Jr., M.D., Daniel Offer, M.D., H. Keith H. Brodie, M.D., Jochen E. Neumann, M.D.

EDUCATIONAL OBJECTIVE:

SUMMARY:

This forum will feature presentation from colleagues whose careers and contributions to psychiatry have been shaped by Dr. Melvin Sabshin. The presenters will discuss their own work and how Dr. Sabshin has influenced their careers. Finally, there will be a review of Dr. Sabshin's broad contributions to the field. In conclusion, Dr. Sabshin will respond with his view of psychiatry's evolving future.

REFERENCES:

1. Sabshin M: Turning Points in Twentieth Century American Psychiatry. *Am J Psychiatry* 147:1267-1274, 1970.
2. Sabshin M, Weissman S: Forces and Choices Shaping American Psychiatry in the 20th Century. In Dickstein L, Riba M, Oldham J (eds): *Review of Psychiatry* 15:507-524. American Psychiatric Press, Washington, DC, 1996.

10. RESILIENCY, VULNERABILITY AND CULTURAL DIVERSITY: LESSONS FROM CHILDREN EXPOSED TO WAR TRAUMA

S. Arshad Husain, M.D., *Department of Psychiatry, University of Missouri, N119 Health Science Center, Columbia, MO 65212-0001*

SUMMARY:

Current research in stress and psychological trauma is beginning to demonstrate that not all child victims of trauma, whether natural or man–made, react to it in the same manner. A number of factors such as gender, age, and developmental stage at the time of trauma and family support are implicated in determining the ultimate impact of the traumatic event on the psyche of the victim. The cultural, spiritual and religious factors have not been studied systematically although some literature is beginning to appear in the scientific journals. The author has been studying 791 Sarajevan (Bosnia and Herzegovina) children who have experienced war atrocities while their city was under the longest seige in the history of mankind. The results of the study reveal that 40% of the children fulfilled the *DSM–IV* criteria of post-traumatic stress disorder. Dr. Husain has identified several factors from this study which correlate significantly with the vulnerability and resiliency to impact of trauma. In this forum Dr. Husain will present a summary of current literature on the subject and predicate it with his research findings on the subject.

REFERENCE:

1. Husain A, Nair J, Holcomb W, et al.: Post–Traumatic Stress Reaction in Children and Adolescents in Sarajevo. *Arch Gen Psych* (in press).

11. PSYCHIATRIC WORKFORCE CONSIDERATIONS IN THE NEXT MILLENNIUM

Chairperson: Herbert S. Sacks, M.D.
Participants: Sidney H. Weissman, M.D., James H. Scully Jr., M.D., D. Ray Freebury, M.D.

EDUCATIONAL OBJECTIVES:

To acquaint participants with forces and factors both inside and outside psychiatry and the rest of medicine which will impact the projected needs for general and child psychiatrist.

SUMMARY:

This forum will first review factors which effect medical student selection of psychiatric careers. Subsequently, we will review various models which attempt to determine how many psychiatrists society needs. Finally there will be an assessment of the impact on our society of implementing any reduction in the current availability of psychiatrists.

REFERENCES:

1. Weissman S: American Psychiatry in the 21st Century: The Discipline, Its Practice, and Its Workforce. *Bull Menninger Clin* 58:502-596, 1994.
2. Scully J, Weissman S: The Psychiatric Workforce in Transition. In: Dickstein L, Riba M, Oldham J (eds): *Review of Psychiatry* 15:567-580. American Psychiatric Press, Washington, DC, 1996.

INDUSTRY SUPPORTED SYMPOSIUM 1— ALZHEIMER'S DISEASE: PRACTICAL USE OF DIAGNOSTIC ALGORITHMS AND TREATMENT GUIDELINES
Supported by Eisai Inc and Pfizer Inc

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, participants will have a greater knowledge of new developments in Alzheimer's disease pathobiology, diagnosis, current and future treatment strategies, and how these findings may apply to clinical psychiatric practice.

No. 1A
DIAGNOSIS OF ALZHEIMER'S DISEASE: APPLICATION OF CRITERIA AND GUIDELINES

P. Murali Doraiswamy, M.D., *Department of Psychiatry, Duke University Hospital, P.O. Box 3018, Durham NC 27710*

SUMMARY:

Although Alzheimer's disease (AD) is the most common cause of dementia in the elderly, currently a clinical diagnosis can be made only after excluding other possible causes of dementia. Several neuroimaging techniques and molecular markers are now available that may facilitate the initial evaluation, improve diagnostic accuracy, and/or assist with monitoring disease progression. Structural imaging (e.g. MRI, CT) can not only aid in the differential diagnosis of AD but can also directly evaluate hippocampal atrophy, a sensitive early marker of AD. Hippocampal atrophy may also have some prognostic significance in subjects with memory complaints too mild for a dementia diagnosis. Functional imaging (e.g. SPECT, PET) can demonstrate reduced temporo-parietal metabolism and blood flow in AD as well as in some subjects at familial or genetic risk for AD. Newer MR-based techniques, such as MRS and dynamic susceptibility contrast scans, can also demonstrate metabolic deficits in AD with higher resolution and without the need for radioactive tracers. Molecular biomarkers currently being marketed for clinical use in evaluating the probability of AD include the apolipoprotein E (ApoE) genotype, and CSF levels of Tau and $A\beta_{42}$. This presentation will discuss practical issues related to integrating imaging and molecular markers with clinical assessment and accepted diagnostic criteria for the initial evaluation of AD.

No. 1B
THE CHOLINERGIC DEFICIT OF ALZHEIMER'S DISEASE

Peter J. Whitehouse, M.D., *Alzheimer's Center, University Hosp. of Cleveland, 12200 Fairhill Road, C2222, Cleveland OH 44120*

SUMMARY:

The neurobiological basis of Alzheimer's disease is dysfunction in multiple neurotransmitter systems, which must be understood at molecular, cellular, and systems levels. An understanding of the basic biology of the cholinergic basal forebrain has contributed to the development of medications. Therapeutic attempts should be focused not only on symptomatic improvement through actions on muscarinic and nicotinic receptors but also on slowing the progression of neuronal loss in the basal forebrain and other structures. Moreover, our therapeutic focus need not be exclusively directed toward memory but should involve attention, arousal, and other noncognitive symptoms. Although we can celebrate the development over the last 15 years of cholinesterase inhibitors and receptor agonists, we still need more effective therapies that significantly improve the quality of life of patients and caregivers.

No. 1C
CHOLINERGIC THERAPY OF BEHAVIOR

Jeffrey L. Cummings, M.D., *Department of Neurology, UCLA School of Medicine, 710 Westwood Plaza, Los Angeles CA 90095*

SUMMARY:

Alzheimer's disease (AD) is characterized clinically by neuropsychologic, neuropsychiatric, and neurologic disorders, and pathologically by histologic and neurochemical alterations. The most marked and consistent neurochemical disturbance is a deficiency in cholinergic function. Acetylcholine is synthesized by choline acetyltransferase (CAT) and CAT is manufactured in the nucleus basalis of Meynert in the basal forebrain. The nucleus basalis is affected early in the course of AD, leading to a deficiency of CAT and failure to synthesize sufficient acetylcholine. Neuropsychological impairments of AD have been attributed to the cholinergic deficiency and, more recently, neuropsychiatric disorders have also been linked to the cholinergic disturbance. The nucleus basalis is positioned between limbic afferents and cortical efferents where it may disrupt emotional function. Psychosis has been correlated with the cholinergic deficiency of Lewy body dementia, a dementia syndrome that shares many features with AD. Delusions may improve with cholinergic therapy. Agitation, apathy, anxiety, disinhibition, and purposeless activities also have been reported to improve with cholinomimetic treatment. Cholinergic agents may improve behavior and lack the adverse side effects of other types of psychotropic agents used in the treatment of neuropsychiatric disorders in AD. Effective AD therapy will likely consist of a combination of agents that slow progression of the illness and cholinergic therapies that improve existing cognitive and behavioral disorders.

No. 1D
NEW CHOLINERGIC TREATMENT TOOLS FOR PSYCHIATRISTS

Trey Sunderland, M.D., *Dept. of Geriatric Psych., Nat'l Inst. of Mental Health, 10 Center Dr. MSC1264, 10-3D41, Bethesda MD 20892*

SUMMARY:

While the cholinergic hypothesis is certainly not the only explanation for the underlying biochemical changes in Alzheimer's disease (AD), cholinergic therapies remain the mainstay of research and clinical treatment with AD patients. Currently, there are over a dozen cholinergic drugs under development by the pharmaceutical industry, and it is likely that one or more of these drugs will soon join the ranks of clinically available medications for use by the practitioner. How are we to differentiate these many medications, and what can we expect clinically for our patients? First, it is important to recognize that cholinergic medications come in many varieties: direct cholinergic agonists (both nicotinic and muscarinic), dietary cholinergic precursors, and acetylcholinesterase inhibitors (AChEI's). Examples of each of these drugs under development will be discussed in detail, along with the appropriate clinical and biochemical tools to help differentiate them, particularly with respect to liver toxicity and other side effect profiles. As for the expected therapeutic results, practitioners must become accustomed to modest changes in what is a slow and unrelenting clinical course. Current cholinergic therapies are not equipped to reverse the AD process, but until more etiologically specific treatments become available, cholinergic therapies are the best and only treatment for the cognitive symptoms of AD, and clinicians should become familiar with their use.

No. 1E
MAXIMIZING THE ROLE OF THE PSYCHIATRIST IN ALZHEIMER'S DISEASE CARE

Peter V. Rabins, M.D., *Department of Psychiatry, Johns Hopkins Hospital, 600 N. Wolfe Street/Meyer 279, Baltimore MD 21287-7279*

SUMMARY:

The addition of cognition-enhancing drugs to the armamentarium of treatments for Alzheimer's disease provides the psychiatrist with the ability to offer several treatments aimed at the common impairments and comorbidities induced by Alzheimer disease. The skills of the psychiatrist in the nonpharmacologic and pharmacologic management of behavior disorder and mood disorder, skills in the pharmacologic treatment of psychotic symptoms, and the prescription of cognition-enhancing pharmacologic agents each has a role in the dementia care model.

The American Psychiatric Association Treatment Guidelines for Alzheimer's Disease and Other Dementias addresses each of these areas. This presentation will use a structured treatment algorithm that identifies options for treatment in each of these problem areas. The focus of the presentation will be on the incorporation of these algorithms into office practice.

REFERENCES:

1. Costa PT Jr, Williams PF, Somerfield M, et al: Recognition and initial assessment of Alzheimer's disease and related dementias. Clinical Practice Guideline No. 19. Rockville MD; US Dept. HHS, AHCPR Pub. 96-0702, in press.
2. Cummings JL, Gorman DG, Shapira J: Physostigmine ameliorates delusions in Alzheimer's disease. *Biol Psychiatry* 33:536-541, 1993.
3. Mace NL, Rabins PV: *The 36-hour Day*. Baltimore, MD. Johns Hopkins Press, 1992.
4. Coffey EC, Cummings JL (eds).: *Textbook of Geriatric Neuropsychiatry*. American Psychiatric Association, Washington, D.C., 1994.

INDUSTRY SUPPORTED SYMPOSIUM 2—CONQUERING PSYCHOSIS: FROM MOLECULES TO MANAGED CARE
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this program, the participant should be able to demonstrate an understanding of (1) the basic and clinical properties of olanzapine and other "atypical" antipsychotic medications; (2) the health economic profile of these medications; (3) principles of disease-state management of the new generation of antipsychotic medications.

No. 2A
THE NEUROPHARMACOLOGY OF ATYPICAL MOLECULES

Stephen M. Stahl, M.D., *Department of Psychiatry, University of CA, San Diego, 8899 University Cntr Lane #130, San Diego CA 92122*

SUMMARY:

The chlorpromazine revolution defined the *typical* molecule for treatment of psychosis. Newer typical antipsychotics evolved as a series of prominent dopamine-2 (D2) antagonists. The clozapine revolution defined the *atypical* molecule, since it marked the first improvement in efficacy over typical antipsychotics. Newer atypical antipsychotics are evolving in a rapid cascade and from two theoretical perspectives: First, serotonin-2 (5HT2) antagonist properties are a key dimension, together with D2 antagonist properties, of the new atypical antipsychotics. Thus, SDA (*serotonin-2 dopamine-2 antagonism*) is one theme for the new agents, which sort themselves across a spectrum of relative 5HT2 versus D2 antagonism. Which balance of SDA will be optimal remains undetermined, but already it seems clear that significant 5HT2 antagonism enhances the tolerability of D2 antagonism. Second, the atypical molecules emulate the other complex pharmacology of the clozapine molecule. This includes alpha 1 antagonist properties, but also, anticholinergic, antihistaminergic, D1, D4, 5HT3, 5HT6, and perhaps even other aspects of the atypical clozapine molecule. A specific portfolio of these properties, in the ideal proportions, is hypothesized to underlie the enhanced efficacy of clozapine. The new atypical molecules all differ in their composition of these properties, and it is possible that one or more of the new compounds might define the efficacy of clozapine without the side effects.

No. 2B
CLINICAL PROFILES OF THE NEW ANTIPSYCHOTIC AGENTS

David Pickar, M.D., *ETB/DIRP, NIMH/NIH, 10 Center Dr. Bldg. 10, 4N-212, Bethesda MD 20812*

SUMMARY:

The success of clozapine and risperidone has helped to stimulate large-scale efforts at new drug development for the treatment of schizophrenia. The recent introduction of olanzapine and sertindole into clinical practice with the expected availability of still other agents in coming years has changed the landscape of the pharmacotherapy of schizophrenia. The clinician, however, will be placed in the difficult position of choosing among new agents. In this presentation, clinical profiles of the new antipsychotic drugs will be delineated, including the relationship between preclinical receptor affinities and these clinical effects. Predictors of drug response will be discussed as well as help to provide the foundation for a new decision tree for the treatment of schizophrenia.

No. 2C
OUTCOMES: RELAPSE AND TARDIVE DYSKINESIA

John M. Kane, M.D., *Department of Psychiatry, Hillside Hospital, 75-59 263rd Street, Glen Oaks NY 11004-1150*

SUMMARY:

Although enormous effort and resources are devoted to the acute treatment of psychotic relapse in schizophrenia, the long-term prevention of relapse should be among the most critical goals of optimum management.

Relapse rates vary enormously both among treated and untreated groups; however, it is clear that maintenance medication can substantially reduce the risk of relapse. In the past ten years considerable research has been directed toward improving the benefit-to-risk ratio of long-term pharmacotherapy, focusing on dosage reduction and/or intermittent treatment.

The risk of tardive dyskinesia has been a particularly important focus and has influenced medication utilization. The potential of new antipsychotics with a significantly reduced risk of neurologic side effects to enhance maintenance treatment effectiveness will be enormous.

No. 2D
THE VALUE OF ATYPICAL ANTIPSYCHOTIC MEDICATIONS

Gary D. Tollefson, M.D., *Lilly Resch Laboratories, Eli Lilly and Company, Lilly Corp Ctr, Drop Code 0538, Indianapolis IN 46285*

SUMMARY:

Beginning with the introduction of chlorpromazine, the majority of antipsychotics have been products of D_2 receptor screening programs. While structurally diverse, this family demonstrated comparable profiles. However, clozapine (CLZ) has catalyzed a new phase of antipsychotic research, i.e., a search for atypicality. CLZ's profile introduces a variety of hypothetical mechanisms; however, which one or combination mediates its unique efficacy is unknown. A broad spectrum receptor approach includes olanzapine (OLZ), which exhibits greater affinity for 5-HT_2 than D_2 and D_4 than D_2 receptors coupled with nanomolar affinity at 5-HT_{1C}, D_1, and select muscarinic binding sites. Alternative efforts to target a subset of CLZ binding sites include risperidone/sertindole/seroquel (5-HT_2/D_2). OLZ selectively diminishes the spontaneous firing rate of A_{10} dopaminergic neurons without decreasing the rate of A_9 neurons on chronic administration. In vivo behavioral studies suggest antipsychotic potential with a low propensity to produce EPSE. OLZ also increases punished responding in a conflict test similar to CLZ and substitutes for CLZ in a drug discrimination test. In a Phase II, double-blind, placebo-controlled trial, 335 patients with DSM-III-R schizophrenia were randomized to one of the five arms: placebo, OLZ-low (2.5-7.5 mg), OLZ-medium (7.5-12.5 mg), OLZ-high (12.5-17.5 mg), or haloperidol (HAL; 10-20 mg). The acute phase of the study lasted six weeks, with evaluations performed weekly. Patients in both the medium- (−12.6 pts.) and high-dose (−15.2 pts.) ranges of OLZ achieved baseline to endpoint reductions in normalized BPRS total scores that were statistically superior to placebo (3.1 pts.). OLZ high dose reduced mean BPRS total score more than haloperidol (−15.2 and −12.9, respectively). OLZ-high also yielded a significant reduction in negative symptoms (SANS composite score) versus HAL or placebo (−13.6, −6.6, and −1.9). Patients receiving OLZ experienced no acute dystonic reactions, significantly fewer EPSE events, and minimal prolactin elevation as compared to HAL. Discontinuations due to an adverse event were highest in the placebo (10.3%) and haloperidol (8.7%) groups.

In summary, these results (and two other trials to be presented) provide evidence that OLZ may fulfill criteria as a novel "atypical antipsychotic." These observations will be contrasted with several other agents in the later stages of drug development.

No. 2E
DISEASE-STATE MANAGEMENT AND PSYCHOTIC ILLNESS

William M. Glazer, M.D., *Mass General Hospital, Harvard Univ. School of Med., Beach Plum Lane, Menemsha MA 02552*

SUMMARY:

The health care reform movement in the United States is altering roles of the treaters and the treated. Since 1983 when Arizona undertook the first statewide Medicaid managed care demonstration project, state planners have shown considerable interest in methods to organize mental health services for persons suffering from conditions like the chronic psychoses. The majority of states are now experimenting with various management strategies that are affecting populations with severe and persistent mental illnesses. Such strategies include allocating capitated or risk-based reimbursements to organized delivery systems, carving out the mental health and pharmaceutical benefits, privatizing services, and merging related funding agencies. As these initiatives evolve, positive and negative trends are becoming apparent. In this presentation, such trends will be presented with examples. Findings from a consumer-based monitoring study of a model managed care program in the Tidewater Virginia area will also be presented. Mental health professionals, families, and consumers need to assure that managed mental health systems do not cut costs without protecting the quality of care delivered. Strategies for individuals and organizations to influence these programs will be considered.

REFERENCES:

1. Stahl, SM: *Essential Psychopharmacology*. Cambridge University Press, New York, 1996.
2. Pickar D: Prospects for pharmacotherapy of schizophrenia. *The Lancet* 1995;345:557-562
3. Kane JM: Schizophrenia. *N Engl J Med* 334(1):34-41, 1996.
4. Gerlach J, Peacock L: New antipsychotics: the present status. *Int Clin Psychopharmacology* 10(Suppl 3):39-48, 1995.
5. Bazelon Center for Mental Health Law Report: *Managing Managed Care for Publically Financed Mental Health Services*, Washington, DC 1995.

INDUSTRY SUPPORTED SYMPOSIUM 3—THE EXPERT CONSENSUS: TREATMENT OF OCD
Supported by Solvay Pharmaceuticals, Inc. and Pharmacia & Upjohn, Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to identify the crucial points in the disease management of OCD and implement expert consensus guidelines for dealing with them.

No. 3A
OCD METHODOLOGY

Allen J. Frances, M.D., *Department of Psychiatry, Duke University, P.O. Box 3950, Durham NC 27710*

SUMMARY:

The expert consensus method of guideline development provides an unusual opportunity to aggregate and quantify the opinions of a large group of the leading experts on obsessive-compulsive disorder on those questions that are most pertinent to clinicians in their everyday practice. First, we will discuss how our method evolved from, but advances upon, previous methods of practice guideline development. Next, we will discuss how questions are framed to deal with the most vexing clinical problems, how the experts' answers are framed in an easy to understand format, and what are the ways in which expert consensus opinions are transformed into guideline recommendations. We will then outline the ways in which these recommendations can be applied in practice, with special attention to the important role of clinical judgment and the tailoring of suggestions to the particular needs and preferences of the individual patient with obsessive-compulsive disorder.

No. 3B
DIFFERENTIAL DIAGNOSIS OF OCD

Michael R. Liebowitz, M.D., *Department of Psychiatry, NY State Psychiatric Institute, 722 West 168th Street/MB #120, New York NY 10032-2603*

SUMMARY:

There are a number of situations in which the diagnosis of obsessive-compulsive disorder may be difficult to make. This presentation will attempt to provide guidance for these situations, including the following: (a) differentiating between obsessive thoughts and mental compulsions such as counting; (b) deciding in certain cases whether there is enough insight, either currently or historically, to meet the criterion that the obsessions or compulsions have been recognized as excessive or unreasonable; (c) differentiating between obsessive-compulsive disorder, specific illness phobia, and hypochondriasis in the face of severe and excessive fears of illness; (d) determining when the behavioral or mental compulsions are driven by fears of discomfort rather than of danger were they not to be performed. There are certain comorbid conditions that commonly accompany obsessive-compulsive disorder and, when present, have important ramifications for treatment and outcome; yet they tend to be underdiagnosed or ignored. Panic disorder, social phobia, and major depressive disorder are three such conditions. Comorbid substance abuse and character pathology can also complicate both diagnosis and treatment.

No. 3C
EXPERT CONSENSUS GUIDELINES FOR THE TREATMENT OF OCD

John S. March, M.D., *Department of Psychiatry, Duke University Medical Center, P.O. Box 3527, Durham NC 27710*

SUMMARY:

This presentation will review findings from the Expert Consensus Guidelines for Obsessive-Compulsive Disorder, which surveyed national and international academic experts in treatment of OCD regarding the treatment of OCD across the lifespan. Among other clinically relevant questions, the guidelines hone in on crucial elements in the pharmacotherapeutic and psychotherapeutic treatment of OCD as well as how best to combine these treatment modalities. Specific guidelines include: selecting initial treatment strategies, minimizing medication side effects, managing the treatment-resistant patient, maintenance treatment, treatment discontinuation, OC spectrum disorders, and managing OCD in the face of comorbidity. Finally, we review findings that provide guidance on how best to allocate treatment resources to the child, adolescent, or adult with OCD.

No. 3D
THE IMPLEMENTATION OF OCD TREATMENT GUIDELINES

John P. Docherty, M.D., *Department of Psychiatry, New York Hospital/Cornell, 21 Bloomingdale Road, New York NY 10605*

SUMMARY:

Although approximately 2,000 guidelines currently exist, current data suggest that very few of these are actually used. Two major problems appear to be responsible for this lack of use: the nature and quality of the guidelines themselves, and the lack of integration of the guidelines as part of an overall health delivery system. We will review an approach to guidelines that attempts to rectify these two problems. This approach involves a novel process for the development of more useful guidelines. Usefulness is defined as guidelines that are impartial, representative, practical, quantitatively derived, verifiable, and modifiable during use. Second, it involves a program of implementation that follows a public health model. Level one of the intervention entails a systematic process for developing awareness and broad acceptance of the guidelines among the stakeholders in the treatment process, including policymakers, administrators, providers of care, patients, and their families. The second level involves a program of effective education involving both didactic presentation and the opportunity for paradigmatic "hands-on" experience in the use of the guidelines. Level three involves a program for sustained involvement of the providers in the use of the guidelines, by using "network" technology. This entails an interactive process in which data on the use of the guidelines provide information regarding their feasibility and validity, and support a continuous process of modification and refinement. This network is supported through the use of tools appropriate to the particular guidelines, including paper and pencil forms as well as closed-loop computer systems. Specific issues arising in this implementation program for OCD will be discussed.

No. 3E
OCD PRACTICE GUIDELINES

James N. Broatch, M.S.W., *OCD Foundation, P.O. Box 70, Milford CT 06460*

SUMMARY:

The introduction of any set of practice guidelines should take into account their impact on the consumer—both patient and family. We will discuss the optimal ways of including patients and families in a psychoeducational program about OCD and in negotiating the best match of available treatment options with the specifics of patient preferences, previous treatment experiences, symptom presentation, and other needs. We will also discuss the role of the OCD Foundation in providing support for patients and their families and in enhancing public education, treatment, and research efforts for this important problem.

REFERENCES:

1. Frances A, Kahn D, Carpenter D, et al: *The Expert Consensus Practice Guideline Project: A New Method of Establishing Best Practice*, (in press).
2. Carrasco JC, Hollander E, Schneier FR, Liebowitz MR: Treatment outcome of obsessive-compulsive disorder with comorbid social phobia. *Journal of Clinical Psychopharmacology* 53: 387-391, 1996.
3. March J, Liebowitz M, Frances A, et al: The expert consensus guidelines for obsessive compulsive disorder. *J Clinical Psychiatry* (suppl) in preparation.

INDUSTRY SUPPORTED SYMPOSIUM 4—THE EARLY STAGES OF SCHIZOPHRENIA
Supported by Janssen Pharmaceutica and Research Foundation

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The objective of the symposium is to describe the initial neuropsychiatric investigations into the early stages of schizophrenia and to integrate these findings with pharmacologic and family interventions.

No. 4A
TREATMENT OF FIRST-EPISODE SCHIZOPHRENIA: EFFECTS OF CONVENTIONAL AND ATYPICAL DRUGS

Jeffrey A. Lieberman, M.D., *Department of Psychiatry, University of North Carolina, Medical School Wing B CB#7160, Chapel Hill NC 27599*

SUMMARY:

Studies have shown that first-episode or recent-onset schizophrenia patients have differential treatment responses from chronic multi-episode patients. These include a greater proportion of patients recovering, decreased levels of residual symptoms, and increased levels of sensitivity to side effects and response to lower doses of treatment. In addition, early effective intervention during the initial episode of illness can improve long-term outcome. An important question is whether atypical antipsychotic drugs can provide any greater efficacy in the treatment of patients in this stage of their illness. This presentation will describe data from studies on the treatment outcomes of first-episode patients receiving conventional and atypical antipsychotic medication. The differential effects on side effects, psychopathology, and long-term outcome will be presented and discussed.

No. 4B
OPTIMAL ANTIPSYCHOTIC DOSING FOR FIRST-EPISODE SCHIZOPHRENIA

Robert B. Zipursky, M.D., *Clarke Inst of Schizophrenia, 250 College Street, Room 732, Toronto, M5T 1R8 ON, Canada*

SUMMARY:

Treatment of a first episode of schizophrenia represents a critical opportunity for psychiatrists to facilitate the fullest degree of remission early in the course of illness. It is also important that the patient's experience with antipsychotic medication be a positive one. If a patient experiences distressing side effects, it can be expected that long-term compliance and long-term outcome may be compromised. Determination of the optimal antipsychotic dose for the treatment of a first episode of schizophrenia is, therefore, of critical importance.

We have been conducting a study to determine the minimal dose of antipsychotic medication required for the treatment of a first episode of schizophrenia. Our preliminary results suggest that many patients respond very well to doses of haloperidol in the range of 2-5 mg/day. Such dosages are well tolerated with a low incidence of extrapyramidal side effects. The majority of patients who experienced clinical improvement had plasma haloperidol levels below 5 ng/ml.

Our experience suggests that patients receiving treatment for a first episode of schizophrenia are both very responsive and sensitive to antipsychotic medication. Low dose treatment is effective and well tolerated for many of these patients. Our current understanding of the therapeutic range of plasma levels for haloperidol may not be applicable to patients experiencing a first episode of schizophrenia.

No. 4C
CHILDHOOD-ONSET SCHIZOPHRENIA

Judith H.L. Rapoport, M.D., *Child Psychiatry Branch, Nat'l Inst. of Mental Health, 9000 Rockville Pike, 10 6N-240, Bethesda MD 20892-0001;* Sanjiv Kumra, M.D., Leslie K. Jacobsen, M.D.

SUMMARY:

The study of very early onset schizophrenia (VEOS) may provide clues to risk factors or etiology of the disorder. Since 1990, a study of children and adolescents with onset of schizophrenia by age 12 has extended previous studies showing that VEOS represents a clinically malignant form of the disorder.

Neurobiological studies with this population utilizing measures of smooth pursuit eye movements, autonomic activity, and anatomic brain imaging have demonstrated clear continuity with adult-onset disorder. Similar to clinical findings, the neurobiological markers resemble those for poor-outcome adult patients. Anatomic MRI findings include larger ventricular volume and decreased brain volume. No temporal lobe abnormalities were seen.

There is no evidence of greater familial schizophrenia, abnormalities in obstetrical history, pubertal development, or psychosocial stressors for the very early onset group. Most striking is the more dramatic decrease in brain volume, and stronger relationship between decreased brain volume and negative symptoms than reported for adult cases. There is an increased rate of mental retardation and learning disorders in the full siblings of the early-onset cases.

In summary, VEOS represents a group with greater impairment of early brain development than adult cases. Some aspects of this may be familial.

No. 4D
SCHIZOPHRENIA DURING ADOLESCENCE

S. Charles Schulz, M.D., *Department of Psychiatry, Case Western Reserve Univ., 11100 Euclid Avenue, Cleveland OH 44106;* Robert L. Findling, M.D., Lee Friedman, Ph.D., John Kenney, Ph.D., Diane Cola,

SUMMARY:

Introduction: The average age of onset of definitive symptoms of schizophrenia is in late teen-age years, yet few neuropsychiatric or pharmacologic studies have examined patients during adolescence. The purpose of this presentation is to describe results of MRI and neuropsychological tests performed on adolescents with schizophrenia and teen-age control subjects. Also, an open trial of the atypical antipsychotic, risperidone, will be discussed.

Results: Seventeen teenagers diagnosed as schizophrenic or schizoaffective were found to have smaller brain size but not smaller VBR than the control group. In addition, a neuropsychological test battery showed the schizophrenic teenagers to have poorer performance than controls especially in attention and memory. Another cohort of teenagers had their response to risperidone assessed by chart review. There was substantial decrease in BPRS scores during risperidone treatment and the medication was well tolerated.

Discussion: Studies in teenagers with schizophrenia may lead to clues about the development of the illness. To date neuropsychiatric measures are similar but not identical to those seen in adult patients. Treatment studies can lead to empirically supported pharmacologic approaches and to the best dosing strategies for young people.

No. 4E
PARENTS OF TEENAGERS WITH PSYCHOSIS

Marilyn A. Davis, Ph.D., *Department of Psychiatry, Case Western Reserve University, 11100 Euclid Avenue, Cleveland, OH 44106*

SUMMARY:

This paper considers the diverse models that have been devised to offer psychoeducational family management for psychotic patients. The efficacy of each format (i.e. groups for relatives only, individual family programs, multiple family groups, etc.) for schizophrenic patients and their close relatives will be reviewed with particular relevance to their applicability to patients in the earliest stages of their disorder. Data will be presented from a re-analysis of the first generation of controlled trials testing the efficacy of these programs, which strongly suggest that the format and content of psychoeducational programs need to be modified to be consonant with the phase of a specific episode as well as the stages of a patient's disorder.

More recent controlled trials will be discussed that consider whether and in what stages of a schizophrenic disorder psychoeducational programs focused on the individual patient may be more relevant than those that engage members of the patient's family as well.

The implications of findings from persons with schizophrenia for persons on the earliest stages of bipolar-manic and schizoaffective

disorder will be discussed using data from recently completed randomized controlled trials with these populations, which tested the addition of family psychoeducation to routine pharmacotherapy.

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3. Findling R, Grcevich S, Lopez I et al: Antipsychotic medications in children and adolescents. *J Clin Psychiatry* 57 (suppl 9):19-23, 1996.
4. Goldstein MJ: Psychoeducation and family treatment related to the phase of a psychotic disorder. *International Clinical Psychopharmacology*, 11, supplement 2, 77-84, 1996.

INDUSTRY SUPPORTED SYMPOSIUM 5—CLINICAL IMPLICATIONS OF SEROTONERGIC DRUG ACTIONS Supported by Bristol-Myers Squibb

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session the participant should be familiar with differences in serotonergic antidepressant drug action and the implications of these differences for clinical treatment of depression.

No. 5A
PHARMACOLOGY OF THE SEROTONERGIC ANTIDEPRESSANTS

J. Craig Nelson, M.D., *Department of Psychiatry, Yale University, 20 York Street, New Haven CT 06504*

SUMMARY:

During the past decade several new antidepressants have been introduced. Most have a serotonergic mechanism of action. The first of this group, the SSRIs, are "selective" in that they block the serotonin (5-HT) transporter but have little effect on other neurotransmitters. Yet within the serotonin system, the SSRIs have a diffuse effect on 5-HT receptors. Seven classes of serotonin receptors have been identified, some with subreceptors. These receptors control or modulate many functions including sleep, appetite, aggression, and sexual function, and several specific symptoms such as pain, nausea, obsessions, anxiety, and depression. When an SSRI blocks reuptake, serotonin transmission is enhanced not only at the intended sites of action, but at all serotonin receptors. This can result in unintended adverse effects. Some of the most recent antidepressants have been developed to target specific 5-HT receptors. The objective is to enhance effects at the intended site of action and reduce unwanted effects at other 5-HT receptors. This presentation will review the serotonin system and the functional correlates of specific receptors, and will consider the implications of this information for the use of serotonergic antidepressants in clinical practice.

No. 5B
ADDRESSING ANXIETY IN THE MANAGEMENT OF DEPRESSION

Jan A. Fawcett, M.D., *Department of Psychiatry, Rush-Presbyterian Medical Cntr, 1725 West Harrison, Suite 955, Chicago IL 60612*

SUMMARY:

What is the frequency of occurrence of anxiety symptoms in depression? What is the clinical significance, how should anxiety be assessed, and what are helpful management considerations and tactics? This presentation will address these questions with data from the literature relating to the frequency, severity, relationship to poor outcomes, and suicidal behavior associated with comorbid anxiety. Specific types of anxiety of special significance in patients manifesting depression will be reviewed, covering the importance of panic attacks, anxious ruminations, psychotic anxiety, and anxiety/agitation induced by antidepressant medications. Various possible mechanisms of anxiety will be addressed in terms of a discussion of pharmacologic approaches to the treatment of severe anxiety/agitation in the presence of depression, including the use of short-acting benzodiazepines, neuroleptics, anticonvulsants, 5HT2 blocking antidepressants, beta-blockers, and other medications.

No. 5C
THE EFFECTS OF ANTIDEPRESSANT MEDICATIONS ON SLEEP

A. John Rush, M.D., *Department of Psychiatry, UT Southwestern Medical Center, 5959 Harry Hines Blvd, Ste 600, Dallas TX 75235-9070*

SUMMARY:

Most classical antidepressant medications prolong rapid eye movement (REM) latency and suppress REM sleep without increasing deep slow wave (Stage 3/4) sleep. The newer agents are more selective in their effects on neurotransmission, and some appear distinguishable from the classic agents by a different effect on EEG sleep. This presentation will (1) review what is known about the effects of antidepressants on the sleep of healthy subjects and depressed patients, (2) review the effects of pharmacological agents (norepinephrine or serotonin agonists and antagonists) on sleep in animals and humans, and (3) review new data on the differential effects of nefazodone on the sleep of depressed patients, as compared to tricyclics, selective serotonin reuptake inhibitors, and other agents. The theoretical as well as potential clinical implications of these findings will be discussed.

No. 5D
SEROTONERGIC DRUG ACTIONS: SIDE-EFFECT IMPLICATIONS

Anthony J. Rothschild, M.D., *Department of Psychiatry, Univ of Mass Medical Center, 55 Lake Avenue N., Room S7-802, Worcester MA 01655*

SUMMARY:

Clinicians now have available an array of drugs that have effects on the serotonin system. The ever-expanding list of serotonin receptors requires a continual re-evaluation of so-called "selective" agents as new populations of serotonin receptors are discovered. The differing actions of serotonergic agents and the implications of these differences as they pertain to side effect profiles will be discussed. A particular focus of the lecture will be the effects of serotonergic drugs on sexual function and the relationship of the medication's pharmacologic profile to this troublesome side effect. Practical clinical strategies for decreasing serotonergic drug-induced side effects will be reviewed.

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3. Armitage R, Rush AJ, Trivedi MH, et al: The effects of nefazodone on sleep architecture in depression. *Neuropsychopharmacology, 10*:123-127, 1994.
4. Glennon RA, Dukat M: Serotonin receptor subtypes, In: Bloom FE, Kupfer DJ (eds): *Psychopharmacology: The Fourth Generation of Progress*; Raven Press, Ltd., New York, 1995.

INDUSTRY SUPPORTED SYMPOSIUM 6—VIOLENCE AND AGITATION: EMERGING STRATEGIES FOR AN UNDERTREATED PROBLEM
Supported by Abbott Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, participants will be able to recognize violence and agitation in a wide spectrum of patients; discuss the current therapies for treating these conditions and their limitations; identify the newer pharmacologic agents; and better treat these patients psychologically.

No. 6A
THE DIAGNOSIS AND EPIDEMIOLOGY OF VIOLENCE AND AGITATION

Trey Sunderland, M.D., *Dept. of Geriatric Psych., Nat'l Inst. of Mental Health, 10 Center Dr. MSC1264, 10-3D41, Bethesda MD 20892*

SUMMARY:

Most people think they know about violence and aggression. They have seen it, perhaps felt it, and certainly feared it in one form or another across all levels of society. For years, the epidemic of violence has been well recognized and frequently chronicled in popular culture as well as daily newspaper and magazine articles. Even without formal study, most Americans know about many of the gender and ethnic breakdowns associated with youth violence in this country. The labeling of violent behaviors is obvious in young adults, and multifaceted explanations are commonly proposed, including alcohol and drug abuse, personality disorders, and underlying psychiatric syndromes. More enigmatic, however, is the diagnosis and epidemiologic pattern of violence and aggression in the elderly population. While not as common or as personally threatening as in younger populations, behavioral disturbances in the elderly can be just as damaging to individual lives and institutional settings. To better understand the diagnosis of violence and aggression, basic statistics for the incidence and persistence of violent acts will be reviewed across the age spectrum. Since many different underlying causes lead to the final common pathway of aggression, these various etiologies must be carefully differentiated to set the stage for appropriate clinical treatment whenever possible.

No. 6B
CURRENT PHARMACOTHERAPY FOR AGITATION AND VIOLENCE

Pierre N. Tariot, M.D., *Department of Psychiatry, Monroe Community Hospital, 435 East Henrietta Road, Rochester NY 14620*

SUMMARY:

Agitated and aggressive behaviors occur in numerous clinical conditions, ranging from mental retardation to late-life neurodegenerative disorders. To the extent that pharmacotherapeutic approaches show benefit, there is very limited evidence suggesting that the specific syndromal diagnosis is critical. It is possible that this is related in part to hypotheses regarding neurobiologic underpinnings to behaviors of this nature. The treatment of these signs and symptoms begins with the identification and amelioration of physical, environmental, social, and psychiatric factors. A systematic approach to these issues will be presented. For agitated and aggressive behaviors that remain despite conservative approaches, empirical administration of pharmacologic agents may be appropriate. An example of a first step in this process is to inventory the specific behaviors and develop a "therapeutic metaphor," i.e., subtype the agitated or aggressive behaviors according to the presence of target symptoms likely to be responsive to specific classes of medication. Available evidence is reviewed regarding the efficacy of somatic therapies for this problem, including antipsychotics, antidepressants, anticonvulsants, antianxiety agents, beta-blockers, cholinergic therapies, and miscellaneous therapies including L-tryptophan, hormonal therapy, and opiate antagonists.

No. 6C
THE MOOD COMPONENT OF AGITATION AND VIOLENCE

Susan L. McElroy, M.D., *Department of Psychiatry, Univ of Cincinnati Col of Med, 231 Bethesda Avenue, ML 559, Cincinnati OH 45267-0559*

SUMMARY:

Agitation and violent behavior associated with a variety of medical and nonaffective psychiatric disorders are often accompanied by affective symptoms. Although often unrecognized, the affective component of agitation and violence may have important clinical implications. To illustrate this, research into the phenomenology and psychopharmacologic treatment response of three conditions characterized by agitation and/or violence—namely, behavioral agitation of dementia, intermittent explosive disorder, and paraphilias—will be reviewed. It will be suggested that behavioral agitation of dementia may represent a form of secondary mixed mania (i.e., mixed mania due to a general medical condition), and that intermittent explosive disorder and paraphilias may represent phenotypes of bipolar disorder. Wider implications for the diagnosis and treatment of agitation and violence in general will then be suggested.

No. 6D
PSYCHOSOCIAL TREATMENTS FOR AGITATION AND VIOLENCE

Linda Teri, Ph.D., *Department of Psychiatry, University of WA Medical Cntr., 1959 NE Pacific Street, Seattle WA 98195*

SUMMARY:

Agitation and violence are serious problems facing dementia patients and their caregivers. Currently both pharmacological and nonpharmacological approaches are discussed in the literature, yet little empirical data are available to guide the clinician in the selection of the most efficacious approach. This presentation will focus on nonpharmacological approaches to the treatment of agitation and violence in dementia patients.

One such approach utilizes a systematic behavioral treatment program designed to train caregivers in methods of behavioral observations and change, identifying and developing strategies to maximize patient function, and teaching effective problem-solving skills for

day-to-day difficulties in patient care. Specific strategies used in this approach will be discussed as well as the overall model of care, entitled the ABCs of Behavior Management. In addition, an ongoing controlled clinical trial in which this technique is being evaluated will be discussed.

No. 6E
EMERGING ANTIPSYCHOTIC TREATMENTS OF VIOLENCE

Rajiv Tandon, M.D., *Department of Psychiatry, Univ of MI Medical Center, 1500 E Medical Ctr Dr/UH8D8806, Ann Arbor MI 48109-0116*

SUMMARY:

Violent behavior presents a significant management problem in a variety of psychiatric disorders. A range of pharmacological strategies have been employed to treat this problem of aggression; these include antipsychotics, benzodiazepines, SSRIs, anticonvulsants and other mood stabilizers, and beta-blockers. Antipsychotic medications are among the most commonly used agents to treat aggression. While typical antipsychotics or neuroleptics are moderately effective in the management of aggressive behavior, their use presents problems as well. Extrapyramidal side effects, the risk of tardive dyskinesia, and a range of other side effects present difficulties and also hinder patient acceptance and compliance. Akathisia, a not uncommon neuroleptic side effect, can "drive" aggressive tendencies and other psychopathology. Atypical antipsychotics such as clozapine and risperidone are significantly better than the neuroleptics with regard to the above side effects. Additionally, studies indicate that clozapine and to some extent risperidone have a specific antiaggressive effect in populations of schizophrenic patients. Several new atypical antipsychotics are in the process of being introduced into clinical use. These include sertindole, olanzapine, quetiapine, and ziprasidone. Preliminary data indicate that sertindole and olanzapine may also possess a specific antiaggressive property in addition to being superior to traditional antipsychotics with regard to the above side effects. The 5-HT-2A blocking activity common to all of these agents may be the basis of this common property; it is well-known that dysregulation of the serotonin system is a major factor in aggressive behavior. In this presentation, differences between the traditional neuroleptics and the atypical antipsychotics will be discussed with particular reference to their effects on aggression. Differences between individual atypical antipsychotics will be summarized as well. Data from recent studies will be reviewed and possible underlying mechanisms discussed. Finally, the potential of the emerging atypical antipsychotics to more effectively manage the problem of aggression will be discussed.

REFERENCES:

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2. Christoffel KK, Anzinger NK, Merril DA: Age-related patterns of violent death, Cook County, Illinois, 1977 through 1982. Northwestern Univ; Univ of Illinois, Chicago. *A J Dis Child* 143:1403-1409, 1989.
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4. Tariot PN, Schneider L, Katz I: Anticonvulsants and other nonneuroleptic treatment of agitation in dementia. *J Geriatr Psychiatry Neurology* 8(suppl 1):S28-S39, 1995.
5. McElroy SM, Pope HG Jr, Keck PE Jr, et al: Are impulse-control disorders related to bipolar disorder? *Comprehensive Psychiatry* 37:229-240, 1996.

INDUSTRY SUPPORTED SYMPOSIUM 7—DEPRESSION AND ITS SUBTYPES: A TREATMENT UPDATE
Supported by Organon Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participants should be able to recognize, diagnose, and treat major depressive subtypes including atypical, hostile, anxious, and bipolar. In addition, the attendees will become familiar with new antidepressant modalities and mechanisms of action.

No. 7A
COURSE AND TREATMENT OF ATYPICAL DEPRESSION

Andrew A. Nierenberg, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street WAC 815, Boston MA 02114-3117*

SUMMARY:

Atypical depression is the most common form of depression in outpatients, but little is known about its comorbidity, course, and treatment compared to melancholia. Beyond the well-characterized constellation of symptoms that define atypical depression (mood reactivity, hypersomnia, leaden paralysis, hyperphagia, and rejection sensitivity), specific Axis I and II comorbid conditions may differentiate atypical from other depressed patients. Similarly, age of onset, duration of episodes, frequency of relapses and recurrences, and frequency of complete remission in atypical depression may be different. It has not been established if atypical depression is a stable subtype or if it is just one of several forms of depression that an individual may express during a lifetime of recurrent depressions. MAOIs are superior to TCAs for the treatment of atypical depression, but no studies have compared MAOIs to the newer generation of antidepressants (SSRIs, bupropion, venlafaxine, nefazodone, and mirtazapine). Because of the favorable benefit/risk ratio, clinicians tend to use these newer antidepressants for all outpatients, including those with atypical depression, even though the literature is limited. A review and critique of the relevant literature on atypical depression will be presented.

No. 7B
ANXIOUS DEPRESSION: CLINICAL CHARACTERISTICS AND TREATMENT OPTIONS

R. Bruce Lydiard, M.D., *Department of Psychiatry, Medical University of SC, 171 Ashley Avenue, Charleston SC 29425*

SUMMARY:

Depression and anxiety co-occur frequently in depressed patients. Studies indicate that over half of patients presenting with major depression may have a concomitant anxiety disorder. An additional percentage have subdiagnostic anxiety symptoms that are clinically significant. The most commonly observed anxiety disorders detected in patients seeking treatment for depression include generalized anxiety disorder, panic disorder, and social phobia. There are few literature references regarding optimal treatment of patients with comorbid major depression and anxiety disorders. However, it is clear that

when major depression co-occurs with anxiety disorders, treatment resistance is unfortunately common. In the long term, there is increased risk for psychosocial impairment, financial disability, and suicide for these unfortunate individuals. Because comorbidity of anxiety and depression is extremely common, optimal treatment is essential.

Following an overview of the existing literature, potential treatment strategies will be presented, and remaining questions will be discussed.

No. 7C
DEPRESSION AND ANGER ATTACKS

Maurizio Fava, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, ACC 815, Boston MA 02114*

SUMMARY:

Major depressive disorder is frequently accompanied by irritability, hostility, and anger attacks. This presentation will focus on depression with anger attacks (hostile depression), which is characterized by the presence of sudden spells of anger associated with general irritability and autonomic arousal symptoms such as tachycardia, sweating, flushing, and a feeling of being out of control. Hostile depression was first introduced by John Overall who identified this subtype as being characterized by high levels of hostility, suspiciousness, somatic symptoms, and anxiety. We have subsequently replicated Overall's findings in two separate studies of depressed outpatients with anger attacks. Depressed patients with anger attacks tend to present with more pathologic behaviors than depressed patients without anger attacks, and anger attacks subside in most patients following antidepressant treatment. Although there is anecdotal evidence that TCAs may be less effective than SSRIs in treating this subtype of depression, a recent double-blind, placebo-controlled study found similar response rates to sertraline and imipramine among depressed patients with anger attacks.

No. 7D
BIPOLAR DISORDER: SPECIFIC TREATMENTS?

William Z. Potter, M.D., *CNS, Lilly Research Laboratories, DC: 0532, Indianapolis IN 46285*

SUMMARY:

To date, no treatment has been *specifically* developed for the treatment of the depressed phase of manic-depressive illness. Many reports indicate that at least in some patients drugs indicated for unipolar depression may precipitate mania and/or worsen the long-term course of the illness. An example of this phenomenon is the association of rapid cycles with the use of trycyclic antidepressants (TCAs).

There are clinical reports for non-TCA antidepressants—MAOIs, SSRIs, buproprion—suggesting superiority over TCAs for bipolar depression. Systematic controlled studies, however, are not available to test these possibilities. Most recently, it has been suggested that compounds as disparate as selective alpha 2 adrenoreceptor antagonists and novel antiepileptics (e.g., lamotrigine) may have special efficacy. These various pharmacologic approaches to bipolar depression will be reviewed in terms of what is known about the distinguishing biochemical actions of each drug class. Since no common pattern emerges, it will be argued that agents with novel actions be more systematically assessed in the treatment of bipolar depression. The importance of finding a "maintenance antidepressant" for some patients who do not respond to lithium monotherapy will be emphasized with a critical evaluation of the potential of newer drugs.

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6. Sachs GS, Lafer B, Stoll AL, et al: A double-blind trial of bupropion versus desipramine for bipolar disorder. *J Clin Psychiatry* 55:391-393, 1994.

No. 7E
NEW ANTIDEPRESSANT MECHANISMS AND IMPLICATIONS FOR DEPRESSIVE SUBTYPES

Jerrold F. Rosenbaum, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC 815, Boston MA 02114;* Stephen M. Stahl, M.D.,

SUMMARY:

Five new pharmacological classes of antidepressants have been introduced since the tricyclic antidepressants and the monoamine oxidase inhibitors. These include the selective serotonin reuptake inhibitors, a norepinephrine dopamine reuptake inhibitor, a serotonin norepinephrine reuptake inhibitor, and a serotonin-2 antagonist/reuptake inhibitor. Most recently introduced is mirtazapine, an alpha-2 antagonist with several additional pharmacological actions, sometimes referred to as a NASSA (noradrenergic, antihistaminergic, and specific serotonergic antidepressant).

Mirtazapine is the first alpha-2 antagonist marketed in the U.S. By blocking alpha-2 receptors on noradrenergic (NE) neurons, NE release is enhanced. By similarly blocking alpha-2 heteroreceptors on serotonin (5-HT) neurons, 5-HT release is enhanced. A second mechanism acts to enhance 5-HT release, namely the increase of NE at excitatory post-synaptic alpha-1 receptors on 5-HT neurons. Such actions increase both NE and 5-HT, not unlike dual reuptake inhibitors, but by an entirely separate and unique mechanism.

Although the evidence for one antidepressant acting in any given depressive subtype (more effectively than another) requires further study, it is evident from some differences already observed (MAOIs vs. TCAs in atypical depression), that different mechanisms of action may well have relevance for enhanced therapeutic efficacy in particular subtypes of depression. Certainly different mechanisms of action are associated with different side effect profiles.

INDUSTRY SUPPORTED SYMPOSIUM 8—ANTIPSYCHOTICS IN UNIQUE PATIENT POPULATIONS

Supported by Janssen Pharmaceutica and Research Foundation

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, participants should be able to describe what is currently understood about the use of newer and traditional antipsychotics in refractory schizophrenia, child and adolescent schizophrenia, mood disorders, aggressive and violent behavior, and behavioral disorders in the developmentally disabled.

No. 8A
TREATING THE PERSISTENTLY VIOLENT PSYCHOTIC PATIENT

Jan Volavka, M.D., *Clinical Research, Nathan S. Kline Institute, 140 Old Orangeburg Road, Orangeburg, NY 10962*

SUMMARY:

Atypical antipsychotics reduce violent behavior and hostility in schizophrenic and schizoaffective patients. For clozapine and risperidone, these specific antiaggressive effects exceed the general antipsychotic effects of these compounds, and are exerted—at least in part—independently of the general antipsychotic effects. The antiaggressive effect of risperidone is greater than that of a comparable dose of haloperidol. This is probably also true for the antiaggressive effects of clozapine, although experimental evidence for this is not yet available. Head-to-head comparison of antiaggressive effects of risperidone, clozapine, and haloperidol is currently underway in a multicenter trial.

Antiaggressive effects of selective serotonin reuptake inhibitors have been studied in patients with personality disorders as well as in schizophrenic patients. The results are encouraging. Carbamazepine or valproic acid appear to be commonly used as antiaggressive supplemental treatment of schizophrenic and schizoaffective patients, although the effectiveness of these treatments has not been thoroughly tested.

No. 8B
ANTIPSYCHOTICS IN TREATMENT-REFRACTORY PATIENTS

Stephen R. Marder, M.D., *Department of Psychiatry, UCLA/West Los Angeles VA, 11301 Wilshire Blvd. (116A), Los Angeles CA 90073*

SUMMARY:

A substantial proportion of patients with schizophrenia fail to respond adequately to antipsychotic medications. This paper will characterize different subgroups of refractory patients including those with refractory positive symptoms, refractory negative symptoms, and an intolerance to the side effects of antipsychotics. The introduction of newer antipsychotics—including clozapine, risperidone, olanzapine, and sertindole—has changed our approaches to each of these subgroups. Clozapine has been demonstrated to be effective for a majority of patients with treatment-refractory illnesses. Recent controlled studies suggest that risperidone may also be more effective than conventional antipsychotics for some of these patients. The possible role of olanazapine and sertindole for treatment-refractory subgroups will also be discussed. This presentation will conclude with practical suggestions for managing treatment-refractory patients.

No. 8C
MANAGING SYMPTOMS IN THE DEVELOPMENTALLY DISABLED

Daniel J. Luchins, M.D., *Department of Psychiatry, University of Chicago, 5841 S. Maryland Ave., MC-3077, Chicago IL 60637-2602*

SUMMARY:

Studies suggest that almost one half of institutionalized retarded individuals receive psychotropic medication, mostly antipsychotic agents. In a small fraction of cases this medication is used to treat psychotic disorders. This presentation will review the literature on treatment of psychosis in this population with special emphasis on issues related to medication choice, dosage, and side effects. In the majority of retarded individuals, antipsychotic medication is used to treat the behavioral manifestation of nonpsychotic disorders. The use of antipsychotic medication in such situations is controversial. The available controlled studies suggesting that these drugs may have a place in treating these disorders will be reviewed, as will studies dealing with factors that appear to promote or impede reduction or discontinuation of antipsychotic medication. Finally, the experience with newer antipsychotic agents including clozapine and risperidone will be reviewed, including as yet unpublished analysis of the total experience with these agents at state facilities for the developmentally disabled in Illinois.

No. 8D
ROLE OF ANTIPSYCHOTICS IN TREATING MOOD DISORDERS

Paul E. Keck, Jr., M.D., *Department of Psychiatry, University of Cincinnati, PO Box 670559 231 Bethesda Ave, Cincinnati OH 45267;* Susan L. McElroy, M.D., Stephen M. Strakowski, M.D.,

SUMMARY:

Although psychotic symptoms often occur during acute mania in patients with bipolar disorder, psychotic mania has been and continues to be misdiagnosed as schizophrenia or other psychotic illnesses. Furthermore, similar diagnostic confusion may surround patients presenting with psychotic depression.

The role of antipsychotic agents in the acute and maintenance treatment of psychotic mania remains unclear. Data from recent studies suggest that a surprisingly high proportion of patients with bipolar disorder receive maintenance antipsychotic treatment, despite the availability of lithium, valproate, and carbamazepine. However, preliminary evidence suggests that clozapine may be a useful treatment alternative in patients with treatment-refractory bipolar disorder. New antipsychotics may also play such a role.

Data from controlled studies indicate that combination treatment of psychotic depression with an antidepressant and antipsychotic is more effective than with either agent alone. However, the need for and subsequent duration of maintenance antipsychotic treatment in psychotic depression is not well established.

No. 8E
ANTIPSYCHOTICS FOR YOUNG PEOPLE WITH SCHIZOPHRENIA

Gabrielle A. Carlson, M.D., *Department of Psychiatry, SUNY Stony Brook, Putnam Hall, Stony Brook NY 11794-8790*

SUMMARY:

There are three issues relevant to the discussion of antipsychotic medication use in young people. (1) Although children and adolescents are usually combined, important differences phenomenologically and developmentally must be considered. In adults, antipsychotic medications are most frequently used to treat psychosis. In

children, these drugs are rarely given for this indication, probably because schizophrenia is rare (1/10,000 in the general population). The diagnostic blur with developmental disorders is greater. The rate of schizophrenia increases five-fold in adolescence at which time the disorder also is more likely to be confused with other acute psychoses. (2) Since it takes at least six months from the onset of psychotic symptoms to begin to clarify diagnosis with certainty, one often treats adolescents without being entirely sure how their psychosis will sort out diagnostically. (3) Because psychotic disorders are rare, systematic clinical research on treatment is scanty and drug companies have not included children and adolescents in their stage 1-3 drug trials so that one is left to extrapolate from adults to youths of all ages. Pharmacology of the older and newer antipsychotics for treatment of aggression and mood disorders in young people will be described. I will discuss the information we have about the specific efficacy and practical problems of treating both children and adolescents with psychosis, taking information from the literature and personal experience as both a practicing child psychiatrist and a consultant to long-term units treating psychotic youths.

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INDUSTRY SUPPORTED SYMPOSIUM 9— PERENNIAL ISSUES IN THE MANAGEMENT OF DEPRESSION
Wyeth-Ayerst Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to (1) treat bipolar depression, SSRI nonresponders, comorbid panic/depression, and geriatric depression; (2) limit drug-drug interactions.

No. 9A
TREATING DEPRESSION IN THE BIPOLAR PATIENT

Charles B. Nemeroff, M.D., *Department of Psychiatry, Emory Univ. School of Medicine, 1639 Pierce Drive, Suite 4000, Atlanta GA 30322*

SUMMARY:

Considerable attention has been paid in recent years to managing bipolar disorder patients. Most of the emphasis has been placed on treating and preventing hypomanic or manic phases. Less attention has been paid to the treatment of the depressed phase of the illness.

Some bipolar patients who experience depression may be managed by altering the dose of thymoleptic. This strategy is reviewed and guidelines presented for what doses and plasma levels to aim for as well as for whom to combine thymoleptics. Although this strategy may help obviate the need for using antidepressants, which in themselves can precipitate mania or hypomania or change cycling, some patients cannot be so managed. For them, the addition of an antidepressant is warranted. Many of the antidepressants have proven efficacy in bipolar disorder and virtually all are at risk for producing hypomania or mania. Recent data suggest bupropion may be less problematic. Guidelines are presented for choosing specific antidepressants, dosing schedules, and how long to use them. Of importance is maintaining bipolar disorder patients on thymoleptics while using antidepressants.

No. 9B
WHERE DO YOU TURN WHEN SSRI'S FAIL?

Alan F. Schatzberg, M.D., *Dept of Psych & Behav Sci, Stanford Univ School of Med, 401 Quarry Road, Stanford CA 94305-5548*

SUMMARY:

Although the selective serotonin reuptake inhibitors (SSRIs) have had a tremendous impact on the treatment of depressed patients, some patients fail to respond to a trial of one of these agents. This talk will discuss what to do when this occurs.

For some patients, dosage adjustment of the SSRI (either an increase or a decrease) may be helpful. Data suggest increases from 20 mg. to 40 mg./day of fluoxetine may bring out a response in patients who had not previously responded. A dosage decrease may be helpful in other patients, particularly in those who had experienced an initial response at low doses (e.g., 10-20 mg. of fluoxetine) but who lost the response as dosages were increased (e.g., to doses of 60-80 mg./day). In patients where dosage adjustment has not been successful, several strategies may be tried. First, the addition of bupropion or a tricyclic antidepressant may be helpful. Dosages of these agents and drug interaction issues are discussed. Second, we will review the efficacy of adding T3, lithium, or pindolol to SSRIs. Lastly, a recent alternative has been to switch to venlafaxine, which enjoys both norepinephrine and serotonin reuptake blocking properties. Data on efficacy of venlafaxine are presented and side effects and dosages are discussed.

No. 9C
THE DEPRESSED OLDER PATIENT

Carl Salzman, M.D., *Department of Psychiatry, Harvard Medical School, 74 Fenwood Road, Boston MA 02115-6106*

SUMMARY:

This presentation will update the diagnosis and treatment of late-life depression. Diagnostically, the appearance of depression in the older patient varies widely. Although many elderly patients have typical MDD symptoms, many do not. For example, the depression of frail over 80-year-olds is characterized by withdrawal of interest, irritability, and somatic symptoms. Sadness, hopelessness, suicidality, pessimism, and guilt are less apparent in the very elderly compared with the younger elderly. Among all older patients, anxiety is extremely common and memory complaints are typical. There is often poor concordance between patient self-ratings of depression, doctors' ratings of depression, and nurses' 24-hour ratings of depression. The concept of a "Persistently Miserable Syndrome" to describe late-life depression will be introduced.

All antidepressants may be used to treat the elderly. Tricyclics are usually reserved for the most severely ill or for nonresponders to other antidepressants. Hydroxymetabolites of tricyclics may be cardiotoxic. SSRIs are currently the first-choice antidepressant treatment. Starting doses should be low and initial side effects may be prominent. Newer antidepressants such as venlafaxine and nefazodone are highly promising for this age group. Bupropion is widely

used, but may be activating; data on mirtazepine are lacking in the elderly. Drug and metabolic enzyme interactions may be more serious in the elderly; common examples will be presented.

No. 9D
ANXIETY AND DEPRESSION

Philip T. Ninan, M.D., *Department of Psychiatry, Emory University, 1701 Uppergate Drive, Room 130, Atlanta GA 30322*

SUMMARY:

The syndrome of major depression is characterized by the core emotion of sadness. Similarly, the syndromes considered anxiety disorders have worry as their core component. However, anxiety in its various manifestations is seen in the majority of patients with major depression. Comorbidity of subsyndromal and syndromal anxiety disorders and major depression occur frequently at the time of evaluation and historically. In addition, the presence of an anxiety disorder increases the risk for the development of major depression in the future. Thus, the categorical distinction of major depression and the anxiety disorders is often confounded in clinical practice. Concurrent subsyndromal anxiety and depressive symptoms has been termed mixed anxiety–depressive disorder. Comorbidity of anxiety and depressive syndromes can be a sign of greater severity. Various biochemical, behavioral, and other theoretical explanations have been proposed for comorbid anxiety and depression.

The treatment of comorbid anxiety and depression is a particular challenge to clinicians. Various pharmacological and psychotherapeutic treatments are available. The pharmacological management of patients with comorbid symptoms vs. syndromes will be discussed. Clinical medicine attempts to treat syndromes rather than independently treat individual symptoms. The pros and cons of symptomatic versus syndromal management will be discussed in relationship to anxiolytics and sedative/hypnotics.

No. 9E
THE POTENTIAL FOR DRUG INTERACTIONS

Larry Ereshefsky, Pharm.D., *University of Texas, 7703 Floyd Curl Drive, San Antonio TX 78284-6220*

SUMMARY:

Long-term medication maintenance for depression increases the likelihood of the need for additional drug therapy to treat comorbid psychiatric and medical illness. The cytochrome P450 system (CYP450) isoenzymes most likely to be affected by antidepressant therapy are: CYP1A2, CYP2D6, CYP2C8/9, CYP2C19, CYP3A3/4. Serotonin selective reuptake inhibitors variably inhibit these CYP enzymes: Fluoxetine 20 mg/day significantly inhibits CYP2C19 and CYP2D6, and modestly inhibits CYP1A2 and CYP3A3/4; Paroxetine 20 mg/day significantly inhibits CYP2D6; while sertraline 100 mg/day modestly inhibits CYP2D6 and CYP3A3/4. Venlafaxine and mirtazapine are, overall, modestly or weakly inhibiting at the CYP systems. Clinical data evaluating venlafaxine, fluoxetine, paroxetine, and sertraline using dextromethorphan probe methodology will be presented. Significant antidepressant interactions at CYP2D6 include: codeine, phenothiazines, tricyclic antidepressants, and cough products. At CYP3A significant drug interactions include: terfenadine, astemizole, cisapride, alprazolam, protease inhibitors, steroids, calcium channel blockers, and carbamazepine. The clinical relevance of these interactions will be explored using a relative-risk approach and a critical look at our adverse drug reaction surveillance system.

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INDUSTRY SUPPORTED SYMPOSIUM 10—ALZHEIMER'S DISEASE: COMPREHENSIVE TREATMENT APPROACH
Supported by Novartis Pharmaceuticals Corporation

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The participant should understand the comprehensive approach required in the treatment of Alzheimer's patients and caregivers including pharmaceutical treatment options and psychosocial intervention. Cholinergic and noncholinergic treatment options will be explored as will the importance of comprehensive support programs.

No. 10A
EVALUATION AND DIFFERENTIAL DIAGNOSIS

Steven T. DeKosky, M.D., *Director, Alzheimer's Disease Research Center, University of Pittsburgh Medical Center, 3811 O'Hara Street, Pittsburgh, PA 15213*

SUMMARY:

Diagnosis of Alzheimer's disease (AD) has evolved from an uncertain clinical label, assigned after a litany of blood studies and central nervous system (CNS) investigations, to a specific diagnosis based on clinical features. Although there is not a specific diagnostic test for AD (other than in carriers of the rare gene mutations on chromosomes 1, 14, and 21), the clinical diagnosis of AD can be made with a high degree of specificity and sensitivity with a clinical examination. A comprehensive patient history, complete physical examination, and neuropsychological testing both point to the diagnosis and exclude other causes of symptoms. The diagnosis should not simply be considered a "diagnosis of exclusion." Physical, neurological, and neuropsychiatric evaluations can identify possible symptoms and interventions, both cognitive and behavioral, and promote realistic outcome expectations of patients, families, and physicians. At this time, the implications of apolipoprotein E genotyping and biological markers for dementia diagnosis or screening are still under evaluation, as are some of the newer functional brain imaging techniques.

No. 10B
ASSESSMENT OF COGNITIVE AND NONCOGNITIVE SYMPTOMS

Marshal F. Folstein, M.D., *Department of Psychiatry, New England Medical Center, 750 Washington Street, Box 1007, Boston, MA 02111*

SUMMARY:

Evaluation and staging of Alzheimer's disease require quantitative meeasures of mental status that can be reassessed over long periods of time. Scales of cognitive performance effectively measure deficits in memory and mental function for both early- and late-stage patients. Assessment of emerging treatments depends heavily on consistent and effective use of these data.

No. 10C
EVALUATION OF BEHAVIORAL ABNORMALITIES

Jeffrey L. Cummings, M.D., *Department of Neurology, UCLA School of Medicine, 710 Westwood Plaza, Los Angeles, CA 90095*

SUMMARY:

Behavioral abnormalities occur in nearly all patients with Alzheimer's disease (AD). Apathy, agitation, irritability, depressive symptoms, anxiety, agitation, disinhibition, and delusions are frequent behavioral manifestations of AD. Correlations between cognitive decline and behavioral abnormalities are modest. Behavioral disturbances are more severe as the disease progresses but may be present early in the course. Once present, the neuropsychiatric manifestations of AD tend to recur frequently. Some neuropsychiatric abnormalities have implications for the course of the illness: delusional patients exhibit more rapid cognitive decline than nondelusional patients. Behavioral symptoms are a major source of distress for the patient, contribute importantly to caregiver burden. and are the principal cause of institutionalization of AD patients. Functional neuroimaging studies with positron emission tomography and single photon emission computed tomography suggest that the frontal and temporal lobes are more affected in patients manifesting behavioral symptoms than in equally demented patients without neuropsychiatric disturbances. Behavioral abnormalities improve with treatment with conventional psychotropic agents, and some behaviors benefit from treatment with cholinergic drugs. There are multiple approaches to detecting and quantifying behavioral symptoms in AD and several rating scales that aid in this process. Recognition and treatment of the behavioral alterations of AD are an important part of managing AD patients and supporting their caregivers.

No. 10D
CURRENT SYMPTOMATIC TREATMENT OF ALZHEIMER'S DISEASE

Andrew Satlin, M.D., *Department of Psychiatry, McLean Hospital, Belmont, MA 02178*

SUMMARY:

In the absence of a cure, physicians attending Alzheimer's disease patients often utilize medications and behavioral therapy to offer relief from mental and behavioral symptoms. Selection and evaluation of treatments are made more difficult by the complex nature of the disease itself, comedications, and the frequent presence of comorbidities in the elderly patient. Improvement in cognitive deficits can sometimes be achieved by treatment of psychiatric symptoms. In addition, psychosocial support for caregivers has been shown to reduce treatment costs, delay institutionalization, and improve quality of life for both patients and caregivers.

No. 10E
BEYOND PALLIATIVE TREATMENT: ALTERING THE COURSE OF ALZHEIMER'S DISEASE

Kenneth L. Davis, M.D., *Department of Psychiatry, Mt. Sinai Medical Center, One Gustave L. Levy Place, New York, NY 10029*

SUMMARY:

Laboratory and clinical research efforts continue to reveal new facets of the complex biochemistry of Alzheimer's disease. Recent discoveries include increased beta-amyloid depostion, metabolic disorders, abnormal neuropeptide levels, and physical anomalies that progress in Alzheimer's disease patients. Any of these may become intervention points for changing the natural history of the disease. New molecules and specific treatments will be discussed.

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INDUSTRY SUPPORTED SYMPOSIUM 11—DIAGNOSIS AND TREATMENT OF PRIMARY HEADACHE DISORDERS FOR THE PRACTICING PSYCHIATRIST
Supported by Bristol-Myers Squibb

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able 1. to properly diagnose primary headache disorders; 2. to understand the prevalence and impact of primary headache on the population in the United States; 3. to learn recent advances in the pathophysiology of primary headache and their application to new advances in pharmacotherapy; 4. to understand psychiatric aspects from etiologic, psychophysiologic and comorbid perspectives; 5. to learn modern behavioral and nonpharmacologic techniques.

No. 11A
PREVALENCE AND IMPACT OF PRIMARY HEADACHE DISORDERS

Richard Lipton, M.D., *Headache Unit, Albert Einstein College, 111 East 210th Street, Bronx NY 10467*

SUMMARY:

Primary headache disorders are common and quite often disabling. Tension-type headache, the most common of the primary headache disorders, affects up to 70% of the population. Though it rarely causes work absenteeism, it is associated with decrements in performance in a variety of spheres. Migraine affects about 12% of the population and is a major cause of work absenteeism as well as disability at work. Both disorders are most common in mid-life and more common in women. Migraine prevalence is inversely related to socioeconomic status. Primary headache disorders have an influence that extends well beyond the acute attack. These disorders are associated with substantial direct and indirect costs as well as measurable enduring decrements in quality of life. The enormous ictal and inter-ictal impact of headache disorders provides an appropriate target for acute and preventive treatment.

No. 11B
THE DIAGNOSIS AND CLASSIFICATION OF PRIMARY HEADACHE DISORDERS

Alan M. Rapoport, M.D., *New England Ctr for Headache, 778 Long Ridge Road, Stamford CT 06902*

SUMMARY:

Accurate headache diagnosis requires a detailed history of the various types of headaches, plus relevant medical history, a careful physical and detailed neurological examination, and a working knowledge of different headache types. The currently recognized headache classification was derived by headache specialists from many countries, who were part of the Classification Committee of the International Headache Society, and was published in the journal *Cephalagia* in 1988. There are 13 major headache classifications, including three primary headache disorders. The most common type is tension-type headache, affecting a large segment of the population and presenting as a mild to moderate, bilateral, steady and non-throbbing pain anywhere in the head, which is usually brief in duration, easy to treat, and not very frequent. Migraine is a more severe, long-lasting, throbbing, often unilateral headache occurring one to four times a month and more prevalent in women. It is sometimes associated with visual aura and is often triggered by hormonal events in women. The most painful type is cluster headache, which is much more prevalent in men. It is usually episodic, occurring for four to six weeks in the year and coming back on a daily basis during that period of time. The pain is excruciating with a periorbital or eye pain, which is boring in nature and associated with certain autonomic findings such as red and tearing eye, stuffed and running nostril, all on the side of the pain. These primary headache disorders can be differentiated from psychiatric and secondary organic headache disorders by careful history, examination, and ocassionally appropriate laboratory testing.

No. 11C
PATHOPHYSIOLOGY OF PRIMARY HEADACHE DISORDERS

Ninan T. Mathew, M.D., *Houston Headache Clinic, 1213 Herman Drive, Suite 350, Houston TX 77004*

SUMMARY:

The old concepts that cranial vascular dilatation and pericranial muscle contraction are the basic mechanisms of migraine and tension-type headache, respectively, are not substantiated. Data accumulated recently indicate that there is a generator of migraine in the upper brain stem periaqueductal dorsal rhaphe area. Activation of ascending pathways from the brain stem, particularly to the occipital cortex, may result in spreading oligemia (most probably secondary to spreading cortical depression) and may account for the aura of migraine. Clinical and neurophysiological observations suggest a central neuronal hyperexcitability in migraineurs. Low cerebral magnesium levels and increased glutamate activity have been postulated as mechanisms underlying the central neuronal hyperexcitability. Prophylactic antimigraine agents act centrally, altering this process.

Pain of migraine originates at the perivascular nerve endings of intracranial extra-cerebral blood vessels (trigeminal vascular system). Experimental and clinical evidence suggest vasodilatation and neurogenic inflammation as the processes that transduce pain. Specific antimigraine agents, particularly 5-HT_1 agonists, cause vasoconstriction and reduce neurogenic inflammation.

Central and peripheral (trigeminal vascular system) serotonin systems are important in migraine pathophysiology. Disturbances of central neurotransmitter systems, including serotonin, may explain frequent comorbidity of migraine with other disorders such as depression, bipolar illness, and anxiety. Evidence for possible central origin of tension-type headache will also be presented.

No. 11D
PHARMACOLOGIC TREATMENT OF PRIMARY HEADACHE DISORDERS

Joel Saper, M.D., *Neuro Institute, Michigan Head Pain, 3120 Professional Drive, Ann Arbor MI 48104-5199*

SUMMARY:

Modern techniques for the pharmacological treatment of headaches are now focused on using medications that directly influence neurotransmission and receptor/neurotransmitter function. More than ever before, this pharmacological approach blends the neuroscience experience of both neurology and psychiatry. With the recognition that many, if not most, patients with difficult headache disorders suffer from neuropsychiatric comorbidities, treatment strategies have employed neuropsychiatric phenomena.

The symptomatic treatment of headache revolves around the use of medications, such as the ergot derivatives, sumatriptan, analgesics, nonsteroidal medications, and a variety of peripheral drugs. Also, a more enlightened attitude regarding the use of opioids in selected cases of intractable pain deserves mention.

The preventive treatment of headache, while still employing the use of beta blockers and other vasoactive medications, is now reflecting the increased interest in centrally acting drugs that affect upper brainstem neurotransmission. In addition to the tricyclic antidepressants, which have become one of the pillars of headache prophylaxis, agents being used with increasing frequency and success include SSRIs, anticonvulsants (valproic acid, gabapentin, etc.) MAO inhibitors, and others.

As part of this presentation, a review of guidelines for the use of opioid medications in the treatment of headache will be provided, as well as a brief review of protocols for intractable and persistent headache. A review of why patients do not improve will also be offered.

No. 11E
PSYCHIATRIC ASPECTS INCLUDING COMORBIDITY

Fred D. Sheftell, M.D., *New England Ctr for Headache, 7781 Long Ridge Road, Stamford CT 06902-1227*

SUMMARY:

There is much ongoing debate with respect to the pathophysiologic basis of primary headache disorders. The role of psychiatric aspects remains controversial. Research has demonstrated neurobiologic mechanisms as being present in migraine, tension-type, and cluster headache disorders. Historically, disorders whose causes have been poorly understood have been ascribed to psychiatric causality. At one time these views were held in regard to the origins of epilepsy, Parkinson's disease, Huntington's chorea, and others.

It would be useful to view psychiatric factors in primary headache disorders from the three major perspectives of etiologic, psychophysiologic, and comorbid factors. The bulk of primary headache disorders will fall into the area of psychophysiologic concepts where a biological vulnerability does exist, which can be affected by psychiatric factors. Finally, advances in our psychobiologic and neurobiologic investigations reveal that the neurotransmitters involved in some of the major psychiatric disorders such as depression and anxiety are also related to headache. A good deal of research in the area of serotonergic mechanisms and epidemiologic data points to shared mechanisms as being a consideration in understanding comorbidity.

No. 11F
BEHAVIORAL AND PSYCHOPHYSIOLOGIC APPROACHES TO PRIMARY HEADACHE DISORDERS

Steven M. Baskin, Ph.D., *New England Ctr for Headache, 7781 Long Ridge Road, Stamford CA 06902*

SUMMARY:

The present review describes a biobehavioral approach that has emerged from psychobiologic models of primary headache disorders. The first phase of this model is a thorough assessment with multiple types of data collected including clinical interview and psychophysiologic evaluation. Treatment strategies are based upon the detailed behavioral assessment. Psychological and pharmacological interventions are often combined in a comprehensive multifaceted program. A detailed educational program is undertaken. Patients learn a group of coping skills that foster self-regulation incorporating sensory and reactive components. The sensory component involves perception of pain sensations. It can be altered through biofeedback and relaxation techniques. The reactive component consists of thoughts and feelings that accompany head pain and may lead to problematic behaviors. Headache-specific cognitive and behavioral psychotherapies are effective change agents. Behavioral strategies to enhance compliance with drug regimens have been shown to maximize outcome. Recent research has shown a comorbidity of migraine, tension-type headache, and mood and anxiety disorders. Treating these comorbid psychiatric factors is important to successful treatment especially in the refractory patient. These behavioral therapies help the headache sufferer incorporate a variety of coping skills, encouraging personal involvement and responsibility. They expand the scope of treatment to include emotional, cognitive, behavioral, and social factors that often have a bearing on outcome.

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INDUSTRY SUPPORTED SYMPOSIUM 12—DIAGNOSTIC AND TREATMENT ADVANCES IN MANIC DEPRESSION
Supported by Abbott Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to appreciate special challenges in the differential diagnosis of bipolar disorder, recognize the emerging clinical significance of "soft" bipolar disorders, understand the impact of newer treatments on length of stay in manic depressive illness, distinguish special features of adolescent mania, and comprehend the implications of new findings in brain imaging in bipolarity.

No. 12A
BIPOLAR DISORDER: ON THE EDGE OF DSM-IV

Jan A. Fawcett, M.D., *Department of Psychiatry, Rush-Presbyterian Medical Cntr, 1725 West Harrison, Suite 955, Chicago IL 60612*

SUMMARY:

The DSMs and specifically DSM-IV have made useful changes in the effort to make the diagnosis of bipolar disorder more precise and more valid. Since psychiatric diagnosis is based entirely upon symptom presentation and history without the help of clinical laboratory studies, precise ascertainment of diagnostic criteria is a desirable goal. The drawing of diagnostic borders leaves questions concerning individual cases, which become important in terms of treatment decisions. This presentation will focus on some clinically relevant questions that occur "around the edges." Diagnostic considerations such as the diagnosis and treatment of bipolar disorder with comorbid alcohol and substance abuse, and the differentiation of psychosis in bipolar disorder, schizophrenia, and schizoaffective disorder will be discussed. The differentiation of recurrent major depression from "covert cycling," which does not meet criteria for bipolar disorder, will also be addressed. Treatment issues such as the risk factors for suicide in bipolar patients and the problems of addressing depressive episodes in the bipolar patient will also be considered. In this context, in practice, an awareness of the spectrum of bipolar presentations may be more important than the shifting standard resulting from rigorous classification.

No. 12B
BIPOLAR II: CLINICAL PICTURE, COURSE, AND TREATMENT

Hagop S. Akiskal, M.D., *Department of Psychiatry, Univ. of California, San Diego, 9500 Gilman Drive, La Jolla CA 92093-0603*

SUMMARY:

Between the extremes of full-blown manic-depressive illness, where the person has one acute manic episode (bipolar I), and strictly defined unipolar depression without personal or family history of mania (unipolar I), there exists a prevalent spectrum of "soft" bipolar conditions with depression and hypomania (bipolar II). Actually, their prevalence is three to four times that of full blown bipolars. Depressive episodes in bipolar II typically arise from the substrate of irritable, cyclothymic, and/or hyperthymic temperamental dysregulation. As a result, mood swings in bipolar II are cyclic, biphasic, and abrupt, and often induced by antidepressants (or stimulant abuse) and/or by seasonal changes and, possibly, by transmeridian travel. Falling in and out of love—and other excitements that could lead to sleep deprivation—represent other possible contributory factors to the instability of these patients. Such instability often leads to Axis II cluster B diagnoses, which further obscure the recognition of the bipolar nature of their pathology. Current data indicate intriguing associations between cyclothymia and artistic creativity on the one hand, and hyperthymia and leadership on the other. These considerations have significant implications for theory, practice, and public health, especially in outpatient psychiatric settings where soft bipolar conditions are prevalent.

No. 12C
ADOLESCENT MANIA: RECOGNITION AND LONG-TERM MANAGEMENT

Gary S. Sachs, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC-815, Boston MA 02114*

SUMMARY:

Adolescent mania is a common and severe mental health problem. The peak interval for onset of bipolar illness is between 15 and 19 years of age, and a significant percentage experience their first episode before age 15 years (McMahon 1994). Gilberg et al reported the outcome at 30 years of age for 55 adolescents hospitalized for psychosis: "The poorest prognosis of all with regard to pension and long period of sick leave was shown by the group with bipolar disorder. . . ."

Prompt diagnosis and adequate medical therapy offer real hope for improved prognosis, but few adolescents receive either. Instead, behavioral symptoms are often discounted or attributed to schizophrenia, attention deficit disorder, substance abuse, or personality disorder. Delay in treatment can be costly. Studies from Kraepelin's time to the present demonstrate a tendency for progressive shortening of the euthymic period after successive episodes. An untreated bipolar adolescent could expect eight-ten episodes by age 30.

Early recognition and effective treatment can modify the course of bipolar illness and reduce the rate of complications such as suicide, violence, substance abuse, disruption of education, and maladaptive family adjustment. This presentation considers typical presentations of adolescent mania and management strategies.

No. 12D
COSTS AND BENEFITS OF BIPOLAR PHARMACOTHERAPY

Paul E. Keck, Jr., M.D., *Department of Psychiatry, University of Cincinnati, PO Box 670559 231 Bethesda Ave, Cincinnati OH 45267;* Susan L. McElroy, M.D., Jerry A. Bennet, Pharm.D.,

SUMMARY:

Clearly the benefits of successful treatment of bipolar disorder outweigh the costs. These benefits include not only the alleviation of human suffering and prevention of death, but also gains in economic productivity and reductions in costs to health care, social welfare, and criminal justice systems. The major costs associated with treatment of bipolar disorder include physician and other health care visists, medications, and hospitalization. Recent studies suggest that the costs of hospitalization contribute most substantially to the overall cost of treatment. Thus, strategies that prevent syndromal relapse or recurrence and that hasten recovery from an acute mood episode may reduce this cost.

Three mood-stabilizing medications, lithium, valproate, and carbamazepine, are commonly used in the treatment of patients with bipolar disorder. However, there are important differences in the extent to which these agents have been studied in the treatment of all phases of the disorder (acute mania, acute bipolar depression, maintenance therapy), in their time course of onset in acute mania, side effects, and clinical features associated with response. These differences have potential impact on both the choice of medication and the health-economics of treating bipolar disorder.

No. 12E
BRAIN IMAGING IN BIPOLAR DISORDERS

Terence A. Ketter, M.D., *Dept Psych & Behav Sci, Stanford Univ. School of Med., Building 10, Room 3N-212, Stanford CA 94305-5543;* Mark S. George, M.D., Timothy A. Kimbrell, M.D., John T. Little, M.D., Robert M. Post, M.D.,

SUMMARY:

Emotional processes, both in health and in mood disorders, appear related to prefrontal and anterior paralimbic function. Recent studies have demonstrated anterior paralimbic activation during pharmacological (procaine) and neuropsychological (transient self-induced sadness) induction of affective arousal in healthy volunteers. Furthermore, mood disorder patients had blunted anterior paralimbic activation with both of these probes. Most functional imaging rest studies have noted prefrontal and anterior paralimbic hypoactivity in depression, with some variability of findings, perhaps due to clinical heterogeneity. For example, depressed bipolar I patients may have baseline temporal lobe hypermetabolism, while bipolar II depression may be more heterogeneous with either increased or decreased cerebral metabolism. The few functional imaging studies of manic patients suggest frontal and temporal abnormalities.

Preliminary evidence suggests that baseline prefrontal and anterior paralimbic functional abnormalities may provide differential markers of therapeutic responses. Carbamazepine responders may have baseline hypermetabolism, which is attenuated with successful treatment, and nonresponders may have baseline hypometabolism, which is exacerbated by unsuccessful therapy. Brain lithium concentrations are about one half of plasma levels, and appear more closely related to antimanic effects than plasma levels. Future imaging studies should provide further insights into the neurobiology of bipolar disorders, particularly regarding illness subtypes and therapeutic response markers.

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INDUSTRY SUPPORTED SYMPOSIUM 13—MANAGEMENT OF SEXUAL DYSFUNCTION IN DEPRESSION
Supported by Glaxo Wellcome Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to better evaluate sexual dysfunction that originates from organic causes from that which may be an untoward effect of psychotropic medication (with emphasis on antidepressants) with or without psychogenic causes. The participant will have a better understanding of the role that antidepressants and other psychotropic medications may play in causing sexual dysfunction and will understand alternative medications and approaches. They will be able to provide the patient with information on current therapies and interventions in treating sexual dysfunction.

No. 13A
SEXUALITY IN THE MEDICALLY ILL

Thomas N. Wise, M.D., *Department of Psychiatry, Fairfax Hospital, 3300 Gallows Road, Falls Church VA 22046*

SUMMARY:

Sexuality is an important medium of interpersonal communication, which can be comprised by psychological and physical factors. A variety of disease states and their treatments can modify sexual response and create dysfunctions in desire, arousal, and release. This presentation will provide a systematic structure that delineates how best to assess and treat the sexual disorders found in the physically ill or those taking medications that cause sexual side effects. By recognizing the psychological reactions to an illness and understanding the impersonal effects of a disease upon sexuality the clinician can develop a rational treatment plan. Common disease states such as cardiovascular disease, diabetes, and breast cancer will illustrate this method.

No. 13B
SEXUAL DYSFUNCTION DUE TO PSYCHOTROPIC DRUGS

Richard Balon, M.D., *Department of Psychiatry, University Psychiatric Center, 2751 East Jefferson, Suite 200, Detroit MI 48207*

SUMMARY:

Psychotropic medications have been used more and more frequently in the treatment of various mental disorders. Recently, we have broadened our appraisal of psychotropic drugs, from focusing only on efficacy to focusing on the overall quality of life and the lower frequency of medication side effects. Sexual dysfunctions were underreported in the original efficacy studies of various psychotropic medications. However, we have seen an increase in reporting of sexual dysfunctions with various psychotropic drugs. Different sexual dysfunctions have been reported with practically every psychotropic medication. The inherent problem of evaluating sexual dysfunction as a side effect of psychotropic medication is that sexual dysfunction could be a part of symptomatology in many mental disorders. Antidepressants are the best example: they are used in the treatment of mood and anxiety disorders where sexual dysfunction can be part of symptomatology and can reportedly cause various sexual dysfunctions.

This presentation will review sexual dysfunction associated with various psychotropic drugs, namely antidepressants, and will provide some guidance for the management of this serious side effect. In addition, beneficial effects of antidepressants on human sexuality will be reported briefly.

No. 13C
SEXUAL DYSFUNCTION: THE ROLE OF THE PSYCHIATRIST

Virginia A. Sadock, M.D., *Department of Psychiatry, New York University Medical Center, 550 First Avenue, NB22N, New York, NY 10016*

SUMMARY:

Sexual symptoms are not life threatening but they may be severely disruptive or destructive to the individual or to their relationships with their partners. Causes and cures for the prevalent problem of sexual dysfunction have received attention for centuries from scientists as well as charlatans and ministers of religion. Women may participate in coitus without sexual arousal, but men lacking an erection cannot pretend or penetrate.

Although the mechanics of male and female sexual function are well documented, the neurophysiology, endocrinology, hemodynamics, and psychic pathways are not fully understood and await further investigations.

By the time a patient seeks sexual answers from his or her general physician or psychiatrist, cause and effect are so enmeshed that the answer is not apparent. In this presentation the author will seek to clarify the role of the psychiatrist in elucidating the cause and will suggest management techniques that have proved clinically effective in treating sexual dysfunction. In addition, this presentation will provide the participant with an overview of the value of injections used to maintain erection, prosthesis, and commonly available drugs that may enhance sexual function.

No. 13D
PRACTICAL CLINICAL APPROACHES TO SEXUAL DYSFUNCTION

Troy L. Thompson II, M.D., *Department of Psychiatry, Jefferson Medical College, 1025 Walnut Street, Suite 320, Philadelphia PA 19107-5005*

SUMMARY:

Sexual dysfunctions are a common complaint seen in both primary care and psychiatric practices. An accurate diagnosis and classification demand a careful history, an understanding of the action of pharmacologic interventions on sexual activity, and in addition, appropriate physical and laboratory investigation. A systematic approach to the role of medical diseases and their treatments will provide the basis for rational treatment planning that can be developed utilizing both psychotherapeutic and somatic interventions.

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3. Renshaw DC: Sexuality and depression, *Journal of Psychiatric Treatment and Evaluation*, 5:451-455, 1983.
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INDUSTRY SUPPORTED SYMPOSIUM 14—PSYCHIATRIC MANAGEMENT OF LONG-TERM CARE PATIENTS
Supported by Janssen Pharmaceutica and Research Foundation

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The audience will learn about the evaluation, diagnosis, and management of psychoses, mood disorders, and other severe behavioral disturbances in elderly patients in long-term care. The speakers will discuss the use of the newer "atypical" antipsychotics and other psychotropic medications, as well as psychosocial aspects of management in this challenging patient population.

No. 14A
PSYCHOTIC MANIFESTATIONS IN DEMENTIA

Peter J. Whitehouse, M.D., *Alzheimer's Center, University Hosp. of Cleveland, 12200 Fairhill Road, C2222, Cleveland OH 44120*

SUMMARY:

Since the time of Alois Alzheimer clinicians have recognized that Alzheimer's disease affects more than just cognitive abilities. Psychosis occurs commonly in Alzheimer's disease and other dementias and with increasing frequency as the diseases progress. An understanding of the phenomenology of psychosis includes understanding the relationship between cognitive and noncognitive symptoms, for example, between visual/perceptual abnormalities and visual hallucinations. Recently, we have conducted a large study of psychosis behavioral symptoms, including those in Alzheimer's disease, in over 500 patients involved in the National Institute on Aging Cooperative Study and Consortium To Establish A Registry For Alzheimer's Disease (CERAD). We will report the results of the study and its implications for management of long-term care patients.

No. 14B
PHARMACOTHERAPY OF LATE-LIFE PSYCHOSES

Dilip V. Jeste, M.D., *Department of Psychiatry, Veterans Affairs Medical Cntr., 3350 La Jolla Village Drive, San Diego CA 92161-0001;* John H. Eastham, Pharm.D., Enid Rockwell, M.D., M. Jackuelyn Harris, M.D., Jonathan P. Lacro, Pharm.D., James B. Lohr, M.D.,

SUMMARY:

Introduction: Late-life psychoses include a number of disorders such as schizophrenia, delusional disorder, psychotic mood disorder, dementia with delusions or hallucinations, and psychoses secondary to general medical conditions. Psychotic symptoms are a major source of caregiver stress and a frequent cause of institutionalization. Health care costs of schizophrenia in the elderly are probably higher than those at any other period in life.

Conventional or typical neuroleptics: For over 40 years, these neuroleptics have been the mainstay of the treatment of psychotic disorders. Their limitations include a relative lack of efficacy against negative symptoms and side effects, especially extrapyramidal symptoms and tardive dyskinesia. The risk of tardive dyskinesia is five to six times greater in older than in younger adults.

Newer atypical antipsychotics: During the last few years, the introduction of the newer serotonin-dopamine-blocking atypical antipsychotics has considerably improved the outlook for treating psychotic patients, including the elderly. Although mostly uncontrolled, the published studies of the use of clozapine and risperidone have shown efficacy of these agents in elderly psychotic patients. The different atypical antipsychotics differ in their side effect profiles, however. We will discuss recommendations for the clinical use of these agents.

No. 14C
TREATING PSYCHOSIS WITH MEDICAL COMORBIDITY

Ira R. Katz, M.D., *Department of Psychiatry, University of Pennsylvania, 3600 Market Street, Room 812, Philadelphia PA 19104*

SUMMARY:

Psychotic disorders are common among patients with disabling medical and/or neurological illnesses. In some cases, as with the visual hallucinations associated with eye disease (Charles Bonnet syndrome), the symptoms may be benign. Most often, however, psychotic symptoms are associated with difficulties in management, behavioral symptoms, and excess disability. In evaluating patients with psychoses associated with medical illness, clinicians must consider delirium, physiological causes, and adverse drug reactions. Treatment of patients with significant medical illnesses with neuroleptic medications must consider the trade-offs between the increased cardiac, peripheral autonomic, and central anticholinergic symptoms associated with low potency agents versus the increased extrapyramidal symptoms associated with high potency agents. Patients with Parkinson's disease are vulnerable to both extrapyramidal and autonomic side effects; although some authors have claimed benefits of clozapine on the basis of observational studies, further research is needed, especially about its safety. Patients with diffuse Lewy body disease, and, to a lesser extent, those with Alzheimer's disease are vulnerable both to extrapyramidal symptoms and to delirium from anticholinergic medications. Anecdotal reports and case series support the value of risperidone in these contexts, but controlled studies are needed to evaluate both benefits and risks.

No. 14D
ADVANCES IN THE TREATMENT OF MOOD DISORDERS IN THE ELDERLY

George S. Alexopoulos, M.D., *Department of Psychiatry, Cornell University Medical Col, 21 Bloomingdale Road, White Plains NY 10605*

SUMMARY:

Recent treatment studies of geriatric depression have focused on the plasma concentration-efficacy relationships of tricyclic antidepressants, the risk-benefit ratio of serotonin reuptake inhibitors (SRIs), and the efficacy of continuation and maintenance treatment. Small dosages of secondary amine tricyclics often are sufficient to produce plasma concentrations at the therapeutic range. However, the plasma concentrations for the elderly need to be similar to those of younger adults. Cognitive impairment or ventriculomegally may impair the plasma level efficacy relationships of nortriptyline. The hydroxylated metabolite of nortriptyline has been found to be associated with prolonged cardiac conduction. Special attention should be given to patients with bundle branch blocks since they increase by 10-fold the probability of second-degree block.

SRIs appear to be as effective as tertiary amine tricyclics in the acute treatment of depressed geriatric outpatients. Sertraline has been found to be as effective as nortriptyline in elderly depressives. Moreover, a recent geriatric study has shown that sertraline and fluoxetine are equally effective.

Depression occurring in the context of disability may present a therapeutic challenge. Impairment in activities of daily living appears to be related to depressive symptomatology and particularly to anxiety, depressive ideation, retardation, and weight loss. While most of these symptoms respond to antidepressants, depressive ideation and particularly hopelessness appears to be persistent. Hopelessness may be an appropriate focus of psychotherapeutic interventions intended to ameliorate both depressive symptomatology and disability.

Continuation and maintenance treatment studies suggest that nortriptyline is effective in preventing relapse and recurrence of geriatric depression. Studies are needed to examine the efficacy of SRIs as prophylactic agents in the elderly.

No. 14E
PSYCHOSOCIAL MANAGEMENT IN LONG-TERM-CARE PATIENTS

Maurice W. Dysken, M.D., *GRECC Program, Minneapolis Veterans Affairs, One Veterans Drive, Minneapolis MN 55417*

SUMMARY:

Nonpharmacological management of mood and behavioral problems in long-term care patients has focused on interventions to facilitate both initial and long-term adjustment to living in a nursing home. These therapeutic approaches include supportive group therapy, both directive and nondirective, interpersonal and problem-solving skills

training, increased physical contact with staff, and social reinforcement to increase activity. Although the number of comparison and controlled studies is limited, improvements have been demonstrated in depression, anxiety, cognitive functioning, social interaction, self-concept, and life satisfaction. A common finding, however, is the need to continue the intervention to maintain therapeutic gains. In this paper a review of current research in this area will be presented with an emphasis on design issues, mythology, and outcome measures.

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INDUSTRY SUPPORTED SYMPOSIUM 15—AGGRESSION AND VIOLENCE: AN UPDATE
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participants should be able to recognize the signs and symptoms of victimization and the behavioral and psychiatric correlates of violent behavior. The attendees will also become familiar with psychopharmacologic and psychotherapeutic approaches to the management of violent patients and with the medical-legal issues.

No. 15A
MENTAL HEALTH EFFECTS OF DOMESTIC VIOLENCE ON WOMEN AND CHILDREN

Linda A. Lewandowski, Ph.D., *School of Nursing, Johns Hopkins University, 1830 East Monument Street/448, Baltimore MD 21205;* Jacquelyn Campbell, Ph.D.,

SUMMARY:

The mental health effects of intimate partner violence on female victims are well established, with approximately 40% experiencing severe depression and a slightly smaller proportion exhibiting diagnosable post-traumatic stress disorder (PTSD). Sleeping disorders, substance abuse, and anxiety are also common sequelae. Mental health effects on the children of abused women have been less well studied but also include PTSD and behavior problems. This presentation will summarize existing literature and describe results of a recently completed longitudinal study of depression in battered women.

No. 15B
HOMICIDAL BEHAVIORS AMONG PSYCHIATRIC OUTPATIENTS

Gregory M. Asnis, M.D., *Department of Psychiatry, Montefiore Medical Center, 111 East 210th Street, Bronx NY 10467;* Gabriela Hundorfean, M.D., Waheed A. Saeed, M.D., Margaret L. Kaplan, Ph.D.,

SUMMARY:

Introduction: In the last decade, studies have demonstrated a link between violence and mental illness. The prevalence of various violent behaviors and their predisposing factors has been inadequately studied in large samples of psychiatric patients. In this presentation, we present data on the prevalence and interrelationship of violent behaviors in a large psychiatric outpatient study. We will also review other studies on these issues.

Method: 517 patients (204 males and 313 females; ages 13 to 87 years) being screened in a large psychiatric OPD received a number of self-rating forms (SCL-90, suicide and homicidal questionnaires, etc.) prior to being interviewed by a clinician. The questionnaires on violence evaluated both suicidal and homicidal behaviors including ideation, plan, attempt, and family history.

Results: 4% had prior homicidal attempts, 18% homicidal ideation, and 78% had no homicidal behavior. Homicidal behavior was highly associated with suicidal behavior. This was most exemplified by the fact that 90% of the homicidal attempters also made a prior suicide attempt. The homicidal attempt group had a significantly greater number of suicide attempts and multiple suicide attempts than the other groups.

Discussion: The main finding was the significant interrelationship and prevalence of homicidal and suicidal behaviors in psychiatric patients. It will also present replication data as well as review defining characteristics of violent behaviors (e.g., psychiatric diagnoses, demographics).

No. 15C
BIOLOGY AND TREATMENT OF AGGRESSION

Emil F. Coccaro, M.D., *Department of Psychiatry, MCP Hahnemann, 3200 Henry Avenue, Philadelphia PA 19129-1137*

SUMMARY:

Reduced central serotonin (5-HT) system function reflected by reduced concentrations of lumbar cerebrospinal fluid 5-hydroxyindolacetic acid (CSF 5-HIAA) or by altered hormonal responses to 5-HT challenge agents has been associated with impulsive aggressive behaviors in a variety of psychiatric patients, particularly those with personality disorders. In addition, there is emerging evidence of relationships between other neurotransmitters and these behaviors as well as their interaction with the 5-HT system. This presentation will review data from a variety of neurochemical and neuroendocrine studies in psychiatric patients in which history of impulsive aggressive behavior was used as the primary independent variable. Among the variables that have been reported as correlating with impulsive aggressive behavior are: (a) CSF 5-HIAA, (b) PRL response to fenfluramine challenge, (c) platelet 5-HT transporter/5-HT-2a receptors; (d) basal pMHPG and GH response to clonidine challenge (alpha-2 NE); (e) CSF vasopressin. In addition, data from a placebo-controlled double-blind study of fluoxetine in impulsive aggressive personality-disordered individuals will be presented.

No. 15D
PSYCHOPHARMACOLOGY OF PATHOLOGIC AGGRESSION

Maurizio Fava, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, ACC 815, Boston MA 02114*

SUMMARY:

The purpose of this presentation is to review the drug treatments of pathologic anger and aggression, conditions that are observed in

a wide range of psychiatric and neurological disorders. Since very little is known about the natural course of pathologic aggression and violent behaviors, only placebo-controlled studies can provide reliable assessments of the efficacy of drug treatments in these patient populations. Several drugs have in fact been found to be effective and to be superior to placebo in treating pathologic anger and aggression. While the efficacy of anticonvulsants in patients without a seizure disorder remains to be established (with the exception perhaps of valproic acid), lithium and beta blockers appear to be effective treatments of aggression among various neuropsychiatric conditions. Antipsychotics and benzodiazepines can reduce agitation and aggression in certain populations, but they can also induce behavioral disinhibition. Psychostimulants are effective in reducing aggressiveness in brain injured patients as well as in violent adolescents with oppositional or conduct disorders. Antidepressants, particularly selective serotonin reuptake inhibitors (SSRIs), are the treatment of choice for aggressiveness and hostility among patients with unipolar depression. SSRIs have also shown efficacy in the treatment of impulsive aggressive personality-disorder patients, autistic adults, and demented patients, while other serotonergic drugs such as buspirone and trazodone have been found to be helpful in certain populations. Pathologic anger and aggressive behaviors are heterogeneous phenomena whose diversity is reflected in marked differences in clinical presentations and response to treatment.

No. 15E
PSYCHOTHERAPEUTIC APPROACHES TO ANGER AND VIOLENCE

Jonathan E. Alpert, M.D., *Department of Psychiatry, Massachusetts General Hospital, WAC-815, 15 Parkman Street, Boston MA 02114;* Maya Spillmann, M.D.,

SUMMARY:

The emergence of anger and aggression reflects a complex set of neurobiological, psychological, and social factors and occurs across a broad range of overlapping populations including individuals with major mood disorders, psychoses, borderline and antisocial personality disorders, alcohol and other substance abuse and dependence disorders, attention deficit disorders, and mental retardation, dementia and other organic mental disorders. It also occurs in juveniles with disruptive behavioral disorders, sex offenders, and other perpetrators of domestic and non-domestic violence. Treatment occurs in diverse settings including outpatient, inpatient, and residential psychiatric treatment facilities, as well as within school, social services, military, and criminal justice systems. In view of the considerable distress, disruption, and danger to self and others associated with pathological anger and aggression, efforts to develop effective, comprehensive treatment approaches have important public health implications. We will review cognitive, behavioral, and psychodynamic psychotherapeutic strategies directed to the treatment of anger and aggression as well as group, milieu, and psychoeducational approaches. Challenges of future research in this area will be discussed including the need for standardized diagnostic assessment of study populations, the need for assessment of the quality of the therapy, the need for standardized measures of outcome including the incidence of abnormal anger and aggressive behavior, as well as measures of the quality of life, the need for long-term outcome studies of relapse prevention, and the need for controlled studies of combined somatic and psychotherapeutic treatments.

No. 15F
LEGAL ISSUES IN TREATING VIOLENT PATIENTS

Phillip J. Resnick, M.D., *Department of Psychiatry, University Hospital, 11100 Euclid Avenue, Cleveland OH 44106*

SUMMARY:

The purpose of this presentation is to update psychiatrists on legal issues that may arise in their treatment of potentially violent patients. Basic components of malpractice law will be reviewed in relation to violence. The standard of care for violence risk assessments in different contexts will be delineated. Limitations in the accuracy of violence predictions will be reviewed. Special attention will be given to workplace violence.

An update will be provided on extensions of the *Tarasoff* duty to protect potential victims from patient violence, and the trends in *Tarasoff*-limiting statutes and case law will be identified. Protection strategies include notification of police or potential victims (target hardening), hospitalization of the violent patient (containment), or other reasonable steps.

The faculty will discuss the risks and benefits of pressing criminal charges against patients who assault others while in the hospital, procedures for overriding treatment refusals of violent patients, and legal standards for seclusion and restraints will be covered. Finally, the impact of the new wave of sexually violent predator statutes will be elucidated.

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INDUSTRY SUPPORTED SYMPOSIUM 16—DEPRESSION AND COMORBID MEDICAL ILLNESS: RECOGNITION, DIAGNOSIS, AND TREATMENT
Supported by SmithKline Beecham Pharmaceuticals

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to 1. review published data on the epidemiology of depression in the setting of comorbid medical illness. 2. characterize the diagnostic issues associated with depression in the medically ill patient. 3. describe appropriate therapy for depression in patients with comorbid cardiac disease, HIV infection, cancer, premenstrual syndrome, and depression during pregnancy and the postpartum period.

No. 16A
EPIDEMIOLOGY OF COMORBID DEPRESSION AND MEDICAL ILLNESS

Wayne J. Katon, M.D., *Department of Psychiatry, University of Washington, 1959 West Pacific Street, NE, Seattle WA 98195*

SUMMARY:

Depression has a profound impact on patients with chronic medical illness. Community-dwelling patients with one or more chronic medical disorders have a 41% increased risk of having a recent psychiatric

disorder compared with patients without chronic conditions. Utilization of health care resources is also increased, and medical inpatients with comorbid depression have longer hospitalizations and more than twice the readmission rates of controls. Patients with chronic medical illness often must adapt or habituate to persistent aversive symptoms such as pain or fatigue, and major depression adversely affects this habituation process. Depression has also been shown to adversely affect patients' ability to follow many of the self-care regimens associated with chronic medical illness, such as medication compliance, adhering to a specific diet or exercise regimen, and curbing the use of alcohol and tobacco. Patients with comorbid medical illness and major depression experience an additive maladaptive effect on perceived health status, functional limitations, and decrements in social and vocational function. Mortality may also increase in patients with comorbid depression and chronic medical illness, and data exist to support increased death rates in nursing home patients and cardiac patients with comorbid depression. These observations underscore the need for improved screening, diagnosis, and aggressive treatment of depression in patients with chronic medical illness.

No. 16B
DEPRESSION AND COMORBID CARDIOVASCULAR DISEASE

Charles B. Nemeroff, M.D., *Department of Psychiatry, Emory Univ. School of Medicine, 1639 Pierce Drive, Suite 4000, Atlanta GA 30322;* Dominique L. Musselman, M.D.,

SUMMARY:

A burgeoning data base, first from epidemiological studies and more recently from prospective clinical studies, has provided strong evidence that depression is a major risk factor for cardiovascular and cerebrovascular morbidity and mortality. This presentation will review those data, including the seminal studies of Frasure-Smith and colleagues who prospectively followed patients post-myocardial infarction and demonstrated that depression was associated with a much higher risk of both cardiovascular morbidity and mortality. Recent studies in our own laboratory have revealed that drug-free depressed patients show clear platelet alterations, indicative of exaggerated platelet reactivity, when compared to normal comparison subjects. These data, taken together, support the hypothesis that depressed patients are particularly vulnerable to cardiovascular and cerebrovascular disease. Whether treatment with antidepressants reduces this vulnerability and/or normalizes these platelet alterations remains to be determined.

No. 16C
DEPRESSION IN THE SETTING OF HIV INFECTION OR CANCER

Dwight L. Evans, M.D., *Department of Psychiatry, University of Florida, 1600 Archer Road, Gainesville FL 32610*

SUMMARY:

There is increasing evidence that patients with medical illness such as cancer, myocardial infarction, stroke, and HIV infection are at greater risk for and have a higher prevalence of major depression. However, diagnosing clinical depression is especially challenging in patients with comorbid medical illness. Signs and symptoms of depression, such as weight loss, apathy, insomnia, and low energy, may result from either the medical condition or as a complication of medical treatment. Relatedly, there is growing evidence from a small number of recent studies suggesting that stress and depression are independent predictors of disease progression and mortality. For example, stress and depression have been associated with alterations in immunity and recent data indicate that stress and depression may influence the clinical course of immune-based diseases such as cancer and HIV infection. Separate studies have found depression to be an independent risk factor for mortality in patients who have suffered a myocardial infarction. These data suggest that effective antidepressant treatment may not only bring about relief of depression and improved quality of life, but also may influence the morbidity and mortality of the comorbid medical illness. However, the traditional antidepressant medications (TCAs and MAOIs) are generally poorly tolerated in the medically ill, because of the high affinity of these agents for alpha adrenergic, histaminergic, and muscarinic receptors. The SSRIs and the newer antidepressants have little or no affinity for these receptors and therefore have a relatively benign adverse effect profile. The SSRIs and the newer agents are both effective and relatively well tolerated in patients with comorbid depression and medical conditions. Furthermore, there is increasing evidence suggesting that these agents are effective in treating anxiety disorders including panic disorder and obsessive-compulsive disorder. Thus, the SSRIs and newer antidepressant agents offer new, effective, and well-tolerated treatments for individuals with comorbid medical and psychiatric conditions.

No. 16D
DEPRESSION IN WOMEN ACROSS THE REPRODUCTIVE CYCLE

Zachary N. Stowe, M.D., *Department of Psychiatry, Emory University, 1639 Pierce Drive, Atlanta GA 30322*

SUMMARY:

Numerous epidemiological studies have demonstrated an increased rate of major depression in women compared with men. The reasons for this gender bias remain obscure, but previous authors have speculated that neuroendocrine disorders (e.g. thyroid dysfunction), vulnerability to early trauma, and alterations of gonadal hormones may play a role. The female reproductive cycle involves marked alterations in gonadal steroids that may modulate the activity of neurotransmitter systems. There is increasing evidence that late luteal phase dysphoric disorder (LLPDD) predisposes women to develop subsequent mood disorders. In addition, the potential impact of the menstrual cycle and of oral contraceptive agents on the pharmacokinetics of antidepressants warrants further attention. Pregnancy has historically been viewed as a time of emotional well-being; however, few data support the assertion that pregnancy confers any protection from the development of an affective disorder. The postpartum period represents a time of increased vulnerability to develop major depression. The SSRIs have a larger post-marketing and clinically derived data base than other classes of antidepressants for use during pregnancy and lactation. The use of SSRIs in the treatment of major depression comorbid with menstrual cycling worsening, pregnancy, and the puerperium will be discussed.

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INDUSTRY SUPPORTED SYMPOSIUM 17—PANIC DISORDER: DIFFERENT CLINICAL POPULATIONS
Supported by Roche Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to (1) recognize the incidence and manifestation of panic disorder and appreciate the course and prognosis of panic disorder in different clinical populations; (2) increase the overall effectiveness of diagnosis and treatment of panic disorder patients in different clinical populations; and (3) assist primary care practitioners in the management of panic disorder.

No. 17A
PANIC AND ANXIETY IN CHILDREN AND ADOLESCENTS

Michelle G. Craske, Ph.D., *Department of Psychology, Univ. of Calif., Los Angeles, 405 Hilgard Avenue, Los Angeles CA 90095*

SUMMARY:

Estimates of prevalence for anxiety disorders in children and adolescents range from approximately 2% to 9%, and yet relatively little attention has been given to the understanding and treatment of these disorders. This paper will present recent advances in the areas of conceptualization and treatment of anxiety disorders in children and adolescents. The role of temperamental inhibition and trait anxiety (or neuroticism) as predisposing variables for childhood anxiety disorders, including the genetic, biological, and unique individual life experiences on which these predisposing traits are based, will be discussed, as will the chronicity of childhood anxiety disorders and their persistence into adulthood. Comorbidity with other disorders in childhood, particularly depression, parallels findings with regard to adult comorbidity—these data will be presented. In addition, recent evidence of panic attacks occurring in adolescents, which differ from spontaneous panic attacks in adults, potentially due to differing cognitive attributions, will be discussed. Finally, cognitive-behavioral treatment approaches for childhood anxiety disorders and data regarding their efficacy, particularly for separation anxiety and school refusal, will be presented.

No. 17B
TREATMENT OF COMORBID PANIC AND ADDICTION

Robert L. DuPont, M.D., *Inst. for Behavior and Health, 6191 Executive Boulevard, Rockville MD 20852*

SUMMARY:

Panic disorder and addiction to alcohol and other drugs are commonly comorbid, creating potentially serious problems in the management of both disorders. The emergence of the antidepressants, including the SSRIs, as first line treatments for panic disorder has removed one of the biggest problems faced by clinicians: the reliance on benzodiazepines to treat panic, which created a major risk for panic disorder patients comorbid for addiction. Similarly, the emergence of specific cognitive-behavioral treatments (CBT) for panic has opened a new door, which does not have special warnings for addicted patients. Because of the neurotoxic effects of substance use (including intoxication and withdrawal as well as brain sensitization and behavioral disorders), there is good reason to prioritize in favor of addiction treatment when these diseases are cormorbid because it is common for anxiety, including panic, to lessen or even to disappear once a stable recovery is established. Finally, the risks of benzodiazepine use in the treatment of panic disorder patients who are in recovery need to be put into realistic perspective.

No. 17C
PANIC DISORDER IN PRIMARY CARE ISSUES ACROSS THE LIFE SPAN

M. Katherine Shear, M.D., *Dept. of Medical Anxiety, Univ Pittsburgh Med Cntr/WPIC, 3811 O'Hara Street, Pittsburgh PA 15213-2593*

SUMMARY:

Panic disorder is a prevalent and distressing condition associated with disability and help seeking. The purpose of this presentation is to discuss demographic characteristics of patients with panic disorder in primary care, with a special focus on gender and age. Panic disorder makes its appearance in some cases early in life, during childhood. Recognition and treatment of children with panic disorder will be discussed, along with the impact this disorder may have on the mother and the family of the child. Special issues related to panic disorder in adolescents will also be discussed. The impact of life course events in women, such as childbirth, motherhood, and menopause on the clinical presentation and treatment choices will be described. The presentation and treatment of panic disorder in elderly primary care patients will be discussed.

No. 17D
RESISTANT PANIC ACROSS THE LIFE CYCLE

R. Bruce Lydiard, M.D., *Department of Psychiatry, Medical University of SC, 171 Ashley Avenue, Charleston, SC 29425*

SUMMARY:

It is now known that panic disorder (PD) can affect individuals from childhood to old age while most individuals develop PD during the age range of twenty to forty years, onset of PD can occur across the lifespan. This presentation will highlight the approach to patients who do not respond to initial treatment efforts. Special considerations for treatment in the very young and very old will be discussed. Factor such as dose, duration of treatment, identification of the undertreated component, comorbid psychiatric and medical disorders, and environmental factors can be used in a differential diagnostic assessment of incomplete or nonresponse to initial and long-term treatment of PD. Remaining gaps and directions for future research will be reviewed.

No. 17E
TREATING PANIC DISORDER IN DIFFERENT POPULATIONS

James C. Ballenger, M.D., *Department of Psychiatry, Medical University of SC, 171 Ashley Avenue, Charleston SC 29425*

SUMMARY:

This presentation will focus on the most important issues and themes from the other four presentations and attempt to articulate a coherent overall approach to better recognition and treatment of panic disorder patients in these various situations and settings. Suggestions will be made about appropriate actions of individual clinicians and the field as a whole to correct the under-recognition and inadequate treatment most panic disorder patients experience in these nontraditional settings. The presentation will attempt to utilize Dr.

Ballenger's and the other four clinician-researchers' extensive experience in this area to focus on the identified problems and potential solutions.

This presentation will then lead to a question-and-answer interaction with the audience (chaired by Dr. Ballenger), which we hope will be lively and informative.

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2. Shear MK, Reynolds CF: Anxiety disorders across the lifespan: crosscutting themes. *Anxiety.* (In Press).
3. Katon W: *Panic Disorder in the Medical Setting.* National Institute of Mental Health. DHHS Publ. No. (ADM)89-1629. Washington, DC: Supt. of Docs., U.S. Govt. Print Off., 1989.
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INDUSTRY SUPPORTED SYMPOSIUM 18—COMORBIDITY FACTORS AND THE TREATMENT OF DEPRESSION
Supported by Roerig Division/Pfizer, Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, participants should enhance their recognition and treatment of depression by understanding the influence of comorbidity factors such as (1) alcohol dependence, (2) anxiety disorders, (3) pregnancy, (4) cardiovascular disease, and (5) chronicity. Participants will also enhance their knowledge on how these factors influence patient outcomes and cost of treatment for depression.

No. 18A
MANAGEMENT OF DEPRESSION SECONDARY TO ALCOHOLISM

Barbara J. Mason, Ph.D., *Department of Psychiatry, Univ. of Miami School of Med., 1400 NW 10th Ave., Suite 314, Miami FL 33136*

SUMMARY:

Depression has many important health consequences including poor medical care outcomes, longer general hospital stays, and increased risk of suicide in alcoholics. Early diagnosis and effective treatment of depression in alcoholics may thereby result in more cost-effective use of health care dollars. Controversy exists over when and how to treat alcohol-dependent patients with antidepressant medication. A six-month double-blind, placebo-controlled trial of desipramine was conducted in 71 patients with primary alcohol dependence stratified on the presence or absence of major depression. Depression was measured with a Hamilton rating score (HAM-D). Drinking was assessed using a timeline interview, with breath alcohol concentration and collateral verification. Treatment with a clinically determined dose of desipramine was initiated after a median of eight days of abstinence. Among depressed patients, HAM-D scores decreased, number of abstinent days were greater, and patients rated a higher degree of satisfaction with desipramine than placebo. Nondepressed groups did not differ on drinking outcome. In conclusion, major depression secondary to alcohol dependence that is diagnosed after at least one week of abstinence can remain stable in some placebo-treated alcoholics and can respond to antidepressant medication. Treating depression secondary to alcoholism may reduce risk for drinking relapse in some patients. Use of desipramine to reduce relapse in nondepressed alcoholics is not supported.

No. 18B
RECOGNITION AND MANAGEMENT OF ANXIETY

Robert M.A. Hirschfeld, M.D., *Department of Psychiatry, University of Texas, 301 University Boulevard, Galveston TX 77555-0429*

SUMMARY:

The majority of patients with major depression and dysthymia will often suffer from a comorbid anxiety disorder, including panic disorder, obsessive-compulsive disorder, social phobia, generalized anxiety disorder, and post-traumatic stress disorder. Patients with major depression and dysthymia may also suffer from sub-syndromal anxiety symptomatology. The presence of anxiety symptoms or syndromes can have a substantial effect on the patient's clinical presentation and prognosis. The presence of comorbid anxiety and depression substantially influences treatment selection and clinical management. For example, patients with current or recent panic disorder are at substantially higher risk for suicide in the near term. A rationale for the selection of treatment modalities will be presented, focusing on pharmacologic agents that have a broad spectrum of efficacy, including both depression and anxiety disorders, and that have a benign side effect profile.

No. 18C
MAJOR DEPRESSION AND CARDIOVASCULAR MORTALITY

Alexander H. Glassman, M.D., *Clin. Psychopharmacology, NY State Psychiatric Institute, 722 West 168th Street, New York NY 10032-2603*

SUMMARY:

There is now convincing evidence linking depression and cardiovascular death from both prospectively followed healthy populations, as well as from studies that examined populations with pre-existing ischemic heart disease. However, it was possible that the association was merely an artifact of cigarette smoking. The National Health Examination Follow-up Study resolved that issue (Anda et al, 1993). Three thousand adults free of medical illness at baseline were followed for 12½ years. Controlling for smoking and other known risk factors, depression predicted both fatal and non-fatal ischemic heart disease.

In 1988, Carney reported that patients with pre-existing cardiovascular disease undergoing coronary angiography who had major depression were more likely to experience infarction or death over the next 12 months. In 1990, Ahern et al showed that patients with ventricular arrhythmia following infarction were more likely to die if they were depressed. In 1993, examining 222 consecutive MI patients, Frasure-Smith showed that developing symptoms of major depression significantly predicted mortality over the next six months (adjusted hazard 4.29). By 18 months, those individuals who had only modestly elevated Beck depression scores in the intensive care unit were just as likely to die as those patients who had symptoms of major depression. Whether treating this depression will alter the risk of dying remains to be seen.

No. 18D
TREATMENT OF DEPRESSION IN PREGNANCY AND POSTPARTUM

Lori L. Altshuler, M.D., *Department of Psychiatry, Veterans Affairs Medical Cntr., 11301 Wilshire Blvd., B116AA, Los Angeles CA 90073*

SUMMARY:

Although pregnancy has typically been viewed as a time of emotional well-being, recent data do not substantiate this optimistic view for women with prior histories of depression. In this talk, the literature

will be reviewed for the natural history of depression in pregnancy. The potential risks to mother and fetus of untreated psychiatric illness during pregnancy will be reviewed. We will discuss the potential teratogenicity of each class of psychotropic medication, as well as the treatment dilemmas and options of prescribing psychotropic medications to the depressed pregnant patient. Decision-making guidelines regarding whether or not to discontinue medications during pregnancy will be presented. We will also cover the risk for major depression in the postpartum period. Likelihood of postpartum recurrence after one postpartum event will be reviewed and prophylactic strategies will be covered.

No. 18E
MANAGEMENT OF CHRONIC AND RECURRENT DEPRESSION

Alan F. Schatzberg, M.D., *Dept of Psych & Behav Sci, Stanford Univ School of Med, 401 Quarry Road, Stanford CA 94305-5548*

SUMMARY:

Data are presented from an ongoing multicenter study of 635 patients who met criteria for chronic major depression for the past two years or major depression for six months superimposed on dysthymia for the previous two years. Previous treatment history indicates patients had frequently not received somatic therapy or received inadequate trials of medication. Patients in this study were treated with either sertraline or imipramine for 12 weeks under double-blind, random-assignment conditions. Responders were continued for 16 weeks and then enrolled in a maintenance protocol for 76 weeks. Nonresponders during the acute 12-week study were crossed over to the other drug and if they responded were entered into continuation therapy. Data are presented on the acute and continuation phases of the study. Both treatments were effective during acute and continuation phases. The "burn-out" rate during continuation did not differ between the two drugs. Some patients gained further antidepressant effect during continuation. Implications of these data are discussed.

In recent years, several studies have revealed that imipramine, fluoxetine, sertraline, or imipramine are effective in preventing recurrence over one to five years. These studies are reviewed and the issues of dose and side effects during maintenance are discussed.

REFERENCES:

1. Mason BJ, Kocsis JH, Ritvo EC, Cutler RB: A double-blind, placebo-controlled trial of desipramine in primary alcohol dependence stratified on the presence or absence of major depression. *Journal of the American Medical Association*, Vol. 275, No. 10:761-767, 1996.
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3. Frasure-Smith N, Lesperance F, Talajic M, Depression following myocardial infarction: impact on 6-month survival; *JAMA*, Vol. 270. No. 15, 1819-1825, Oct. 20, 1993.
4. Altshuler LL, Cohen L, Szuba M, et al: Psychopharmacologic management of psychiatric illness in pregnancy. *American Journal of Psychiatry*, 153:592-606, 1996.
5. Frank E, Kupfer DJ, Perel DM, et al: Three-year outcome for maintenance treatment in recurrent depression. *Arch Gen Psychiatry*. 47:1093-1099, 1990.

INDUSTRY SUPPORTED SYMPOSIUM 19—PREVENTING RELAPSE IN SCHIZOPHRENIA
Supported by Abbott Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to understand the factors that contribute to increased relapse risk in schizophrenia, manage medications so as to minimize unacceptable drug side effects to improve compliance, and understand the cost impact of relapse in schizophrenia.

No. 19A
PREDICTORS OF OUTCOME IN FIRST-EPISODE PSYCHOSIS

Bruce M. Cohen, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont MA 02178-1048*

SUMMARY:

The study of patients following a first episode of psychosis offers an ideal opportunity for performing research on predictors and determinants of illness outcome. Thus far at McLean Hospital, 342 subjects with a first episode of psychosis and 107 patients with a diagnosis of first-episode nonaffective psychosis (schizophrenia, schizoaffective disorder, delusional disorder, schizophreniform disorder, or brief psychosis) have been prospectively followed with a loss to follow-up under 9%. Clinical predictors of poor outcome include a diagnosis of nonaffective psychosis and, among the cohort with nonaffective psychosis, insidious onset presence of comorbid psychiatric diagnoses, male gender, and being a member of a minority population. Medication noncompliance is also a predictor of poor outcome. As newer drugs promise not only a higher degree of symptom amelioration, but also better tolerance and higher patient satisfaction, treatment compliance and outcome may improve in the near future. In addition to clinical parameters, novel predictors of outcome from brain imaging are being explored. Early findings suggest an association between neurochemical and functional changes in brain, both before and after drug treatment, and outcome.

No. 19B
FAMILY AND PATIENT FACTORS IN RELAPSE PREVENTION

John M. Kane, M.D., *Department of Psychiatry, Hillside Hospital, 75-59 263rd Street, Glen Oaks NY 11004-1150*

SUMMARY:

Relapse in schizophrenia has enormous consequences in terms of morbidity, mortality, family burden, and societal cost. Despite the proven value of antipsychotic medication in reducing risk of psychotic relapse, many patients continue to receive inadequate pharmacologic prophylaxis or relapse despite medication. Factors contributing to relapse prevention include clinician, patient, and family variables. Many clinicians continue to be uncertain as to the benefits and risks of long-term treatment. Patients may suffer from denial or lack of insight, demoralization, negative symptoms, and struggle with the adverse effects of conventional antipsychotics. Families must cope with enormous burden and refrain from over involvement, inordinate expectations, or rejection of the ill relative. Strategies have been developed to help address these issues and when combined with the availability of new medications with better adverse effects profiles, should go a long way toward facilitating optimum outcome.

No. 19C
ANTIPSYCHOTIC DRUG SIDE EFFECTS AND RELAPSE

Daniel E. Casey, M.D., *Department of Psychiatry, Veterans Affairs Medical Cntr., 3710 SW U.S. Veterans Hosp Rd, Portland OR 97201*

SUMMARY:

Although neuroleptic drugs have become the mainstay of treating acute and chronic psychosis, they are substantially limited by troublesome side effects. The traditional neuroleptic drugs have a wide array of central nervous system and peripheral system side effects that often lead to problems in management or patient noncompliance. Of particular difficulty are the extrapyramidal syndromes of akathisia, dystonia, and parkinsonism, as well as tardive dyskinesia. These neurological syndromes produce both motor (objective) and mental (subjective) symptoms that impose additional burdens on patients, and must be distinguished from negative symptoms of psychosis. Other side effects of seizures, sedation, neuroleptic malignant syndrome, and cardiovascular, hematological, endocrinological, and weight gain problems also remain as clinical management challenges posed by existing antipsychotic drug therapy. Progress has been made in improving the neurological side effect profile with the advent of clozapine and risperidone. However, each of these drugs has its own dose-limiting side effect profile. Two new drugs, sertindole and olanzapine, are now added to the pharmacopeia for treating psychosis. They further improve the benefit/risk ratio because they have even fewer neurological and other side effects. Overall, these new antipsychotic agents greatly improve the treatment of psychosis by reducing drug-induced morbidity and improving the quality of life for patients.

No. 19D
THE COST OF RELAPSE IN SCHIZOPHRENIA

Peter J. Weiden, M.D., *Department of Psychiatry, St. Luke's/Roosevelt Hospital, 411 West 114th Street Suite 3B, New York NY 10025;* Mark Olfson, M.D.,

SUMMARY:

Cost of treating relapse: Looked at from a bird's-eye view, there are more than 250,000 short-term rehospitalizations due to relapse each year in the United States. The total direct cost of inpatient treatment of this cohort is approximately 2.3 billion (1993) dollars, or just under $10,000 per patient. A "revolving door" subgroup accounts for much of these costs; follow-up studies show a 50% chance of being rehospitalized within a year of discharge.

Cost of preventing relapse: Costs of preventing relapse can be estimated by determining the risk factors leading to relapse, and then estimating the costs of changing those factors.

- *Patient factors* include medication noncompliance (estimated to cause 40% of all rehospitalizations) and loss of medication response (estimated to cause 60% of rehospitalizations). Fortunately, there is good evidence that new "atypical" antipsychotics are more protective against relapse for medication-compliant patients, and that depot therapy can decrease relapse when compliance is the key issue. Atypical antipsychotics and depot therapy are expensive, but any inroads in relapse prevention will, at least in theory, allow these drugs to pay for themselves.
- *Services factors* include "cost shifting" between multiple payers, discontinuity of care, and inadequate clinician training. The cost savings from decreasing relapse by addressing these factors is often offset by the cost of increasing services; this may be about cost-neutral for the "revolving door" subgroup. While it is expensive to address these services barriers, failing to address them will probably lead to continued increases in the total cost of care.

Translating theory into practice: This presentation will conclude with suggestions about how to translate these theoretical cost findings into better clinical practice.

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1. Tohen M, Stoll AL, Strakowski SM, et al: The McLean first-episode psychosis project: six-month recovery and recurrence outcome. *Schizophrenia Bulletin*, 18:172-183, 1992.
2. Kane JM, McGlashan TH: Treatment of schizophrenia. *Lancet* 346:820-825, 1995.
3. Casey DE: Motor & mental aspects of extrapyramidal syndromes. *International Clinical Psychopharmacology* 10(Suppl.3):105-114, 1995.
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INDUSTRY SUPPORTED SYMPOSIUM 20—SMOKING CESSATION: CLINICAL PRACTICE GUIDELINES FOR PSYCHIATRISTS
Joint Session with the Center for Tobacco Research and Intervention, and supported by Glaxo Wellcome Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be familiar with the AHCPR and APA Smoking Cessation Clinical Practice Guidelines, understand the science that supports these guidelines, have essential information and strategies to assist them in implementing the guideline recommendations into their clinical practice, and be aware of new and emerging treatment modalities and technologies to promote smoking cessation.

No. 20A
BEHAVIORAL STRATEGIES FOR SMOKING CESSATION

Michael G. Goldstein, M.D., *Department of Psychiatry, The Miriam Hospital, 164 Summit Avenue, Providence RI 02906*

SUMMARY:

Behavioral therapy for smoking cessation is based on the theory that learning processes operate in the development, maintenance, and cessation of smoking. Over 100 controlled prospective studies have documented the efficacy of behavior therapy for smoking cessation. Most reviews and meta-analyses have found that multimodal behavioral therapy produces six-month smoking cessation rates of approximately 20% to 25% and behavioral therapy typically increases quit rates two-fold over control groups. Based on these data, the APA Nicotine Dependence Practice Guideline has recommended multimodal behavioral therapy as a first-line therapy and behavioral skills training and stimulus control with moderate clinical confidence. The AHCPR Smoking Cessation Guideline Panel has also recommended that problem solving/skills training be included as a component of smoking cessation treatment. Though aversive behavioral strategies are also efficacious, their use is limited because of health and compliance concerns. Psychiatric patients, including those with substance abuse/dependence, are particularly likely to benefit from behavior therapy for smoking cessation due to their high incidence of psychosocial problems, poor coping skills, and past history of benefit from such therapy.

The use of behavioral strategies for smoking cessation in a psychiatric patient will be demonstrated utilizing a videotaped case vignette.

No. 20B
THE AGENCY FOR HEALTH CARE POLICY AND RESEARCH (AHCPR) SMOKING CESSATION GUIDELINES

Michael C. Flore, M.D., *CTRI, Univ WI Medical Center, 1300 University Avenue, Madison WI 53703*

SUMMARY:

In April, 1996, the Agency for Health Care Policy and Research (AHCPR) *Clinical Practice Guideline on Smoking Cessation* was publicly released. This new guideline provides primary care clinicians, smoking cessation specialists, and health care administrators, insurers, and purchasers with clear and concise recommendations regarding effective, state-of-the-art smoking cessation treatments. The guideline can be summarized in six major points:

- Effective smoking cessation treatments are available and every patient who smokes should be offered one or more of these treatments.
- It is essential that clinicians determine and document the tobacco-use status of every patient who presents to a health care setting.
- Brief cessation treatments are effective, and at least a minimal intervention should be provided to every patient who uses tobacco.
- There is a dose-response relationship between the intensity and duration of a treatment and its effectiveness. In general, the more intense the treatment, the more effective it is in producing long-term abstinence from tobacco.
- Three treatment elements, in particular, were found to be effective components of smoking cessation treatment:
  - Nicotine replacement therapy (nicotine patches or gum)
  - Social support (clinician-provided encouragement and assistance)
  - Skills training (techniques for achieving and maintaining abstinence)
- Effective reduction of tobacco use requires that health care systems make institutional changes that result in the systematic identification of, and intervention with, all tobacco users at every visit.

This presentation will review these new treatment recommendations as they apply to psychologists and their potential to reduce the devastating toll resulting from tobacco addiction in our society.

No. 20C
NON-NICOTINE THERAPIES FOR SMOKING CESSATION

John R. Hughes, M.D., *Department of Psychiatry, University of Vermont, 38 Fletcher Place, Burlington VT 05401-1419*

SUMMARY:

Nicotine replacement is clearly the first-line pharmacotherapy for smoking cessation. Non-nicotine pharmacotherapies may be useful to smokers who have failed nicotine replacement, cannot tolerate nicotine replacement, or who have philosophical objections to replacement therapy. Clonidine is the only proven non-nicotine pharmacotherapy, but appears somewhat less effective than nicotine replacement. Although early studies indicated clonidine is more effective in women, later studies suggest this is unclear. Bupropion appears promising in yet-to-be-published studies. Antidepressants for mildly depressed smokers and buspirone for mildly anxious smokers also show some efficacy in trials thus far. Early results with mecamylamine (a nicotine antagonist) and naltrexone (an opioid antagonist) are encouraging as well. Finally, a citric acid inhaler, which replaces the sensory aspects of smoking, was effective in laboratory and clinical studies. There are few data that anticholinergics, homeopathics, lobeline, silver nitrate, and stimulants are therapeutic.

No. 20D
USING COMMUNICATION TECHNOLOGIES FOR PATIENT EDUCATION

Victor J. Strecher, Ph.D., *Cancer Center, University of Michigan, 107 Simpson Drive, Ann Arbor MI 48109*

SUMMARY:

Computer-based, interactive communications technologies are rapidly evolving into new media forms that will commonly be used in health care, worksite, and home settings. The next ten years hold the promise of a communications revolution unparalleled since the invention of moveable type. Interactive television, the information superhighway, tailored print materials, and other proposed means of providing two-way, interactive communication between mass media senders and receivers offer a distribution system with unlimited potential to target and personalize health information. Are we ready to take advantage of these technological advances? Many feel that technological advances will far outpace programming content. If this is the case, the public may end up simply watching hours of interactive video games instead of meaningful, entertaining programs that address personal and social needs.

The purpose of this presentation is to discuss the potential of advanced communications technologies for patient education interventions, and what we need to do to fully take advantage of these technologies. Intervention programs using advanced communications strategies developed for research purposes and programs developed for national dissemination will be presented and discussed. We will also discuss a vision of future research questions and intervention strategies.

No. 20E
HELPING WOMEN STOP SMOKING: ADDRESSING BARRIERS

Ellen R. Gritz, Ph.D., *Dept Behavioral Science, M.D. Anderson Cancer Center, 1515 Holcombe Blvd., MS 243, Houston TX 77030*

SUMMARY:

Active debate exists over whether women have a more difficult time stopping smoking and remaining abstinent than men. Current national data do not show gender differences; however, clinical studies persist in demonstrating higher rates of cessation and sustained abstinence among men. Physiological factors, psychological characteristics, and sociocultural forces pose potential barriers to women's smoking cessation efforts.

Physiological factors include differential sensitivity to and metabolism of nicotine, menstrual cycle phase during which cessation is initiated, and metabolically induced weight gain following quitting. Pregnancy and the postpartum period pose special challenges and opportunities for cessation, as well.

The major psychological barrier to women's quitting is the utilization of smoking as a coping mechanism for negative affect. Women report higher rates of depression than men, and depressed individuals have lower cessation rates than nondepressed. Typically, minimal intervention treatments are less able to deal with complex psychological issues, although the advent of multi-agent pharmacotherapy (e.g., NRT, antidepressants) for cessation holds promise.

Relevant sociocultural forces include: the norms of family, peers, and society regarding smoking; social support mechanisms; the advertising milieu; social norms for body image and appearance; and social emphasis on "feared" diseases (e.g., breast, not lung, cancer).

No. 20F
OVERVIEW OF APA PRACTICE GUIDELINES FOR THE TREATMENT OF PATIENTS WITH NICOTINE DEPENDENCE

Susan J. Fiester, M.D., *35 Wisconsin Circle, Suite 345, Chevy Chase MD 20815*

SUMMARY:

This presentation will provide an overview and summary of the new APA Practice Guidelines for the Treatment of Patients with Nicotine Dependence, specifically current state-of-the-art knowledge regarding the assessment and treatment of nicotine dependence. The review of assessment will cover areas such as smoking history and diagnosis of nicotine dependence, readiness to change, motivators/barriers to quitting, psychosocial factors, patient preferences, nicotine/cotinine/CO levels, and general psychiatric and medical evaluation. The review of treatment will include: general factors in treatment, establishment of a therapeutic alliance, methods of educating patients to quit, cessation strategies, implementation and timing of cessation attempts, appropriate follow-up, and approaches to managing relapse/treatment resistance. Specific psychosocial treatment approaches will be discussed, including behavioral therapies, self-help materials, and education/support groups. Specific somatic treatments reviewed will include nicotine replacement, antagonist therapy, medications that make nicotine intake aversive, and non-nicotine agents that mimic the effects of nicotine. Special issues such as levels of stepped care, treatment of nicotine dependence on inpatient psychiatric units, and comorbidity of psychiatric and medical conditions will also be addressed, as well as gender, age and race/ethnicity factors relevant to assessment and treatment.

Differences between the recently published AHCPR Clinical Practice Guideline on Smoking Cessation and the APA Practice Guideline will be highlighted, specifically the emphasis placed on the following areas in the APA guidelines:

(1) Greater emphasis on the role of the psychiatric specialist versus the more generic approaches appropriate for the internist/GP; (2) Greater emphasis on the comprehensive assessment of the addiction; (3) Emphasis on more intensive interventions tailored to the needs of specific populations and on the importance of psychiatric comorbidity; (4) Focus on interventions in specific populations, e.g. psychiatric inpatients; (5) Inclusion of a greater number and variety of approaches to treating nicotine dependence; (6) Inclusion of clinician consensus in establishing guidelines as well as the use of three levels of confidence for studies vs. the use of only evidence-based data; and (7) Inclusion of promising areas for future research.

REFERENCES:

1. Brown RA, Goldstein MG, Niaura R, et al: nicotine dependence: Assessment and management. In Stoudemire A, Fogel BS (eds), *Principles of Medical Psychiatry, Second Edition*, (pp. 877-901), 1993.
2. Fiore MC, Bailey WC, Cohen SJ, et al: *Smoking Cessation. Clinical Practice Guideline No. 18.* Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research. AHCPR Publication No. 96-0692. April 1996.
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4. Gritz ER, Nielsen I, Brooks L: Smoking cessation and gender: the influence of physiological, psychological and behavioral factors. *Journal of the American Medical Women's Association* 51:35-42, 1996.
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INDUSTRY SUPPORTED SYMPOSIUM 21—WOMEN AND DEPRESSION: CONTEMPORARY ISSUES
Supported by Wyeth-Ayerst Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to identify women at high risk for depression; recognize factors that contribute to their developing depression and the barriers to treatment; and understand the value of combined pharmacotherapy and psychotherapy as maintenance treatment.

No. 21A
DEPRESSED WOMEN AND THEIR CHILDREN

Myrna M. Weissman, Ph.D., *Dept. Genetic Epidemiology, Columbia University, 722 West 168th Street, Unit 14, New York NY 10032-2603*

SUMMARY:

There are numerous studies showing that children of depressed parents are at high risk of major depression (MDD). None have followed the children into adulthood to learn about their long-term course. New results are reported on the course of MDD over a 10-year period in 182 offspring who by virtue of the parents' psychiatric history were at high or low risk for MDD. Compared to the offspring where neither parent was depressed, the offspring of depressed parents continued to have a three-fold increased risk of MDD. The peak age of first onset of MDD in females was 15 to 25 years regardless of parental diagnosis, suggesting a consistent vulnerability period. The depressed offspring of depressed, as compared to nondepressed parents had more serious and recurrent depression, were more impaired over the follow-up period but were *less* likely to go for treatment. Successful treatment of parental depression may provide primary prevention by reducing the symptoms of depression, which impair parenting. Secondary prevention may be achieved through the early detection and treatment of high-risk offspring who exhibit early forms of depression. Finally, the aggressive treatment of established MDD, tertiary prevention, may reduce the high level of social impairment that characterizes depressed offspring of depressed parents.

No. 21B
ESTROGENS AND PROGESTINS: DO THEY CAUSE MOOD DISORDERS? DO THEY TREAT MOOD DISORDERS?

Lee S. Cohen, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC 815, Boston MA 02114,*

SUMMARY:

While the postpartum period has typically been described as a time of risk for development of affective disorder, pregnancy is frequently considered a time of well-being for women, providing "protection" against emotional disturbance. A growing literature suggests that at least some women continue to manifest symptoms of depression during pregnancy. Women with histories of depression may be more likely to experience depression during pregnancy and are at particular risk for postpartum worsening of mood. Identification of women "at risk" for development of depression during pregnancy and the postpartum period allows for thoughtful treatment

planning, which may include either pharmacologic and/or nonpharmacologic interventions potential prophylactic strategies during the puerperium.

This presentation will review risks associated with psychotropic drug use during pregnancy as well as those of untreated maternal psychiatric disorder. Data regarding risks of prenatal exposure to psychotropics including antipsychotics, antidepressants, benzodiazepines, lithium, and anticonvulsants will be reviewed. Treatment guidelines for psychotropic drug use during pregnancy will be presented. Finally the spectrum of postpartum depressive syndromes will be described as well as a range of appropriate treatments matched to severity of puerperal illness.

No. 21C
MYTHS AND REALITIES SURROUNDING PREMENSTRUAL DYSPHORIC DISORDER

Kimberly A. Yonkers, *Department of Psychiatry, Univ. of Texas Southwestern Medical Center, 5959 Harry Hines Blvd., #520, Dallas, TX 75235-9070*

SUMMARY:

Historically, a great deal of interest in perimenstrual mood disorders has been shared by patients, the media, and the medical profession. This has led to a number of preconceptions regarding women who suffer from premenstrual mood disturbances and to assumptions about which therapeutic interventions are efficacious. Some common myths about women who suffer from severe premenstrual symptoms such as premenstrual dysphoric disorder (PMDD) are that: women who complain about premenstrual depression are difficult to deal with because they have a personality disorder, women with PMDD have nothing more than an exacerbation of an underlying depressive or anxiety disorder, and women who present with premenstrual symptoms suffer from somatization and are just looking for and excuse to complain. A sampling of the misconceptions regarding treatment are that a high protein diet and exercise can rid a woman of severe premenstrual symptoms, hormonal treatments can effectively treat severe premenstrual symptoms, and finally, that severe premenstrual disturbances, such as PMDD, are untreatable. These myths will be countered with the opposing data-based realities of severe premenstrual mood disturbances.

No. 21D
PREVENTING RECURRENCE OF DEPRESSION IN WOMEN

Ellen Frank, Ph.D., *Department of Psychiatry, Western Psychiatric Institute, 3811 O'Hara Street, Pittsburgh PA 15213-2593*

SUMMARY:

For over a decade, we have been interested in the maintenance treatment of recurrent depression using drugs and psychotherapy (Frank et al, 1990; Frank et al, 1991; Frank et al, 1993; Kupfer et al, 1990). We have also had a sustained interest in the treatment needs of women, particularly during the childbearing years. In the Pittsburgh study of Maintenance Therapies for Recurrent Depression, we conducted a three-year randomized clinical trial of 128 patients with recurrent depression. Although numbers of males in each of the five conditions were relatively small, limiting power to detect gender differences, no such differences were observed. We later observed that highly specific (i.e., interpersonally focused) IPT was associated with significantly different ($p \leq .001$) survival time, leading us to design a trial in which women in the childbearing years were treated acutely with IPT alone and then randomly assigned to various "doses" (weekly, biweekly, monthly) of maintenance interpersonal psychotherapy. Early results suggest that while frequency of therapy contact is not directly related to treatment specificity, treatment specificity is, once again, related to the prophylactic efficacy of interpersonal psychotherapy. Overall, the results of this trial have been highly encouraging inasmuch as < 20% of the women who entered maintenance treatment have, thus far, experienced a recurrence of illness.

No. 21E
WHAT PREVENTS DEPRESSED WOMEN FROM SEEKING CARE?

Mark Olfson, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, New York NY 10032*

SUMMARY:

Epidemiologic studies make clear that each year large numbers of depressed American women do not receive treatment for their psychiatric symptoms. Despite the development of a variety of efficacious treatments and efforts by the NIMH to educate patients and practitioners about these treatments, the extent of untreated depression has remained essentially unchanged for the last two decades. Results will be presented from a recently completed ten-year prospective study of persons at high risk for depression, many of whom developed severe, recurrent, and impairing major depressions. The study included a detailed evaluation of specific obstacles to treatment including: economic factors, stigma, lack of family support, denial of illness, pessimism regarding treatment efficacy, service inaccessibility, and the perception that primary care physicians belittle mental health problems. Differential barriers to treatment for women and men will be presented and specific strategies to help reduce these barriers will be discussed.

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INDUSTRY SUPPORTED SYMPOSIUM 22—PRIMARY CARE AND PSYCHIATRY
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

To recognize the importance of integrated health–primary care services, including improved diagnosis and treatment, improved access to psychiatric services, increased cultural sensitivity, and improved communication between providers. In addition, the participant should be able to more critically consider factors necessary to develop an integrated service delivery model.

No. 22A
PSYCHIATRIC DISORDERS IN PRIMARY CARE

Troy L. Thompson II, M.D., *Department of Psychiatry, Jefferson Medical College, 1025 Walnut Street, Suite 320, Philadelphia PA 19107-5005*

SUMMARY:

About 15% of the U.S. population has a clinically significant mental disorder during any given year (and 10% at any given time); at least 4%-20% of patients seen in primary care practices each day have a clinically significant psychiatric disorder. More than 50% of medical and surgical inpatients develop a psychiatric disorder during their hospitalization, which interferes with optimal care. Sixty percent of patients with mental health disorders are seen only in the primary care sector, 20% are not seen by any type of health care professional, 20% are seen by a mental health professional, and only 5% are ever seen by a psychiatrist. Therefore, psychiatrists should spend a great deal of time educating primary care and other clinicians, including when and how to consult and refer to psychiatrists. The latter is increasingly important in the managed care environment because patients often cannot elect to see a psychiatrist as their initial entry into the mental health system. Depression is frequent in primary care practices and often masks as somatic complaints and feelings of "stress," anxiety, tension, insomnia, fatigue, etc. About 20%-40% of medical patients have lifestyle habits (e.g., excessive alcohol and tobacco use) that increase their risk of illness. Many primary care physicians estimate spending between 20%-50% of their time (in visits of 15 minutes) evaluating and treating patients with psychiatric disorders. With good psychiatric education and consultation back-up, primary care physicians could conduct a screening psychiatric evaluation and provide effective psychiatric treatment for many patients, typically carried out over multiple appointments. Likewise, psychiatrists could follow a large number of patients who are concurrently followed in primary care settings.

No. 22B
TWO CULTURES DIVIDED BY COMMON CONCERNS

Mack Lipkin, Jr., M.D., *Department of Medicine, NY University Medical Center, 550 First Avenue, New York NY 10016*

SUMMARY:

Medicine and psychiatry have historically been divided by different paradigms, different work habits, and distinct relations with patients and colleagues. In recent years, psychiatry has moved toward biological approaches and away from its humanistic roots; primary care has been moving to take up these concerns. Simultaneously, attempts to bridge the language barrier created by DSM-*x* have been attempted, particularly in the form of DSM-PC. Efforts to distinguish the phenomenology of mental illness in primary care and in specialty mental health care have led to recognition of the basis of some of the misunderstandings, particularly concerning somatization problems and *formes fruste* of mental disorders as they occur in primary care. These issues will be reviewed both historically and in terms of current findings. The principal areas for remediation of the psychiatry/medicine relationship will be discussed from the primary care perspective.

No. 22C
EDUCATIONAL ISSUES

Leah J. Dickstein, M.D., *Department of Psychiatry, University of Louisville, 323 East Chestnut Street, Louisville KY 40292*

SUMMARY:

Psychiatric education has always included understanding of primary care health issues and the interdependence of psychiatric and primary care for patients. This presentation will outline the major educational issues that must continue to be the basis for the complete psychiatric education of medical students across their four years and for psychiatric residents throughout their training.

Issues such as the need for a complete medical history and physical, including laboratory examination, and personal communication between physicians across specialty lines will be discussed. Experience has clearly shown that increased time with patients and taking a complete medical history result in better treatment outcomes. Suggested lecture and seminar topics, as well as placement of professionals, will be included.

No. 22D
PRIMARY CARE AND PSYCHIATRY: A MODEL

John McIntyre, M.D., *Department of Psychiatry, St. Mary's Hospital 919 Westfall Road, C210, Rochester NY 14618*

SUMMARY:

There are a variety of models for the integration of psychiatric services and primary care. One model used by the department of psychiatry of St. Mary's Hospital in Rochester, New York, will be presented in detail. St. Mary's is a community hospital affiliated with the University of Rochester and located in the inner-city area of Rochester. St. Mary's Health Care System has a core of 20 primary care offices throughout the region. Currently, adult psychiatric services are provided at 16 of these sites and child psychiatric services are being added. This model helps decrease the impact of stigma encountered by patients, promotes communication between mental health staff and primary care providers, and enhances coordination of care. Primary care providers report that the program has greatly increased access to specialized mental health services. Also, the model provides clinicians with opportunities for professional development. A multicultural, multidisciplinary approach has contributed to the personal and professional growth of program staff and has decreased the possibility that cultural differences will be misinterpreted as mental health problems. Some of the financial and logistical difficulties of the program will also be discussed. The presentation will stimulate consideration of the establishment of comparable programs.

No. 22E
SOMATIZATION AND PRIMARY CARE

Ronald Epstein, M.D., *Dept. of Family Medicine, Highland Hospital, 885 south Avenue, Rochester NY 14620*

SUMMARY:

Unexplained somatic symptoms are common in primary care practice. There have been difficulties, however, with the definition, validity, and usefulness of defining patients as "somatizers" for several reasons. These patients constitute a heterogeneous group, with or without coexisting psychiatric diagnoses, functional disorders, and uncharacterized illnesses. Language, cultural factors, and societal attitudes invite stigmatization and drive emotionally distressed patients with psychological or somatic symptoms into the primary care sector. By taking a unified view of mind and body, discarding unhelpful diagnostic categories, utilizing a chronic disease model that emphasizes restoring function, and promoting effective collaboration between primary care physicians and psychiatrists, physicians can better understand and care for patients with unexplained somatic symptoms.

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INDUSTRY SUPPORTED SYMPOSIUM 23—DEPRESSION IN THE ELDERLY: U.S. AND EUROPEAN PERSPECTIVES

Supported by International Academy for Biomedical and Drug Research

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participants should be able to recognize, diagnose, and know how to treat effectively all forms of depressive disorders in the elderly, including differentiation of pseudo-dementia of depression from Alzheimer's disease, and to be thoroughly familiar with the special uses of antidepressant medications in geriatric patients, including when depression is comorbid with other medical and mental disorders.

No. 23A
UNIPOLAR DEPRESSION IN THE ELDERLY: CLINICAL COURSE AND OUTCOME

Lewis L. Judd, M.D., *Department of Psychiatry, UCSD School of Medicine, 9500 Gilman Drive, La Jolla CA 92093-0603*

SUMMARY:

Recent epidemiological studies have established that mental disorders are among the most common diseases that human beings experience. Further analysis of the epidemiological data has revealed that unipolar major depression is the most common mental disorder, afflicting one in ten adults in the U.S. during any one year. Surprisingly, major depressive disorders (MDD) have been found to have a lower prevalence in geriatric patient populations, despite evidence that elderly people are afflicted by depression at rates higher than in other age groups. However, in a series of recent studies, we have found that elderly people often suffer from subsyndromal depressive symptoms (SSD) and minor depressive disorder more frequently than MDD. Thus, the modal presentation of depressive disorders in geriatric patients is dominated by subsyndromal and minor forms of depression. Characteristics of SSD and minor depression found in older people will be described and discussed. Also, the psychosocial impact of depressive symptoms and disorders in the elderly will be described. It is important that all clinicians be aware of how depression presents in the elderly since it is often subtle and may be masked by cognitive decline. These issues will be described and discussed in detail.

No. 23B
MANAGEMENT OF DEPRESSION COMORBID WITH ANXIETY AND OTHER MENTAL DISORDERS IN THE ELDERLY

Carl Salzman, M.D., *Department of Psychiatry, Harvard Medical School, 74 Fenwood Road, Boston MA 02115-6106*

SUMMARY:

Depression commonly occurs in the elderly together with other syndromes, such as anxiety and dementia. Antidepressant drugs of all classes may be helpful in treating symptoms of both depression and anxiety in the elderly. Antidepressants with mild sedating properties are preferred to those with activating properties for the initial treatment of mixed anxiety and depressive states. However, since sedating tricyclic antidepressants also produce unwanted anticholinergic side effects, these drugs tend not to be used as first-line treatments for the elderly. Among the secondary amine tricyclics, nortriptyline is preferred to desipramine because it is less activating. All SSRI drugs may be helpful in treating mixed anxiety and depressive states in the elderly. Although paroxetine is thought to be more sedating than other SSRIs, there is wide variation in response among elderly patients. From a practical perspective, small starting doses of any SSRI should be used to determine whether or not a specific older patient will become activated or agitated. MAO inhibitors, although activating, may be very useful for treatment of mixed anxiety and depressive states; their use is limited by compliance problems that are common in older age groups. New antidepressants such as venlafaxine and nefazodone may also be useful for mixed depressive states in the elderly; low starting doses are recommended with gradual dose increases. Judicious use of benzodiazepines in non-demented elderly depressed patients may be very helpful for these mixed states, and for disrupted sleep. In the most severely agitated, anxious, and depressed patients, usually with melancholia, low-dose judicious use of neuroleptics may also be helpful.

Treatment of depressive symptoms in the demented elderly patient requires caution and usually lower than typical daily doses. All activating antidepressants may make severely demented patients more agitated; depressive symptoms in early stages of dementia may be helped by antidepressant treatment. Drugs with strong anticholinergic properties should be avoided.

Regardless of diagnosis, and regardless of treatments selected, older patients may be more sensitive to the therapeutic as well as toxic effects of psychotropic medication. The principle of "start low and go slow" should be followed. Clinicians must also be aware of potential drug interactions, especially when a state of depression and anxiety exist concomitantly with medical illness that is also under treatment.

No. 23C
RECOGNITION AND MANAGEMENT OF COGNITIVE DEFICITS IN LATE-LIFE DEPRESSION

Carl G. Gottfries, M.D., *Dept. of Neuroscience, Goteborg University, Molndal Hospital, S-43180 Molndal Sweden*

SUMMARY:

In elderly patients with cognitive deficits, e.g. Alzheimer's disease or vascular dementia, depression and emotional disturbances are common symptoms. About one-fourth of patients with Alzheimer's disease fulfill the criteria for major depressive disorder, and if minor depression is also included, the prevalence rate rises to 50%. For vascular dementia, the prevalence rates are even higher. The symptomatology of these kinds of depression may be atypical, and depression is often combined with anxiety and other emotional disturbances.

Use of selective serotonin reuptake inhibitors (SSRIs) has been successful in the treatment of depression in the elderly. According to a study on Alzheimer's disease, not only depressed mood but also anxiety, restlessness, and aggressiveness are symptoms that react favorably to the treatment. Controlled studies have also shown that post-stroke depression reacts favorably to treatment with SSRIs. In a double-blind controlled study (Nyth et al., 1992), citalopram was compared with placebo in the treatment of elderly people (mean age 76 years) with depressed mood according to the Hamilton depression rating scale, and with or without dementia. There was a significantly better effect with citalopram than with placebo, the drug was well tolerated, and there were few interaction problems.

No. 23D
MANAGEMENT OF DEPRESSION COMORBID WITH COMMON MEDICAL DISEASES IN GERIATRIC PATIENTS

Cornelius L. Katona, M.D., *Department of Psychiatry, University College, Ridinghouse Street, London, E97AL, United Kingdom*

SUMMARY:

Elderly patients with physical illness often have symptoms of depression and as many as one third have a full-blown depressive illness. The coexistence of physical illness makes the diagnosis of depression more difficult. Because of uncooperativeness, spuriously high scores on somatic items, and coexistent cognitive impairment, much depression in the physically ill goes unrecorded and untreated. Such depression may, however, interfere with social functioning and self-care, and may also impede recovery from the physical illness. This has been shown to result in extended hospital stays and increased mortality, particularly where the depression coexists with cognitive impairment. Short screening questionnaires can increase detection rates in acute inpatient and casualty settings. Improved detection of such depression is the first step to its successful management. Simple screening scales can increase detection rates considerably. There have been few controlled trials of antidepressant treatment in such patients, partly because the majority of them have contraindications to older tricyclic antidepressants, but available evidence (which will be reviewed) supports their use. Trials of newer, safer antidepressants such as the SSRIs in the physically ill elderly are needed.

No. 23E
DIAGNOSIS AND TREATMENT OF SLEEP DISORDERS IN THE DEPRESSED ELDERLY

Thomas Roth, Ph.D., *Sleep Disorders Center, Henry Ford Hospital, 2921 West Grand Boulevard, Detroit MI 48202*

SUMMARY:

Both depression and aging are known risk factors for sleep disorders. Thus, the absence of a complaint of insomnia in an elderly patient with depression is rare. Yet, it is important to recognize that sleep disorders in general, and in the elderly specifically, have significant morbidity associated with them. For example, one study found that night-time wandering is a major risk factor for institutionalization in elderly males. Effective treatment of sleep disorders in the elderly requires careful diagnosis. Sleep disorder complaints have many more etiologies in the elderly population as compared to their younger counterparts. For example, the elderly when compared to younger patients, more often complain of early morning awakening rather than prolonged sleep onset times. To treat their complaint appropriately, it is important to determine if the early morning awakening is attributable to a phase advance syndrome or a depressive disorder. Phase advance syndrome is treated with evening light exposure while depressive disorders are treated pharmacologically. The pharmacologic management of depression in the elderly also needs careful monitoring. Antidepressant therapy with tricyclics is known to exacerbate periodic leg movements, which are differentially prevalent in the elderly. Similarly, treatment with SSRIs is known to exacerbate sleep problems. The management of sleep disorders in the elderly represents a diagnostic as well as therapeutic challenge to psychiatrists.

No. 23F
MEDICATION DOSAGE, SAFETY AND TOLERANCE OF ANTIDEPRESSANTS IN THE ELDERLY

Lars F. Gram, M.D., *Dept. of Clin. Pharm., Odense University, Winslowparken, 19, Odense, 5000, Denmark*

SUMMARY:

The age-related risk factors in antidepressant treatment arise from changes in pharmacokinetics, pharmacodynamics and physiology, the increased risk of medical illnesses, and the increasing polypharmacy with risk of drug-drug interactions. Both tricyclic antidepressants (TCA) and selective serotonin reuptake inhibitors are mainly eliminated by liver metabolism, which only tends to decline in a fraction of the elderly, increasing the pharmacokinetic variability. Decreased tolerance of TCA in the elderly often relates to pharmacodynamics, confusion, urinary retention, and orthostatic hypotension, the latter limiting the use of TCA in elderly. However, with nortriptyline and blood concentration measurements, the tolerability will not be different from that in younger patients. Cardiac conductance disturbances, myocardial insufficiency, cerebrovascular insufficiency, and prostatic hypertrophia are age-related medical conditions incompatible with TCA but not SSRI. Drug-drug interaction risks are numerous (TCA with antiarrhythmics or ACE-inhibitors), and, pharmacokinetically in relation to certain SSRI, potently inhibiting distinct CYP-enzymes; fluoxetine and paroxetine: CYP2D6 (inhibited metabolism of TCA, antiarrhythmics, betablockers, neuroleptics), fluvoxamine: CYP1A2 (inhibited metabolism of clozapine, theophylline, caffeine). With extensive use of SSRI in elderly (nursing homes, etc.), some adverse reactions have been recorded that rarely are seen in younger patients including vertigo/dizziness/balance problems, extrapyramidal symptoms, confusion and bradycardia.

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INDUSTRY SUPPORTED SYMPOSIUM 24—PANIC DISORDER: THE CHALLENGE OF CHRONICITY
Supported by Roche Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, participants will be able to recognize that chronicity impacts the course and treatment of panic disorder, discuss the medical conditions associated with panic and their impact on treatment, compare and contrast the various psychopharmacologic agents, and apply a model for integrated treatment.

No. 24A
PANIC DISORDER: MORBIDITY, CHRONICITY AND OUTCOME

Jonathan R.T. Davidson, M.D., *Department of Psychiatry, Duke University Medical Center, Box 3812, Durham NC 27710*

SUMMARY:

Panic disorder responds substantially to different categories of treatment (e.g. benzodiazepines, antidepressants, cognitive-behavioral therapy). Nevertheless, the disorder is rarely eradicated by treatment, and most patients endure some degree of chronicity. The

core symptoms, functional impairment, and comorbidity may continue for many years. Theis presentation will review what is known about the short-tem and long-term course of the disorder, drawing on samples obtained in clinical practice and from treatment study volunteers. Other topics to be covered will include defining and predicting outcome, response to nonspecific treatment, and the effect of panic disorder on role function, quality of life, and health status.

No. 24B
MEDICAL COMORBIDITY IN PANIC DISORDER

Wayne J. Katon, M.D., *Department of Psychiatry, University of Washington, 1959 West Pacific Street, NE, Seattle WA 98195*

SUMMARY:

Recent epidemiologic studies have shown that patients with panic disorder frequently have comorbid medical symptoms and disorders. Cardiac symptoms such as palpitations and chest pain, as well as specific cardiac disorders such as mitral valve prolapse, labile hypertension, and cardiomyopathy have been shown to share significant comorbidity with panic disorder. Researchers have also shown significant comorbidity between panic disorder and migraine headaches, chronic obstructive lung disease, asthma, and irritable bowel syndrome. Possible pathophysiologic mechanisms that may explain the association, such as autonomic dysregulation of cardiac and intestinal activity and smooth muscle tone, will be discussed.

No. 24C
PSYCHOPHARMACOLOGY OF THE CHRONIC PATIENT

James C. Ballenger, M.D., *Department of Psychiatry, Medical University of SC, 171 Ashley Avenue, Charleston SC 29425*

SUMMARY:

Depending on definition, most panic disorder patients presenting for treatment benefit from long-term or chronic therapy. Most evidence suggests that patients continue to improve as long as they are on medications, and longer treatment (18 months vs. six months) appears to be associated with lower relapse rates. The strategy of chronic medication management and its interaction with the psychological management of recovery will be discussed. The evidence underlying factors associated with a more complete recovery, as well as poor recovery, will also be reviewed. Reasons for and strategies to taper and discontinue treatment will be reviewed. The psychological and cognitive management aspects of discontinuation of effective psychopharmacological treatment will also be reviewed. Relapse rates vary, and the limited evidence from studies of discontinuation of various medications will be discussed.

No. 24D
INTEGRATED TREATMENT OF PANIC DISORDER

Michelle G. Craske, Ph.D., *Department of Psychology, Univ. of Calif., Los Angeles, 405 Hilgard Avenue, Los Angeles CA 90095*

SUMMARY:

This paper will present the advantages and disadvantages of the combination of medications and cognitive-behavioral therapy for panic disorder. Advantages include (1) facilitation of cognitive-behavioral therapy by the potential for reducing attrition, increasing participation therapy, and elevating mood and/or decreasing anxiety sufficiently to enable full engagement in exposure practices (i.e., practices confronting feared stimuli), and (2) facilitation of medications by increasing medication acceptance and tolerance of side effects, reducing attrition, minimizing relapse, and improving efficacy for patients with personality disorders. Potential disadvantages of combining the two approaches occur mostly with respect to cognitive-behavioral therapy, and include detraction from the development of personal control, interference with exposure by complete suppression of panic and anxiety, and medications being used as safety signals. Data concerning the efficacy of an integrated approach will also be presented; an integrated approach provides a short-term advantage over either approach alone. Long-term data are lacking. Finally, methods for maximizing their integration will be outlined, including the sequencing of medications and cognitive-behavioral therapy, the duration of each approach, and an integrated treatment delivery.

No. 24E
APPROACHING THE TREATMENT-RESISTANT PATIENT

Mark H. Pollack, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC-815, Boston MA 02114*

SUMMARY:

Although a substantial body of clinical trial data and accumulating clinical experience demonstrate the efficacy of pharmacologic and cognitive-behavioral treatments for panic disorder, a substantial proportion of patients with this disorder respond incompletely or not at all to acute treatment. Follow-up studies of treated panic disorder patients suggest that many patients, though improved, remain somewhat symptomatic and some remain significantly impaired over time. In this presentation we review diagnostic issues in the acute and long-term response to treatment of panic disorder and suggest therapeutic strategies to improve treatment outcome.

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INDUSTRY SUPPORTED SYMPOSIUM 25—NEW CLINICAL APPROACHES FOR TREATING ANXIETY AND DEPRESSION: NEW STRATEGIES IN THE RECOGNITION AND TREATMENT OF ANXIETY AND DEPRESSIVE DISORDERS
Supported by Bristol-Myers Squibb

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM AND INDUSTRY SYMPOSIA 30, AND 42

To understand mechanisms of action and metabolism of new antidepressants; to recognize and treat major depression complicated by dysthymia and anxiety disorders; and to provide a treatment strategy for managing agitation and depression in the elderly.

No. 25A
A REVIEW OF THE MECHANISMS OF NEWER ANTIDEPRESSANTS

Jack M. Gorman, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, New York NY 10032*

SUMMARY:

The hallmark of the new generation of antidepressants is their relatively restricted actions in the central nervous system. Tricyclic and monoamino oxidase agents not only interacted with neurotransmitter systems believed relevant to the psychopathology of depression and anxiety, but also interacted with a wide range of probably irrelevant systems, leading to a host of adverse side effects. The newer antidepressants are fluoxetine, sertraline, paroxetine, nefazodone, venlafaxine, and fluvoxamine. All of them have profound effects on the serotonergic system, produced by inhibition of the serotonin reputake transporter molecule. The reuptake blockade has been shown in animal studies to lead to upregulation of the central serotonin neurotransmission system, and it is now believed that this is critical for the alleviation of depression and many of the anxiety disorders. Four of the drugs have actions limited to the serotonin reputake system and, therefore, are commonly referred to as selective serotonin reuptake inhibitors (SSRIs). These are fluoxetine, sertraline, paroxetine, and fluvoxamine. Nefazodone blocks the serotonin reuptake molecule like the SSRIs, but also blocks one of the postsynaptic serotonin receptors, called the 5-HT2 receptor. This action is believed to mediate nefazodone's effects on improving sleep and anxiety levels and its lack of sexual side effects. Venlafaxine blocks both the serotonin and noradrenergic reuptake molecules, giving it actions at both of the major neurotransmitter systems believed involved in anxiety and depression. Importantly, none of the new drugs has significant effects at the cholinergic receptor, yielding important advantages in tolerability over the older antidepressants. Most, but not all, antidepressant medications interact with a hepatic enzyme system called the cytochrome P-450 system. This system is comprised of more than 30 isoenzymes, some of which are inhibited by different antidepressants. It is relatively simple to understand the implications of P-450 interactions when prescribing antidepressants and quickly appreciate that all of the new antidepressants are safe and well tolerated.

No. 25B
ANTIDEPRESSANT AUGMENTATION AND COMBINATION STRATEGIES

Stephen M. Stahl, M.D., *Department of Psychiatry, University of CA, San Diego, 8899 University Cntr Lane #130, San Diego CA 92122*

SUMMARY:

Studies of antidepressants include patients who receive these agents as monotherapies, but in clinical practice most patients are prescribed concomitant medications. Combining antidepressants with other medications is on the increase as psychiatrists see patients who are refractory to single therapeutic agents and who have additional medical illnesses.

To cope with this increased complexity of drug combinations, the clinician can either memorize a list of constantly changing drug interactions or predict favorable and unfavorable drug interactions by gaining a firm understanding of pharmacokinetic and pharmacodynamic principles. To understand pharmacokinetics, or how the body acts on drugs, one must know that every drug is a substrate and potentially an inhibitor of one or more of the cytochrome P450 isozymes. Drug interactions can be predicted if the clinician knows this for every drug the patient is taking. To understand pharmacodynamics, or how drugs act on the body (especially the brain), one must understand the pharmacology of antidepressants at neurotransmitter receptors, and how two or more drugs acting simultaneously at two or more sites can be predictably different from one drug by itself. This presentation will provide practical tips on combining antidepressants with other medications by applying these principles.

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INDUSTRY SUPPORTED SYMPOSIUM 26—BIPOLAR MIXED STATES: THE CLINICAL FRONTIER
Supported by Abbott Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM AND INDUSTRY SYMPOSIA 31, AND 43

To impart an in-depth knowledge on the causes, psychopathology, and clinical subtypes of bipolar disorder mixed states, as well as emerging clinical management strategies, including psychoeducation and sophisticated psychopharmacology.

No. 26A
CLINICAL OVERVIEW AND GENDER ISSUES IN MIXED STATES

Susan L. McElroy, M.D., *Department of Psychiatry, Univ of Cincinnati Col of Med, 231 Bethesda Avenue, ML 559, Cincinnati OH 45267-0559*

SUMMARY:

The purpose of this presentation is to provide an overview of current clinical research into mixed states. First, the concept of the mixed state will be defined and differentiated from the DSM-IV diagnosis of mixed mania. It will be stressed that over-reliance on categorical rather than dimensional systems for the diagnosis and subtyping of bipolar disorder (as is done in DSM-IV) continues to promote the under-recognition of mixed states. Then, recent findings indicating that in persons with bipolar disorder, mixed states may be more common in women than in men, and in children, adolescents, and elders than in adults, will be reviewed. Recent research consistent with earlier observations that mixed mania may respond better to valproate than to lithium will also be reviewed. The clinical implications of these findings will be summarized and future research needs suggested.

No. 26B
THE ROLE OF TEMPERAMENT IN MIXED STATES

Hagop S. Akiskal, M.D., *Department of Psychiatry, Univ. of California, San Diego, 9500 Gilman Drive, La Jolla CA 92093-0603*

SUMMARY:

Previous work by the author has suggested that mixed states can be subtyped on the basis of temperament. Dysphoric mania (bipolar I) seems to arise from a dysthymic temperamental baseline. Bipolar II mixed states, which in DSM-IV terms are often diagnosed as "borderline," typically consist of irritable-cyclothymic temperament with superimposed depressive episodes. Finally, there are protracted mixed states arising from the substrate of a hyperthymic temperament intruding into a major depression and giving rise to racing thoughts

and increased sexuality (bipolar II). Data from three collaborative studies that the author has been involved with have provided further verification for this framework. The first comes from the NIMH Collaborative Depression Study of 559 major depressives who switched to bipolar II. The second, just completed, is the Pisa-San Diego study of 143 mixed states. The third is a French national study in progress involving 100 bipolar I and 600 major depressives. While some of the analyses are preliminary, the overall data tend to support the thesis that the heterogeneity of mixed states is explainable in part as a function of temperaments and effective episodes being of opposite polarity. These data have considerable implications for the acute and long-term management of mixed states.

REFERENCES:

1. McElroy SL, Keck PE, Jr, Pope HG, et al: Clinical and research implications of the diagnosis of dysphoric or mixed mania or hypomania. *Am J Psychiatry* 149:16633-1644, 1992.
2. Akiskal HS: The prevalent clinical spectrum of bipolar disorder: beyond DSM-IV. *J Clin Psychopharmacol* 16(suppl 1):4s-14s, 1996.

INDUSTRY SUPPORTED SYMPOSIUM 27—ANXIETY DISORDERS: IDENTIFYING THE CRITICAL CHALLENGES
Supported by Roerig Division/Pfizer, Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM AND INDUSTRY SYMPOSIA 32, AND 44

At the conclusion of these presentations, participants should enhance their recognition and treatment of anxiety by understanding the: 1) growing role of self-help, support groups, and advocacy; 2) interface between anxiety and substance abuse; 3) barriers to implementing effective treatment of anxiety in women; 4) importance of primary care medicine for anxiety; 5) treatment-resistant anxiety.

No. 27A
ANXIETY AND SUBSTANCE USE DISORDERS

Kathleen T. Brady, M.D., *Department of Psychiatry, Medical University of SC, 171 Ashley Avenue, Charleston SC 29425-0742*

SUMMARY:

Anxiety disorders and substance use disorders commonly co-occur, but the nature of the relationship is often poorly understood. The use of some substances (cocaine, marijuana) can cause symptoms of anxiety, while withdrawal from other substances (alcohol, sedative hypnotics, opiates) is also marked by symptoms of anxiety. It is also likely that individuals with anxiety disorders self-medicate symptoms of anxiety with substances of abuse. This can further complicate the diagnostic picture and make differential diagnosis even more difficult. In this talk, the prevalence of comorbid anxiety disorders and substance use disorders will be discussed. Prevalence of comorbidity from epidemiologic samples and treatment-seeking samples will be compared. Considerations in differential diagnosis, such as order of onset of disorders as well as the minimum necessary period of abstinence for diagnostic clarity, will be discussed. A number of studies exploring both psychotherapeutic and pharmacotherapeutic treatment options in individuals with a variety of anxiety disorders and substance use disorders also will be discussed. Specifically, data will be presented from a pharmacologic treatment study of panic disorder in alcoholics, psychotherapeutic treatment of social phobia in alcoholics, and pharmacotherapeutic and psychotherapeutic approaches to the treatment of post-traumatic stress disorder in individuals with substance use disorders.

No. 27B
TREATMENT-REFRACTORY PANIC, GAD, AND SOCIAL PHOBIA

Peter P. Roy-Byrne, M.D., *Department of Psychiatry, Univ of WA/ Harborview Med Cntr, 325 Ninth Avenue, Box 359911, Seattle WA 98104*

SUMMARY:

Because of the available range of effective treatments for anxiety, most anxiety-related morbidity and cost is associated with treatment refractoriness due to poor patient adherence, clinician error, or frank resistance to treatment. Common clinician errors include inadequate patient education and preparation, misidentification of comorbid psychiatric and medical conditions, incorrect medication dose or duration, or failure to use concomitant cognitive or other psychotherapy. Refractory panic, GAD, and social phobia are often associated with comorbid depression, phobia, substance abuse, personality disorder, specific medical illness (COPD, sleep apnea, epilepsy, Parkinson's or thyroid disease), and prescribed or nonprescribed medication. Utilization of careful diary ratings can pinpoint illness components that remain treatment nonresponsive (anticipatory anxiety, phobia, hypochondriasis, specific panic symptoms, or cognitive vs. somatic anxiety), can guide selection of augmenting pharmacotherapy or specific psychotherapy, and may identify paradoxical anxiogenic effects of usually effective medications. Use of novel medications may also prove beneficial, although careful, systematic trials combining more traditional agents and therapies are usually more productive.

REFERENCES:

1. Kushner MG, Sher KJ, Bietner BD: The relationship between alcohol problems and anxiety disorders. *Am J Psychiatry*, 147:685-695-695, 1990.
2. Roy-Byrne PP, Wingerson D, Cowley D, Dager S: Psychopharmacologic treatment of panic, GAD and social phobia. *Psychiatric Clinics of North America* 16:719-736, 1993.

INDUSTRY SUPPORTED SYMPOSIUM 28—WOMEN'S MENTAL HEALTH IN THE 1990S: TOWARD AN INTEGRATED APPROACH
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM AND INDUSTRY SYMPOSIA 33, AND 45

At the conclusion of these presentations, the participant should be able to evaluate and treat the female patient with eating disorders, affective disorder during pregnancy and the postpartum period, substance use disorders, and anxiety disorders.

No. 28A
SOCIAL SUPPORT AS RISK MODULATOR OF POSTPARTUM MOOD DISTURBANCE IN FIJI

Anne E. Becker, M.D., *Department of Psychiatry, Massachusetts General Hospital, Fruit Street, Boston MA 02114;* Lee S. Cohen, M.D.

SUMMARY:

Objective: Studies have suggested that poor social support is a risk factor for mood disorder in the postpartum. The purpose of this pilot investigation was to assess prevalence and potential predictors of postpartum depression in Fiji with particular attention to social context.

Method: 85 consecutive ethnic Fijian women were recruited after delivery at Sigatoka Hospital. They subsequently underwent translated structured interviews keyed to the mood module of the Structured Clinical Interview for Diagnosis (SCID-P), and responded to the Kellner Symptom Questionnaire and visual analog scales to indicate social supports during the first two to five months postpartum; 82 women completed the study.

Results: Only one woman was noted to have suffered postpartum major mood disorder during the first puerperal months. A subset of 18 women who described symptoms meeting criteria for major depression except for duration (<2 weeks) was also identified. Compared with women who did not demonstrate such a mood disturbance, these women were more likely to report inadequate social supports ($p < 0.02$). Perceived inadequate social support was also associated with higher depressive subscale scores on the Kellner ($p = 0.05$).

Conclusions: The rate of postpartum major mood disturbance appears particularly low in this sample, while perceived inadequate social supports were associated with subsyndromal postpartum mood disturbance. Traditionally intensive social supports may modulate risk for puerperal illness among ethnic Fijians.

No. 28B
MOOD AND ANXIETY DISORDERS ACROSS THE FEMALE LIFE CYCLE

Lee S. Cohen, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC 815, Boston MA 02114;* Anne E. Becker, M.D., Karin M. Nussbaum, B.A., Douglas G. Jacobs, M.D., Mark Blais, Psy.D.

SUMMARY:

The relationship between psychiatric symptoms and female reproductive function remains to be clarified. Investigators continue to examine questions related to premenstrual symptoms of worsening mood and anxiety, affective instability during pregnancy, as well as the phenomenon of postpartum psychiatric disorder. This presentation will highlight issues related to diagnosis and treatment of affective disorder in women of childbearing potential. Specific attention will be given to affective symptoms experienced by women premenstrually. Data will be presented regarding diagnostic status of women who present with premenstrual mood and anxiety symptoms. Diagnosis and treatment of mood and anxiety disorders during pregnancy and the postpartum period will also be reviewed, with particular focus on the heterogeneity of mood and anxiety disorders during pregnancy and the puerperium and the implications for appropriate treatment during these times. A review will also be presented regarding use of psychotropic drugs during pregnancy, which takes into account risk of prenatal exposure to psychotropics compared with the risk of untreated psychiatric disorder.

REFERENCES:

1. O'Hara MW: Social support, life events, and depression during pregnancy and the puerperium. *Arch Gen Psychiatry* 43:569-573, 1986.
2. Altshuler LL, Cohen LS: Pharmacologic management of psychiatric illness during pregnancy: dilemmas and guidelines. *Am J Psych* 153:592-606, 1996.

INDUSTRY SUPPORTED SYMPOSIUM 29—CHALLENGE: MAKING THE MOST OF THERAPY WITH ATYPICAL ANTIPSYCHOTICS

Supported by Janssen Pharmaceutica and Research Foundation

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM AND INDUSTRY SYMPOSIA 34 AND 46

To evaluate the use of the newer atypical antipsychotic agents and understand their role in the treatment of schizophrenia and other psychiatric disorders.

No. 29A
ATYPICAL ANTIPSYCHOTICS: HOW DO THEY COMPARE?

Joseph P. McEvoy, M.D., *Adult Admission Unit, John Umstead Hospital, 1003 12th Street, Butner NC 27509-1695*

SUMMARY:

This presentation will focus on the controlled double-blind trials that compare the new atypical antipsychotic drugs (clozapine, risperidone, olanzapine, sertindole, ziprasidone, quetiapine) with placebo, with conventional antipsychotic drugs, and with each other.

For each trial, the specific patient population included will be characterized, and specific effects on positive and negative psychopathology, and on hostility and depressive affect, will be examined. Effort will be made to delineate for each drug the dose-response relationships for efficacy and for important side effects.

The costs per year of treatment at average optimal dose will be compared for the currently marketed drugs.

No. 29B
PHARMACOLOGY: WHAT SIDE EFFECTS CAN WE EXPECT FROM THE ATYPICAL ANTIPSYCHOTICS?

William C. Wirshing, M.D., *Department of Psychiatry, West LA VA Medical Center, 11301 Wilshire Blvd. (B-151H), Los Angeles CA 90073*

SUMMARY:

Conventional antipsychotic medications appear to exert both their primary antipsychotic efficacy and core extrapyramidal neurotoxicities via the blockade of dopamine-2 receptors (D_2) in the limbic and striatal areas of the brain. While the atypical antipsychotic clozapine does, in fact, weakly block central D_2 receptors, it does so well below the neurotoxic threshold and has substantial affinity for a number of other receptors. Clozapine's atypical properties have prompted the design and development of several newer antipsychotic compounds that, like clozapine, block multiple receptors in addition to the D_2 receptor. Prominent among these other receptors are: $5HT_{2A}$, $5HT_{2C}$, α_1, α_2, M_1, D_1, and D_4. The polyreceptor affinities of these newer compounds has led to a partial mimicking of clozapine's atypicality. However, these novel receptor affinity profiles also cause a number of untoward toxic liabilities. The list includes: weight gain, cardiovascular toxicity, endocrinologic perturbations, sexual dysfunctions, and neurocognitive embarassment. This presentation will focus on the theoretical bases for these additional toxicities among the newer atypical compounds and then emphasize the clinical recognition and management of them.

REFERENCES:

1. Ames D, Marder SR, Wirshing WC: Risperidone: clinical applications. (pp. 15-40) In: Breier, ed: *The New Pharmacotherapy of Schizophrenia (1st Edition)*. Washington, DC: American Psychiatric Association Press, 1996.

INDUSTRY SUPPORTED SYMPOSIUM 30—NEW CLINICAL APPROACHES FOR TREATING ANXIETY AND DEPRESSION: PERILS FOR CLINICIANS IN PHARMACOLOGIC TREATMENT OF DEPRESSION COMPLICATED BY ANXIETY
Supported by Bristol-Myers Squibb

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM
See Page 293—Industry Supported Symposium 25

No. 30A
A SYSTEMATIC APPROACH TO THE MANAGEMENT OF THE DEPRESSED AND ANXIOUS PATIENT

John M. Zajecka, M.D., *Department of Psychiatry, St. Luke's Medical Center, 1725 West Harrison, Suite 955, Chicago IL 60612*

SUMMARY:

Epidemiological and clinically based studies show high comorbidity rates between depression and anxiety. Early recognition and treatment of both depressive and anxiety symptoms can maximize acute and long-term outcomes and reduce potential negative outcomes associated with such comorbidity, such as suicide. There are increasingly effective pharmacological treatment options for the management of depression and anxiety, including monotherapies and augmentation strategies. Updating and organizing this influx of knowledge can lessen the apparent complexity of choosing the most effective treatment(s) for the variety of clinical presentations of depression and anxiety. A systematic approach will be presented for the management of depression associated with generalized anxiety, panic attacks, obsessions/compulsions, and post-traumatic stress disorder.

No. 30B
MANAGING COMMON SIDE EFFECTS OF NEWER ANTIDEPRESSANTS

Norman Sussman, M.D., *Department of Psychiatry, NYU School of Medicine, 201 East 68th St., Suite 204, New York NY 10021-5836*

SUMMARY:

The newer antidepressant drugs introduced since 1988—the SSRIs, venlafaxine, nefazodone, and bupropion—all have side-effect profiles that are different from earlier agents, such as the tricyclics and MAOIs. In general the new drugs are safer and better tolerated, but they are each associated with adverse effects that can limit their clinical use. The SSRIs, for example, are commonly associated with headache, nausea, nervousness, insomnia, and sexual dysfunction. They also cause fatigue, weight gain, and extrapyramidal symptoms, and have been associated with decreased efficacy over time and withdrawal symptoms. In order to facilitate compliance with these agents, clinicians and researchers have attempted to use add-on therapy as a means of mutigating these side effects. Most of the information is anecdotal. There are reports of catecholamine agonists, psychostimulants, and serotonin receptor antagonists being effective in alleviating side effects. They have also altered normal dosing strategies. These include dose increases or decreases, skipping doses, and changing the time of day that the medication is taken. Many adverse effects are dose-related and occur early in treatment. This is particularly true with venlafaxine and nefazodone. Accordingly, with these two agents, dose-titration represents the most effective way of minimizing side effects. Nefazodone is noteworthy for its low incidence of treatment-emergent sexual dysfunction and insomnia. With the exception of CNS activation and risk of seizures in vulnerable individuals, bupropion is well tolerated. Careful dosing is probably the most important way to minimize adverse events associated with bupropion. In general, the side effects associated with the newer antidepressants can be managed more successfully than the tricyclic antidepressants. Many different strategies work some of the time, but none work all of the time. Controlled studies are clearly indicated.

REFERENCES:

1. Zajecka JM, Ross JS: Management of comorbid anxiety and depression. *J Clin Psychiatry* (5b suppl 2):10-13, 1995.
2. Kaplan HI, Sadock BJ: *Pocket Handbook of Psychiatric Drug Treatment.* Williams & Wilkins. Baltimore, 1996.

INDUSTRY SUPPORTED SYMPOSIUM 31—BIPOLAR MIXED STATES: THE CLINICAL FRONTIER
Supported by Abbott Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM
See Page 294—Industry Supported Symposium 26

No. 31A
CHILDHOOD MANIA AND ADHD AS MIXED STATES

Elizabeth B. Weller, M.D., *PA Child Guidance Center, 2 Children's Cntr/34th & Civic, Philadelphia PA 19104-4399*

SUMMARY:

Mania in children had been rarely diagnosed until recently. In Kraepelin's series of adult manics, the occurrence of mania before the age of 10 was 0.5%, with a surge of new cases with the onset of puberty. DSM-III-R added to the confusion of overidentifying mania in children by removing the length of an episode of one week. As a result, children with behavioral disorders such as ADHD and conduct disorder with symptoms of mania such as overactivity, irritability, and reckless behavior were diagnosed to have mania. In this presentation, clinical mania will be contrasted with ADHD and conduct disorder. An emphasis on how to tease the disorders from each other by using proper diagnostic evaluation, structured and semistructured interviews, and rating scales will be presented. The issue of comorbidity with ADHD and conduct disorder will be discussed in the context of mixed manic states.

No. 31B
PHYSIOLOGICAL RIGIDITY AND BEHAVIORAL PATHOLOGY IN BIPOLAR ILLNESS

Peter C. Whybrow, M.D., *Department of Psychiatry, University of Pennsylvania, 305 Blockley Hall, Philadelphia PA 19104*

SUMMARY:

Bipolar disorder is generally accepted as a disorder of limbic regulation. Increasingly, evidence suggests that during periods of pathology, the usual regulatory plasticity of the limbic system is compromised, resulting in episodic oscillation of behavior and presumably the underlying physiological mechanisms. Evidence will be presented for this episodic dysregulation and how it differs from normal behavior. Using mood ratings over an extended period of time and correlating them with drug response, an effort will be made to refine the general concept that illness is rigidity and health is chaos.

REFERENCES:

1. Weller EB, Weller RA, Fristad MA: Bipolar disorder in children: misdiagnosis, underdiagnosis, and future directions. *J of Am Acad of Child and Adolescent Psych.* 5:500-502, 1995.
2. Gottschalk A, Bauer MS, Whybrow PC: Evidence of chaotic mood variation in bipolar disorder. *Arch Gen Psychiatry.* 52:947-964.

INDUSTRY SUPPORTED SYMPOSIUM 32—ANXIETY DISORDERS: IDENTIFYING THE CRITICAL CHALLENGES
Supported by Roerig Division/Pfizer, Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM
See Page 295—Industry Supported Symposium 27

No. 32A
PHARMACOLOGIC TREATMENT OF ANXIETY DISORDERS IN WOMEN

Tana A. Grady, M.D., *Department of Psychiatry, Duke University Medical Center, P.O. Box 3837, Durham NC 27710*

SUMMARY:

Most anxiety disorders are at least twice as common in women as men. This gender difference is important with regard to understanding the etiology of anxiety disorders. Additionally, it is important to recognize the potential role of exogenous hormones, menstrual cycle hormonal changes, and pregnancy on both the etiology and pharmacologic treatment of anxiety disorders in women. This presentation will give an overview of the anxiety disorders that are more common in women, including panic disorder, agoraphobia, simple phobia, generalized anxiety disorder, and post-traumatic stress disorder. Pharmacologic management of these disorders with antidepressants, benzodiazepines, and mood stabilizers will be reviewed, with an emphasis on gender differences concerning efficacy and side-effect profile. There will be specific attention to the potential pharmacodynamic and pharmacokinetic differences across the menstrual cycle and with the use of exogenous hormones, particularly oral contraceptive agents. Additionally, there will be a review of the use of pharmacologic agents for treatment of anxiety disorders during pregnancy, with particular emphasis on the risk and benefit ratio. Finally, there will be a brief discussion of the potential role of novel pharmacologic agents in the treatment of anxiety disorders in women.

No. 32B
ANTIDEPRESSANTS IN PTSD: WHICH DRUG? WHICH PATIENT? WHICH TRAUMA?

Jonathan R.T. Davidson, M.D., *Department of Psychiatry, Duke University Medical Center, Box 3812, Durham NC 27710*

SUMMARY:

A growing literature now exists on the use of medications in PTSD. Early studies focused on combat veterans, who showed positive responses to tricyclic and irreversible MAOI antidepressants. Subsequent studies of SSRI therapy have failed to demonstrate evidence of efficacy in this population, but there is mixed evidence for the benefit of brofaromine in such subjects.

Recent trials of SSRI in civilians with PTSD show good effect, the majority of subjects in these studies being women.

Some symptoms appear to be more drug responsive than others, and findings in this regard depend upon the drug and trauma population under study. Antidepressants can also have a positive effect on symptoms other than the core PTSD features, as will be described.

This presentation will review the major findings to date regarding antidepressants in PTSD, and will report on the possible importance of trauma type and gender as they may influence drug response.

REFERENCES:

1. Yonkers KA, Ellison JM: Anxiety disorders in women and their pharmacological treatment, In: Jensvold MF, Halbreich *Psychopharmacology and Women: Sex, Gender and Hormones.* Washington, DC: American Psychiatric Press, Inc., pp. 261-285, 1996.

INDUSTRY SUPPORTED SYMPOSIUM 33—WOMEN'S MENTAL HEALTH IN THE 1990S: TOWARD AN INTEGRATED APPROACH
Support by Eli Lilly and Company

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM
See Page 295—Industry Supported Symposium 28

No. 33A
ANXIETY DISORDERS IN WOMEN

Henrietta L. Leonard, M.D., *Department of Psychiatry, Brown University/RI Hospital, 593 Eddy Street, Providence RI 02903*

SUMMARY:

Epidemiologic studies report that women have higher prevalences of anxiety disorders. Recently, the National Comorbidity Survey (NCS) reported that of women surveyed, lifetime prevalence for any anxiety disorder was 30%; and social phobia (15%), simple phobia (15%), agoraphobia without panic disorder (7%), generalized anxiety (7%), and panic disorder (5%) were not uncommon. Despite the higher prevalence in women, various explanations for the differences have been discussed but not clearly delineated. For some disorders, the age of onset differs between the genders. For example, women have a later onset of obsessive-compulsive disorder, and neuroendocrine hypotheses have been reported. This talk will summarize the differences between the genders in their onset, course, prevalence, and phenomenology of the anxiety disorders. Future directions for research will be emphasized.

No. 33B
SUBSTANCE USE DISORDERS IN WOMEN

Kathleen T. Brady, M.D., *Department of Psychiatry, Medical University of SC, 171 Ashley Avenue, Charleston SC 29425-0742*

SUMMARY:

The issue of gender differences in substance use disorders has received increasing attention in recent years. A number of studies

have indicated that substance-abusing women are less likely to be employed and have lower educational and socioeconomic status than men. Other studies have highlighted differences in attribution of etiology noting that women are more likely to attribute the initiation of substance abuse to a specific event or stressor, and women are more likely to report guilt and self-reproach as a result of substance use. Another area of important gender difference in substance use disorders is that of psychiatric comorbidity. A number of studies have reported more Axis I psychopathology in women substance users. In the current presentation, gender comparisons in data collected from 100 treatment-seeking substance users (50 men/50 women) will be discussed. Women were more likely to have another Axis I disorder ($p < 0.05$), in particular anxiety disorders ($p < 0.05$), but these differences were not substantially different from gender differences in the general population. Gender differences in psychiatric comorbidity by substance of choice will be presented. Data concerning gender differences in order of onset for psychiatric disorders and substance use disorders will also be presented. The treatment implications of gender differences in the presentation, psychosocial status, and psychiatric comorbidity of individuals with substance use disorders will be discussed.

REFERENCES:

1. Kessler RC, McGonagel KA, Zhae S, et al: Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: results from the National Comorbidity Survey. *Arch Gen Psych* 51:8-19, 1994.
2. Brady KT, Grice DE, Dustan L, Randall C: Gender differences in substance use disorders. *Am J Psychiatry* 150:1707-1711, 1993.

INDUSTRY SUPPORTED SYMPOSIUM 34—CHALLENGE: MAKING THE MOST OF THERAPY WITH ATYPICAL ANTIPSYCHOTICS

Supported by Janssen Pharmaceutica and Research Foundation

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM

See Page 296—Industry Supported Symposium 29

No. 34A
LONG-TERM USE OF ATYPICAL ANTIPSYCHOTICS

Del D. Miller, M.D., *Department of Psychiatry, University of Iowa, #2880 JPP/200 Hawkins Drive, Iowa City IA 52242*

SUMMARY:

During the past 40 years antipsychotic medications have become the mainstay in the treatment of schizophrenia, both for acute exacerbations and chronic maintenance treatment. Conventional antipsychotics are particularly effective in treating positive symptoms including hallucinations, delusions, bizarre behavior, and disorganization during acute treatment and in preventing relapse in persons with schizophrenia. However, the conventional antipsychotics are less effective in treating negative symptoms such as blunted affect, apathy, anhedonia, and alogia, and these symptoms appear to persist more often in the chronic phases of schizophrenia.

In clinical trials involving acutely exacerbated persons with schizophrenia, newer antipsychotics (e.g., clozapine, risperidone, olanzapine, sertindole, quetiapine, etc.) have been shown to be effective in treating both positive and negative symptoms with improved side-effect profiles when compared with conventional antipsychotics. In addition, data from long-term studies suggest that the advantages of some of these newer antipsychotics may be enhanced with greater duration of treatment. Results from these long-term trials will be reviewed, and guidelines for optimizing the long-term use of the newer antipsychotics will be offered.

No. 34B
USE OF ATYPICAL ANTIPSYCHOTICS IN THE TREATMENT OF DISORDERS OTHER THAN SCHIZOPHRENIA

Prakash S. Masand, M.D., *Department of Psychiatry, SUNY Health Sciences Center, 750 East Adams Street, Syracuse NY 13210*

SUMMARY:

Atypical antipsychotics have been used in the treatment of disorders other than schizophrenia, including bipolar disorders, schizoaffective disorders, dementia, delirium, obsessive-compulsive disorder (as an augmentation strategy), Tourette's syndrome, and psychosis associated with medical illnesses (i.e., HIV infection, lupus, and multiple sclerosis). The atypical neuroleptics, such as clozapine and risperidone, offer several advantages over the conventional neuroleptics, including a lower propensity to cause extrapyramidal side effects such as tardive dyskinesia, improvement of negative symptoms, decreased rates of rehospitalization, and better cognitive functioning. The talk will discuss the efficacy of the atypical neuroleptics in patients with disorders other than schizophrenia. The advantages and disadvantages of the atypical and conventional neuroleptics will be compared. The talk will also address the pharmacodynamic and pharmacokinetic interactions with the atypical neuroleptics that are important in patients with comorbid medical illnesses.

REFERENCES:

1. Miller DD, Schultz S, Alexander B: Rational pharmacological approaches in the management of treatment-resistant schizophrenia. *Psychiatric Clinics of North America* 3:89-118, 1996.
2. Keck PE, Wilson DR, Strakowski SM, et al: Clinical predictors of acute risperidone response in schizophrenia, schizoaffective disorders, and psychotic mood disorders. *Journal of Clinical Psychiatry* 56(10):466-470, 1995.

INDUSTRY SUPPORTED SYMPOSIUM 35—SLEEP ASPECTS OF MOOD AND ANXIETY DISORDERS

Supported by Bristol-Myers Squibb

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

To convey current information on the inter-relationships of sleep disturbance and mood and anxiety disorders; to highlight core features of these disorders that manifest during or from sleep; and to address implications for mechanisms of illness and issues for treatment.

No. 35A
SEROTONIN AND LOCAL CEREBRAL GLUCOSE METABOLIC RATE

J. Christian Gillin, M.D., *Department of Psychiatry, Univ of CA, San Diego/VAMC, 3350 La Jolla Village Drive, San Diego CA 92161-0001;* Tahir I Bhatti, M.D., Joseph C. Wu, M.D., Monte S. Buchsbaum, M.D., William E. Bunney, Jr., M.D., Polly Moore

SUMMARY:

This presentation will provide an overview of two areas of recent research linking sleep to depression: 1) The role of serotonin: Tryptophan depletion in normal volunteers by the tryptophan-free drink (TFD) simulates sleep in depression, i.e., short REM latency, but does not increase self-rated depression. In our study, the TFD reversed the REM-suppressing effects of SSRIs in euthymic patients with MDD but did not increase depression. This latter observation did not confirm the reports of Delgado, et al that the TFD reversed the antidepressant effects of SSRIs. Our patients, however, had been treated for four to six months, compared with four to six weeks, and were less depressed (HRSD 1-3 compared with about 7-10) than the patients in the Delgado group. These results suggest that REM measures can be disassociated from mood in both normals and depressed patients, and tryptophan depletion may reverse the antidepressant effects of SSRIs only early during treatment in relatively mildly depressed but improving patients.

Local cerebral glucose metabolic rate (LCGMR) during nonREM sleep and sleep deprivation. In collaboration with the Brain Imaging Center at UCI, we have recently found that elevated LCGMR in cingulate at baseline is associated with the antidepressant effects of total sleep deprivation in depressed patients. In addition, we have found global and local elevations of LCGMR during the first non-REM period of the night in mildly to moderately depressed patients compared with normal controls.

No. 35B
SLEEP AND SLEEP BREATHING IN PANIC DISORDER

Murray B. Stein, M.D., *Department of Psychiatry, Univ. of California, San Diego, 9500 Gilman Drive, #0985, La Jolla CA 92093-0985;* Meir H. Kryger, M.D.

SUMMARY:

Panic disorder is characterized by the occurrence of anxiety attacks that can occur during wakefulness or sleep. Approximately one in five patients with panic disorder has frequent sleep panic attacks. These are particularly common in persons with sleep breathing problems, subtle variations of which may occur relatively frequently in patients with panic disorder. Sleep panic attacks can be frightening and can often set up a cycle in which sleep phobia (the fear of going to sleep) and sleep deprivation serve to exacerbate an individual's daytime panic attacks and increase his or her functional impairment. Despite the occurence of sleep panic attacks in some cases, the sleep architecture of patients with panic is remarkably normal, showing none of the REM abnormalities characteristic of major depression. The meaning of these findings with reference to the pathophysiology of panic disorder will be discussed.

No. 35C
SLEEP DISTURBANCES IN PTSD

Thomas A. Mellman, M.D., *Department of Psychiatry, Veterans Affairs Medical Ctr, 1201 NW 16th Street, 116A, Miami FL 33125;* Bruce Nolan, M.D., Daniella David, M.D., Lydia Barza

SUMMARY:

Sleep disturbances are prominent components of the reexperiencing and heightened arousal symptom clusters of post-traumatic stress disorder (PTSD). Recurrent nightmares that replicate traumatic events have been considered a cardinal feature of PTSD and have focused attention on rapid eye movement (REM) sleep. Descriptive studies document awakenings with somatic anxiety and body movement during sleep to be prominent PTSD symptoms.

In the sleep laboratory we found combat veterans with PTSD to have increased awakenings and microawakenings, limb and gross body movement, reduced sleep efficiency, and nondiminished noradrenergic production at night, compared with controls. Our laboratory investigation of hurricane subjects during a more acute phase of PTSD revealed increased shifts from sleep toward more highly aroused states (e.g. stage 1 or wake EEG).

We and others have found a tendency for symptomatic awakenings in PTSD to arise from REM, increased REM density at night, and preliminary evidence for abnormal REM "pressure" to manifest during the day. Studies suggest that REM and dreaming can facilitate information processing and emotional adaptation. Normal dream patterns associated with REM appear to involve more diffuse memory networks than in PTSD.

Theoretical and treatment implications for observations related to sleep and arousal regulation and to REM and dreaming in PTSD will be explored.

No. 35D
EFFECTS OF ANTIDEPRESSANTS ON SLEEP IN DEPRESSION

Roseanne Armitage, Ph.D., *Department of Psychiatry, UT Southwestern Medical Center, 5323 Harry Hines Boulevard, Dallas TX 75235-9070;* Robert Hoffmann, Ph.D., A. John Rush, M.D., Madhukar H. Trivedi, M.D., Kimberly A. Yonkers, M.D.

SUMMARY:

This presentation will review the effects of antidepressants on sleep and the clinical relevance of sleep disturbances to MDD. Most antidepressants, including tricyclics (TCAs) and selective serotonin reuptake inhibitors (SSRIs), act as potent REM sleep suppressors, increasing the latency to REM and decreasing the total amount of REM sleep. Several researchers have suggested that antidepressant efficacy is linked to REM sleep suppression. But SSRIs, in particular fluoxetine, have been shown to increase arousals and fragment sleep above baseline levels in patients with MDD.

The sleep effects of nefazodone, a 5-HT_2 antagonist that also inhibits serotonin reuptake, differ from SSRIs and TCAs. Nefazodone improves sleep disturbance in patients with MDD, decreasing the number of arousals and light Stage 1 sleep. Nefazodone also has remarkably little effect on REM sleep. The improvement in sleep architecture has been reported in both open-trial studies and double-blind comparisons of nefazodone with fluoxetine. Data will be presented from several studies of the effects of nefazodone on sleep architecture in depression.

Results indicate that nefazodone is an efficacious antidepressant associated with significant improvement in both objective and subjective sleep measures. These findings also suggest that the antidepressant efficacy of nefazodone is not tied to REM sleep suppression.

No. 35E
SLEEP AND PSYCHOTHERAPY RESPONSE IN DEPRESSION

Michael E. Thase, M.D., *Department of Psychiatry, Western Psychiatric Institute, 3811 O'Hara Street, Pittsburgh PA 15210*

SUMMARY:

Sleep disturbances commonly characterize severe depressive states and are included among most sets of criteria for melancholia or endogenous depression. Moreover, sleep electroencephalograms (EEG) of severely depressed patients often reveal disturbances such as reduced rapid eye movement (REM) sleep latency, increased phasic REM activity, and poor sleep efficiency. These alterations, in turn, reflect neurophysiological dysfunction within the brainstem

and limbic system that may impair waking cognitive processes and regulation of affect. As such, it has been proposed that EEG sleep abnormalities may identify depressed patients who are too neurobiologically disturbed to benefit from psychotherapy alone, and hence require pharmacotherapy or ECT. In this presentation, evidence pertaining to this specific model of differential therapeutics will be reviewed. Although depressed patients with multiple EEG sleep abnormalities are relatively less responsive to cognitive or interpersonal psychotherapies, about one-third of such patients do remit with nonsomatic therapy. Response to cognitive therapy was particularly good in first-episode patients. Further, these remitted patients experienced a partial normalization of EEG sleep profiles. The theoretical and clinical implications of these findings will be discussed.

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INDUSTRY SUPPORTED SYMPOSIUM 36—BENZODIAZEPINES: LOOKING BACK, MOVING FORWARD
Supported by Roche Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, participants will be able to discuss the applications for benzodiazepines in anxiety; compare and contrast various anxiolytic agents; understand the issues related to benzodiazepine use during pregnancy; recognize the difference between appropriate use and dependence; utilize effective strategies for tapering and withdrawal.

No. 36A
THE HISTORY OF BENZODIAZEPINES

John R. Marshall, M.D., *Department of Psychiatry, University of Wisconsin, 3433 Crestwood Drive, Madison WI 57305*

SUMMARY:

This discussion traces the early development of "tranquilizers," and how benzodiazepines eventually developed their own identity and clinical uses and achieved an important role in the pharmacologic treatment of mental disorders. Despite an extremely broad spectrum of indications for use in medical conditions, controversy (the damnation of benzodiazepines) has historically surrounded their use and hindered appropriate prescribing by physicians, as well as causing unnecessary concern among patients. Breakthroughs in neurochemistry and neurology, as well as additional clinical experience, now allow a rational perspective on this useful class of medications.

No. 36B
CLINICAL APPLICATIONS OF BENZODIAZEPINES FOR ANXIETY

John H. Greist, M.D., *The Dean Foundation, 8000 Excelsior Drive, Ste 302, Madison WI 53717-1914*

SUMMARY:

For 40 years benzodiazepines have been widely prescribed as treatment for anxiety disorders. Strengths include rapid onset of effect, broad spectrum of antianxiety effects, limited risk of abuse, and low lethality in overdose. Limitations include behavioral toxicity in the forms of sedation and ataxia, possible anterograde amnesia, frequent relapse on discontinuation, physical dependence with extended use, discontinuation difficulty, and potential for abuse. With a longer list of limitations than strengths, one may ask why benzodiazepines continue in such prominent use.

This presentation will refine appropriate anxiety disorder indications for benzodiazepines and review proper prescribing practices including long-term use.

No. 36C
BENZODIAZEPINES: APPROPRIATE USE VERSUS ADDICTION

Brian B. Doyle, M.D., *1325 18th Street, NW, Ste. 209, Washington DC 20036-6511*

SUMMARY:

There is widespread confusion among physicians as well as the lay public about "addiction" and benzodiazepines. The great majority of persons who take benzodiazepine medications do so safely and responsibly. All who take benzodiazepine medication regularly for some weeks will develop discontinuation symptoms. These include anxiety, insomnia, and perhaps tremulousness or lightheadedness. However, these symptoms are time-limited and essentially harmless, especially if the user has appropriately tapered the dose. Appropriate medical dependence on a benzodiazepine is different from addiction. The patient with appropriate medical dependence takes the medication at a dosage prescribed by a physician. In these patients, their established dosage stays stable or declines. Such patients take the medication to feel normal, not to feel high. Addicted patients take the medication without prescription and to feel high. They continue to use despite evidence of problems caused by the drug abuse, in a drug-seeking, drug-centered lifestyle. They use escalating doses of the medication. A disproportionate number of benzodiazepine "addicts" are young men who also abuse alcohol, cocaine, and marijuana. Perhaps 1% of the adult population of the United States abuse benzodiazepines.

No. 36D
STRATEGIES FOR DISCONTINUATION

Michael W. Otto, Ph.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, ACC-815, Boston MA 02114*

SUMMARY:

Relative to antidepressant agents, benzodiazepines have been identified as having the advantages of a quick onset of action and more tolerable side-effect profile for the acute treatment of panic disorder. Although both types of agents have been associated with risk of relapse upon medication discontinuation, discontinuation difficulties associated with benzodiazepine treatment have received particular

attention. Some patients may respond to slow-taper strategies or the use of pharmacologic adjuncts; however, many continue to experience significant difficulties during benzodiazepine discontinuation. Recently, a number of controlled trials have provided evidence for the success of brief cognitive-behavioral programs to aid benzodiazepine discontinuation while maintaining treatment gains. In this paper, benzodiazepine discontinuation difficulties will be discussed from a cognitive-behavioral perspective that emphasizes the role of fears of anxiety symptoms in maintaining panic disorder and hindering discontinuation attempts. Elements of treatment and available treatment manuals will be discussed, as will strategies for optimally combining cognitive-behavioral and pharmacologic strategies as part of an overall treatment program.

No. 36E
BENZODIAZEPINE USE DURING PREGNANCY

Lisa S. Weinstock, M.D., *Department of Psychiatry, New York Hospital, Westchester, 21 Bloomingdale Roady, White Plains NY 10605*

SUMMARY:

Given the high prevalence of anxiety disorders in young adult women, treatment decisions are frequently made regarding use of benzodiazepines during pregnancy. Strategies for appropriate decision making involve weighing relative risks of fetal exposure to benzodiazepines on one hand, against the risks of medication discontinuation during pregnancy and subsequent impact of untreated anxiety on fetal well-being on the other. This presentation will review these risks and discuss guidelines for clinical management of patients with anxiety disorders who wish to conceive.

Risks to the fetus that are associated with psychotropic drug exposure during pregnancy include organ malformation, neonatal toxicity, and postnatal behavorial sequelae. This presentation will review the literature regarding these risks when benzodiazepines are used during pregnancy. In addition, data from a naturalistic longitudinal study of 39 pregnant women with a history of pregravid panic disorder and fetal exposure to clonazepam will be reviewed. The extent to which factors such as intensity and duration of fetal clonazepam exposure as well as severity of panic symptoms during pregnancy may affect maternal and neonatal well-being will be discussed. Strategies for appropriate use of benzodiazepines during pregnancy will be addressed.

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INDUSTRY SUPPORTED SYMPOSIUM 37—CNS SPECTRUMS: EMERGING NEUROPSYCHIATRIC CONCEPTS Supported by Solvay Pharmaceuticals, Inc. and Pharmacia & Upjohn, Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to recognize that focus on central nervous system (CNS) spectrums and symptom domains may highlight functional deficits, link these to specific genes, and allow for more precise subtyping, neurobiological markers, and clinical treatments.

No. 37A
OBSESSIVE-COMPULSIVE AND AUTISM CNS SPECTRUMS

Eric Hollander, M.D., *Department of Psychiatry, Mt. Sinai Medical Center, 1 Gustave Levy Place, New York NY 10029;* Cheryl M. Wong, M.D., Concetta M. Decaria, Ph.D., Bonnie A. Aronowitz, Ph.D., Serge A. Mosovich, M.D., Jee Kwon, B.A.

SUMMARY:

Central nervous system (CNS) functions, including neural circuits, neurotransmitter/neuropeptide receptor systems, and gene expression, may go awry following interactions between genetic vulnerabilities and environmental insults, producing symptoms that cut across traditional psychiatric and neurological categories of illness. For example, the CNS mechanisms of serotonergic dysfunction and hyperactive frontal-striatal-thalamic circuits that drive the repetitive behaviors and harm avoidence of obsessive-compulsive disorder (OCD) may also be associated with a spectrum of related disorders. Other CNS mechanisms involved in social attachment, sexual behavior, and parental bonding, such as limbic system oxytocin function, may also be perturbed secondary to genetic and environmental insults, contributing to social deficits found in autism spectrum disorders. Understanding the phenomenology, genetics, neurobiology, and neurotransmitter/neuropeptide function involved in core compulsive and social deficit syndromes helps the clinician to recognize and manage obsessive-compulsive and autism spectrum patients, and to appreciate these dimensions of human behavior.

No. 37B
THE SCHIZOPHRENIA SPECTRUM

Larry J. Siever, M.D., *Department of Psychiatry, Bronx VA Medical School, 130 West Kingsbridge RD (116A), Bronx NY 10468*

SUMMARY:

The schizophrenia spectrum consists of disorders ranging from the severe, unremitting psychosis of chronic schizophrenia to the more mildly symptomatic schizophrenia-related personality disorders. Adoptive, twin, and family studies suggest common genetic substrates for this spectrum of disorders, with schizophrenia-related personality disorders representing the more common phenotype. Schizotypal personality disorder (SPD) is the prototype of the schizophrenia-related personality disorders. SPD and schizophrenia share a common attentional and cognitive impairment including deficits in working memory, verbal learning, and sustained attention. Preliminary data suggest that abnormalities in frontal and temporal regions may be associated with working memory and verbal learning deficits, respectively. These cognitive impairments may be associated with reduced dopaminergic indices, and amphetamine can partially reverse the cognitive abnormalities of SPD. Functional image studies with

FDG suggest alterations in brain metabolism, such as reduced frontal activity and altered temporal laterazation during cognitive activity, consistent with previous studies of schizophrenic patients. While SPD patients resemble schizophrenic patients in many respects in relation to these biologic variables, suggestions of differences found in pilot studies, such as increases in frontal volume in SPD patients as well as a lower vulnerability to psychotic-like symptoms after dopaminergic stimulation, open up the possibility of defining protective factors that help spare the schizotypal individual from developing a chronic psychosis.

No. 37C
MOVEMENT DISORDERS SPECTRUM

Mitchell Brin, M.D., *Department of Neurology, Mount Sinai School of Medicine, One Gustave Levy Place, #1052, New York NY 10029;* Cheryl M. Wong, M.D., Bonnie A. Aronowitz, Ph.D., Concetta M. Decaria, Ph.D., Lorraine Simon, M.A., Eric Hollander, M.D.,

SUMMARY:

The movement disorders spectrum consists of a variety of fascinating disorders affecting a sizable portion of the U.S. population. They are often disabling and have a high comorbidity with other neuropsychiatric illnesses, such as depression and dementia. In a larger sense, these disorders may overlap in symptomatology, clinical course, demographics, familial/genetic predisposition, comorbidity, neurobiology, and response to specific treatments. While there may be different etiologies for specific movements disorders, important clinical-anatomical correlations exist. Most involuntary movement disorders arise from basal ganglia abnormalities including Tourette's syndrome, athetosis, chorea, hemiballismus, and dystonia. Others do not conform to classical patterns of symptomatology, and their etiologies are not fully understood. These include focal dystonias, tics, tremors., and myoclonus. Of interest, drug-related disorders, dementias, neurodegenerative disorders, mood and psychotic disorders, pervasive developmental disorders, and sleep disorders also have associated movement disorders. This presentation will highlight and describe this spectrum of disorders, review the neuropsychiatric and neurotransmitter basis for movement disorders, note similarities and differences among disorders, and discuss current and potential treatments for this spectrum of disorders.

No. 37D
THE TRAUMA SPECTRUM

Joseph Zohar, M.D., *Department of Psychiatry, Chain Sheba Medical Center, Tel-Hashomer, 52621, Israel;* Yehuda Sasson, M.D., Daniella Amital, M.D., Julian Iancu, M.D., Ella Koren, M.D., Yafka Zinger

SUMMARY:

Post-traumatic stress disorder (PTSD) has been given many names, probably reflecting the differing attitudes toward the disorder across the years. It has been called "shell-shock," "soldier's heart," "combat neurosis," "operational fatigue," "traumatic neurosis," to name a few. In recent years, there has been increased awareness of the importance of PTSD both in relation to its prevalence and its devastating impact on the quality of life. Patients who suffer from PTSD act and feel as if the traumatic event were actually reoccurring, and experience intense psychological and physiological distress while exposed to it. They attempt to avoid stimuli associated with the trauma and experience a numbing of general responsiveness. The classic presentation of PTSD is the result of a war; however, there are also increasing reports of PTSD following events such as earthquake, fire, rape, robbery, or car accident. In recent years the importance of the late onset of PTSD has surfaced, an example being war veterans who develop PTSD following a terrorist attack or even a reunion of their unit. Brain imaging studies have directed our attention to the hippocampal area in PTSD and have advanced our knowledge, as have neuroendocrinal studies, regarding the pathophysiological basis of trauma. These recent advances may help us to better understand, diagnose, and conceptualize the trauma spectrum in the future.

No. 37E
FUNCTIONAL AND STRUCTURAL BRAIN IMAGING: SCHIZOPHRENIA AND AUTISM CNS SPECTRUMS

Monte S. Buchsbaum, M.D., *Department of Psychiatry, Mt. Sinai Medical Center, One Gustave Levy Place, New York NY 10029*

SUMMARY:

Imaging studies have established anatomical changes in ventricular size in schizophrenia and suggested functional changes in the frontal lobe and basal ganglia in schizophrenia, obsessive-compulsive disorder, and possibly autism. Our own studies evaluate the contribution of imaging to the spectrum approach in three independent spectrum samples: 1) a pedigree of 11 individuals in which we have obtained evidence for a linkage marker for schizophrenia on the short arm of chromosome 5(D5S111); 2) 13 patients with schizotypal personality disorder (SPD) contrasted with 27 age- and sex-matched patients with schizophrenia, and 3) 14 patients with autism or Asberger's syndrome. In the pedigree study we previously obtained evidence indicating a genetic linkage marker for schizophrenia and related disorders (two-point lod score = 3.72, $p = 0.01$) on the short arm of chromosome 5(5p14.1-13.1) in one large pedigree. Of the 11 subjects who underwent computed tomography, six (three schizophrenic, two with schizotypal personality disorder, and one unaffected) carried the marker allele that cosegregated with schizophrenia-related disorders, while five (all unaffected) did not. The family members with the marker allele linked to schizophrenia-spectrum disorders had significantly larger ventricle-brain ratios than the family members lacking the schizophrenia-related marker allele ($N = 5$). The three individuals with the largest ventricle-brain ratios all carried the marker, although they received diagnoses of no schizophrenia-related disorder, schizotypal personality disorder, and schizophrenia.

In the study of PET contrasts of SPD and schizophrenia, intermediate levels of hypofrontality and ventricular enlargement were observed. Similar analyses were carried out in the autism/Asbergers spectrum. Taken together these imaging results support spectrum concepts and might enhance the power of classical linkage studies that emphasize psychiatric symptomatology. Such a combined strategy may reduce problems related to the long-suspected heterogeneity of these illnesses.

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INDUSTRY SUPPORTED SYMPOSIUM 38—ESTROGEN AND MENTAL ILLNESS IN AGING
Supported by Wyeth-Ayerst Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium the participants will have a greater knowledge and appreciation of therapeutics and mental health issues involving women in late-life with respect to gender differences in mood, cognition, illness, treatment issues, and the use of estrogen replacement therapy.

No. 38A
GENDER DIFFERENCES IN MOOD AND COGNITION

Asenath La Rue, Ph.D., *Department of Psychiatry, University of New Mexico, 2400 Tucker, NE, Albuquerque NM 87552*

SUMMARY:

This presentation will summarize findings regarding cognitive and emotional differences between older men and women, using outcomes of a recent epidemiologic study of elderly Hispanic and non-Hispanic adults to illustrate sex differences. Among mentally healthy older adults, research suggests only subtle differences between the two sexes in cognitive function. In some studies, older women perform better than men on verbal memory and verbal fluency tests, whereas men may perform slightly better than women on some psychomotor-speeded and visuospatial tasks. Cohort effects may be responsible, in part, for the observed sex differences. Among demented older adults, several epidemiologic studies suggest sex differences in the relative prevalence of different forms of dementia. Relatively consistent differences in prevalence of depression and anxiety disorders have been reported for men and women, with such conditions more commonly diagnosed in women, at least until advanced old age. Understanding typical cognitive and mood profiles will be important for designing therapies uniquely suited to mental health problems in older women.

No. 38B
ESTROGEN EFFECTS ON BRAIN FUNCTION

Gary W. Small, M.D., *Department of Psychiatry, UCLA Neuropsychiatric Inst., 760 Westwood Plaza, Los Angeles CA 90024-8300*

SUMMARY:

The increased longevity of the past century allows women to live a third of their lives after menopause in an estrogen-deficient state. A large literature documenting sex steroid effects on mood and cognition, however, suggests that estrogen may benefit many postmenopausal women through a variety of brain effects. Neurons with specific estrogen receptors are located in several brain regions, particularly pituitary, hypothalamus, limbic forebrain (including the amygdala and lateral septum), and cerebral cortex. Circulating estrogen is thus likely to influence limbic system function, which mediates emotional states. Estrogen also can affect brain biochemistry through its influence on such neurotransmitters as serotonin. For example, estrogen enhances monoamine oxidase degradation and serotonin transport, and such actions may explain its possible antidepressant effects, since depression is often considered a serotonin-deficient condition. Estrogen's stimulatory effects also may be modulated by other hormones, such as progestogens, which lower brain serotonin concentrations. In addition to influences on mood, several estrogen brain effects may explain its potential for enhancing cognitive function. For example, estrogen receptors are present in hippocampus, a brain structure critical to learning and memory. Estrogen also may offset cholinergic deficits by increasing choline acetyltransferase, the enzyme necessary for acetylcholine synthesis. Other relevant effects include enhancing synaptogenesis in brain regions critical to memory function. This presentation will review these various estrogen effects on brain function that may explain its influence on mood and cognition.

No. 38C
GENDER, AGING AND PSYCHOTROPIC DRUG METABOLISM

Bruce G. Pollock, M.D., *Department of Psychiatry, Western Psychiatric Institute, 3811 O'Hara Street, Room E1228, Pittsburgh PA 15213-2593*

SUMMARY:

Older women are the greatest consumers of psychotropics and they experience a higher frequency of adverse drug reactions. As more is learned about the diversity of cytochrome P450 enzymes, a structure is emerging for categorizing gender and age-associated differences in drug metabolism. CYP3A4 is quantitatively the most prevalent P450 isozyme and metabolizes many clinically important medications. CYP3A4 is now believed to account for as much as 80% of estradiol hydroxylation. There is also evidence that 3A4 activity is greater in younger women than men and postmenopausal women. Higher plasma levels of CYP3A4 substrates such as nefazodone have been found in older women compared with younger subjects and older men. Induction of 3A4 may have antiatherogenic activity, and declining 3A4 function in older women may account for significant cholesterol increases found in menopausal women but not men of similar age. CYP1A2 is another important isozyme responsible for estrogen metabolism and higher plasma levels of the 1A2 drug substrates tacrine, clozapine, and fluvoxamine have been found in women. Recently, it has been reported that estrogen replacement therapy (ERT) may enhance response to tacrine. This may be a result of estrogen amplifying tacrine's modest bioavailability. Metabolism of estrogen by two alternative and competing pathways results in 2-OH-estradiol (less active) and the very active 16α-OH and 4-OH metabolites, which have been implicated in carcinogenesis. Therefore, it is vital that data be obtained on the differential effects of psychotropics that inhibit CYPs 3A4 and 1A2 on the metabolism of estrogen in women receiving ERT.

No. 38D
ESTROGEN AND ALZHEIMER'S DISEASE: PALLIATION OR PREVENTION?

Lon S. Schneider, M.D., *Department of Psychiatry, University of Southern CA, 2011 Zonal Avenue, HMR-101, Los Angeles CA 90033*

SUMMARY:

Emerging evidence over the last decade has implicated estrogen as a potentially important growth factor and modulator of the expression of Alzheimer's disease. This presentation will review the basic research on how estrogens may affect the central nervous system, cholinergic function, and the expression of pathology in Alzheimer's. It will then review the descriptive, observational research suggesting that estrogen deficiency increases the risk for Alzheimer's disease, and that estrogen replacement therapy lowers the risk in women. The

clinical trials evidence that estrogen is associated with a symptomatic cognitive improvement over the short term in Alzheimer's will be reviewed, as will new data that estrogen may augment the effect of cholinergic drugs in Alzheimer's disease. Lastly, ongoing multicenter trials will be discussed in which estrogen replacement is being used as either symptomatic treatment to slow the progression of the illness or to prevent the onset of dementia entirely.

No. 38E
ESTROGEN FOR DEPRESSED PERIMENOPAUSAL WOMEN

Lori L. Altshuler, M.D., *Department of Psychiatry, Veterans Affairs Medical Center, 11301 Wilshire Blvd., B116AA, Los Angeles CA 90073*

SUMMARY:

This presentation will describe the biologic changes occurring in peri- and post-menopause and review those epidemiologic studies that shed light on the relationship between perimenopause and mood. Approaches to the treatment of the peri- and post-menopausal woman presenting with depressive symptoms will be discussed.

Data from widely varying methodologic papers suggest a positive association between depressive symptoms and the perimenopause. No careful study of the incidence of DSM-IV major depression associated with perimenopause has been done, but a history of depression has been associated with depressive symptoms in perimenopause. Estrogen replacement appears to improve depressive *symptoms* in nondepressed perimenopausal patients. Data regarding the use of estrogen as a primary or adjunctive treatment for major depressive *disorder* in the perimenopause are contradictory.

Rigorously controlled studies are needed to definitively characterize the prevalence of depressive symptoms in the perimenopause and to assess the effect on mood symptoms of varying doses of estrogen in perimenopausal women with depressive symptoms. Whether estrogen replacement has a role as an adjunct to standard antidepressant therapy for depression in perimenopausal and postmenopausal women requires further study.

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INDUSTRY SUPPORTED SYMPOSIUM 39—LATE-LIFE DEPRESSION: COMPLEX PROBLEMS, NEW STRATEGIES
Supported by Roerig Division/Pfizer, Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

To inform the clinician about new data relevant to the complex clinical problems associated with the treatment of late-life depression.

No. 39A
ANTIDEPRESSANT RESPONSE IN LATE-LIFE DEPRESSION

Steven P. Roose, M.D., *Clin. Psychopharmacology, NY State Psychiatric Institute, 722 West 168th Street, PI 98, New York NY 10032*

SUMMARY:

Which antidepressant is most effective in late-life depression? Which antidepressant is better tolerated? How long does an older patient need to be treated and at what dose of drug? These are some of the important questions about antidepressant treatment of late-life depression. Currently, there is enough information to address some questions, but insufficient data to answer others.

This talk will review studies that compare the effectiveness of tricyclics to the SSRIs in depressed patients over age 60. The conclusions that can be drawn are limited by methodological problems common in these studies, including comparative doses of medication and definition of treatment response. Special attention will be given to the comparative side-effect profiles in the acute treatment phase and the impact of side effects over the months and years that some patients continue on antidepressants. Only by considering robustness of response and the long-term impact of side effects can the SSRIs and tricyclics be truly compared with respect to their impact on health-related quality of life in this patient population.

No. 39B
CLINICAL INTERFACE OF DEPRESSION AND DEMENTIA

Murray A. Raskind, M.D., *Department of Psychiatry, VA Puget Sound Medical Center, 1660 S. Columbian Way, 116A, Seattle WA 98108*

SUMMARY:

Depression interacts with the dementia syndrome in several areas. Primary late-life depression can manifest mild to moderate cognitive impairment and mimic a dementing disorder. Patients with this "depressive pseudodementia" presentation often have a history of depressive episodes, predominant deficits in attention and motivation, and lack aphasia or apraxia. Much more common is depression complicating pre-existent Alzheimer's disease, vascular dementia, or the dementia of Parkinson's disease. Although antidepressant medication is the accepted treatment for such patients, controlled treatment outcome trials are scarce. In the only placebo-controlled trial of a marketed antidepressant for Alzheimer's disease complicated by DSM-III major depressive episode, both imipramine and placebo were substantially but equally effective. Anecdotal reports suggest that SSRI antidepressants and psychotherapeutic approaches may be effective for depression complicating dementia. There may be neurobiologic links between late-life depression and dementia. Late-life depression is associated with increased, albeit nonspecific, brain neuroimaging abnormalities. Late-life depression also may increase the risk of subsequent Alzheimer's disease. The hypercortisolemia of late-life depression may lower the threshold for hippocampal neuronal loss in Alzheimer's disease.

No. 39C
DYSTHYMIA IN YOUNG VERSUS ELDERLY ADULTS

James H. Kocsis, M.D., *Department of Psychiatry, New York Hospital, 525 East 68th Street, Box 147, New York NY 10021-4873*

SUMMARY:

Chronic, mild forms of depression were reconceptualized as affective disorders and defined under the dysthymia rubric as of the

publication of DSM-III in 1980. Since that time several major studies have elucidated the epidemiology of dysthymia. Great strides have also been made in the pharmacotherapy of dysthymia with and without concurrent major depression, i.e., "double-depression" and "pure dysthymia." Both tricyclic antidepressants and selective serotonin reuptake inhibitors have been shown to be effective for dysthymia in controlled clinical trials.

Epidemiologic surveys conducted in community samples have revealed prevalences of dysthymia in the elderly that are substantial (1%-2%), although lower than those found in younger adults (2%-5%). Why has dysthymia in the elderly received so little attention, given a prevalence greater than most psychiatric disorders in this age group?

This presentation will review the existing literature and data from the author's research comparing clinical characteristics and treatment response in cohorts of dysthymics from young adult and geriatric age groups in an effort to explain the relative neglect of this problem and to make suggestions for clinical management of elderly dysthymics.

No. 39D
ANTIDEPRESSANT THERAPY IN POST-MYOCARDIAL INFARCTION PATIENTS

Alexander H. Glassman, M.D., *Clin. Psychopharmacology, NY State Psychiatric Institute, 722 West 168th Street, New York NY 10032-2603*

SUMMARY:

Convincing data now exist showing that depression increases the risk of dying following myocardial infarction (MI). However, the safety of antidepressant drugs in the immediate post-MI period has not been tested. Until recently, tricyclic antidepressants (TCAs) appeared safe in patients with heart disease, except for those with orthostatic hypotension and conduction prolongations in patients with pre-existing conduction disease. However, a series of studies in cardiology would seem to indicate that tricyclic antidepressants are a risk in patients with ischemic heart disease.

Until now there has been no information about the effects of SSRIs in patients with pre-existing heart disease. We have studied 30 depressed patients with serious, but stable heart disease who are taking fluoxetine, and have recently completed a pilot study of 26 patients immediately post MI on sertraline. In both instances we found no evidence of harm. Blood pressure and conduction intervals were essentially unchanged. Heart rates slowed especially in contrast to the tachycardias seen with TCAs, and there was no influence on patients with pre-existing arrhythmias. Surprisingly, the data suggest a beneficial role in heart failure. Taken together these studies are reassuring. However, 56 patients do not prove safety, and the question of efficacy remains to be documented.

No. 39E
PHARMACOKINETIC INTERACTIONS OF ANTIDEPRESSANTS

Elliott Richelson, M.D., *Department of Research, Mayo Clinic, 4500 San Pablo Road, Jacksonville FL 32224-1865*

SUMMARY:

Antidepressants and most other drugs are metabolized by enzymes in the liver by reactions called phase-I and phase-II. The latter reactions are catalyzed by a complex group of enzymes called cytochrome P450 (CYP). Many of the new generation antidepressants are potent inhibitors of the CYP enzymes. The isoforms of the CYP enzymes that are most relevant to the use of antidepressants are CYP 1A2, CYP 2C9, CYP 2C19, CYP 2D6, and CYP 3A4. CYP inhibition may affect the metabolism of a multitude of drugs of several different classes that are substrates for these isoenzymes, with potentially serious consequences. The drug-drug interactions and potential consequences are critical for the practitioner to keep in mind when prescribing one of these antidepressants in order to minimize the potential for an adverse event. A primer on drug metabolism is presented, which serves as a basis for understanding these interactions. CYP isoenzymes are discussed in relation to the drugs they metabolize, and appropriate cautions are recommended for concurrent administration of these new-age antidepressants and other drugs frequently prescribed to elderly patients.

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5. Meyer, et al: Antidepressants and drug-metabolizing enzymes: expert group report. *Acta Psychiatrica Scandinavica* 93:71-79, 1996.

INDUSTRY SUPPORTED SYMPOSIUM 40—PERSISTENT ADHD: CLINICAL ASSESSMENT AND TREATMENT
Supported by Glaxo Wellcome Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

To recognize how symptoms of ADHD that persist into adolescence and adulthood often differ from the juvenile model of ADHD; to diagnose persistent ADHD in adolescents and adults; to utilize appropriate medications for persistent ADHD complicated by comorbid mood, anxiety, and/or substance abuse disorders; to tailor appropriate treatments for the diversity of adolescents and adults with persistent ADHD.

No. 40A
CLINICAL ASSESSMENT OF PERSISTENT ADHD

Thomas E, Brown, Ph.D., *Department of Psychology, Yale University, P.O. Box 6694, Hamden CT 06517*

SUMMARY:

ADHD persists into adolescence and adulthood for over 50% of those diagnosed in childhood, but its symptom profile tends to alter over time. Recent research indicates that hyperactive-impulsive symptoms of ADHD often diminish during childhood and adolescence, while inattention symptoms tend to persist and take on more importance.

Studies of adolescents and adults with ADHD indicate that many suffer from a wide spectrum of chronic cognitive impairments including not only problems in sustaining attention, but also persistent difficulties in organizing and activating for work; sustaining alertness, energy, and effort for work tasks; managing affective interference; and short-term working memory. This presentation will describe the wide spectrum of cognitive impairments common in persistent ADHD and will introduce practical clinical techniques for assessment of these symptoms in adolescents and adults. Utilization of semistructured interviews, self-report/collateral report symptom scales, standardized measures of IQ and verbal memory impairments,

and comorbidity screening will be described to provide a model for assessment/diagnosis of ADHD and for systematic monitoring of treatment effectiveness.

No. 40B
COMBINING MEDICATIONS FOR ADHD WITH COMORBID MOOD DISORDERS

Thomas J. Spencer, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, ACC 725, Boston MA 02114*

SUMMARY:

Among cases of ADHD that persist into adolescence and adulthood, there is a disproportionately high incidence of mood disorders: dysthymia, major depressive disorders, and mania. Each of these disorders occurs among adolescents and adults with ADHD at markedly elevated rates compared with incidence in both the general population and the population of children with ADHD. When mood disorders are comorbid with ADHD, clinicians may overlook either the ADHD or the mood disorder, attributing all symptoms to just one of the two applicable diagnoses. This presentation will describe 1) principles of differential diagnosis of patients with concurrent ADHD and mood disorders from those who suffer from just ADHD or an uncomplicated mood disorder; 2) how individuals with mood disorders and concurrent ADHD sometimes respond favorably to treatment with the usual ADHD treatments, stimulants, or tricyclic antidepressants; 3) how usual ADHD treatments alone may be insufficent or adverse for individuals with concurrent ADHD and mood disorder; and 4) indications and principles for using combined medications, e.g. stimulants, antidepressants, and/or mood stabilizers to treat individuals with concurrent ADHD and mood disorders. The need for careful assessment and tailoring interventions to each particular case will be emphasized.

No. 40C
ADHD AND COMORBID ANXIETY: MEDICATION SENSITIVITY

Rosemary Tannock, Ph.D., *Department of Psychiatry, Hospital for Sick Children, 555 University Avenue, Toronto Ontario M5G 1X8, Canada*

SUMMARY:

About 30% to 40% of clinic-referred persons with ADHD also meet diagnostic criteria for one or more anxiety disorders, e.g. generalized anxiety disorder, panic disorder, social phobia, or obsessive-compulsive disorder. Since "working memory," a function critical to many aspects of learning and information processing, can be impaired by both ADHD and by anxiety, individuals with this comorbid combination are at special risk and may need treatment to alleviate both sets of symptoms.

Treatment of individuals with concurrent ADHD and anxiety disorders is complicated by the fact that stimulant medications, the usual first-line treatment for ADHD, are not well-tolerated by many of those whose ADHD is complicated by high levels of anxiety. Moreover, stimulants seem less effective in improving working memory functions of patients with ADHD + anxiety than for those whose ADHD is uncomplicated by anxiety.

This presentation will 1) report symptoms and incidence of anxiety disorders with persistent ADHD; 2) describe working memory and its disruption by anxiety and ADHD; 3) review elevated sensitivity of individuals with ADHD and concurrent anxiety to adverse effects of stimulant medications; and 4) identify alternative treatment strategies for those whose ADHD is complicated by anxiety and oversensitivity to stimulants.

No. 40D
TREATMENTS FOR ADHD WITH SUBSTANCE ABUSE

Timothy E. Wilens, M.D., *Dept of Psychopharmacology, Mass General Hospital, 15 Parkman Street, ACC 725, Boston MA 02114*

SUMMARY:

Many studies have demonstrated that adolescents and adults with persistent ADHD have significantly elevated lifetime incidence of psychoactive substance use disorder (PSUD). From 17% to 45% of adults with ADHD report histories of alcohol abuse or dependence, while 9% to 30% of adults with ADHD have histories of drug abuse or dependence. These elevated incidence rates, are probably related to both genetic and self-medication influences. Though many clinicians are reluctant to use medications in treatment of patients with ADHD and history of substance abuse, there is some evidence to suggest that aggressive treatment of ADHD symptoms with appropriate medications may help to improve functioning and reduce probability of relapse in such patients. Yet medications alone are not likely to be sufficient treatment for persons with ADHD and a history of PSUD; often 12-step programs, cognitive-behavioral treatments, and coordination of care with addiction counselors may be necessary.

This presentation will 1) describe appropriate techniques to screen for PSUD in individuals with persistent ADHD; 2) identify effective nonmedication treatment resources for persons with comorbid ADHD and PSUD; and 3) review appropriate protocols for use of medications to treat individuals with both ADHD and lifetime or concurrent PSUD.

No. 40E
TAILORING ADHD TREATMENT FOR PATIENT DIVERSITY

Peter S. Jensen, M.D., *Child & Adolescent Disord, National Institute of Mtl Hlth, 5600 Fishers Lane, Room 18-C17, Rockville MD 20857*

SUMMARY:

For decades, the standard recommendation for treatment of ADHD has been "multimodal treatment." Usually this has meant some combination of patient education, medication, behavioral interventions, and counseling or psychotherapy for the identified patient and family, with or without additional interventions. This broad-based treatment recommendation, probably honored more in theory than in practice, has remained the standard of care for ADHD despite the lack of sufficient research to validate it. Recent and ongoing studies of treatment outcome for patients with ADHD have called into question the assumption that the full range of multimodal treatment interventions is appropriate in every case. Some research has suggested that multimodal treatments of persons with ADHD may offer little added benefit over treatment with medications alone. These findings do not imply that all individuals with ADHD should be treated only with medications. Rather, they highlight the need to fit treatments to the needs of each particular patient. This presentation will 1) review recent research re outcomes of various combinations of treatments for ADHD; 2) identify levels of care that may be appropriate for various patients with ADHD; and 3) describe how clinicians can tailor appropriate treatment plans for the diversity of individuals with persistent ADHDs.

REFERENCES:

1. Brown TE: Differential diagnosis of ADD vs. ADHD in adults. In K.G. Nadeau (ed.): *A Comprehensive Guide to Attention Deficit Disorder in Adults*. New York: Brunner/Mazel, pp. 93-108, 1995.

2. Spencer TJ, Biederman J, Wilens TE, et al: Pharmacotherapy of ADHD across the life cycle. *J Amer Acad Child Adolescent Psychiatry* 35:409-432, 1996.
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4. Wilens TE, Biederman J, Spencer TJ, Frances RJ: Comorbidity of ADHD and psychoactive substance use disorders. *Hospital & Community Psychiatry*, 45(5):421-435, 1994.
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INDUSTRY SUPPORTED SYMPOSIUM 41—EXTRAPYRAMIDAL SIGNS IN SCHIZOPHRENIA AND THEIR INFLUENCE ON TREATMENT OUTCOME

Supported by Zeneca Pharmaceuticals Group

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the completion of this presentation, the participant should be able to recognize extrapyramidal symptoms and tardive dyskinesia in schizophrenia patients of all ages, list who is at greatest risk for the development of these side effects, select medications least likely to induce them, and provide palliative measures when they occur.

No. 41A
THE SPECTRUM OF EXTRAPYRAMIDAL SYMPTOMS

Daniel E. Casey, M.D., *Department of Psychiatry, Veterans Affairs Medical Cntr., 3710 SW U.S. Veterans Hosp Rd, Portland OR 97201*

SUMMARY:

Disorders of normal movement in schizophrenia can occur prior to treatment or as a consequence of neuroleptic drug therapy. Long ago Kraepelin and Bleuler described abnormalities in motor function such as catatonia, stereotypies, and mannerisms, as well as tremors and increased muscle rigidity as common features of psychosis. They also noted tardive dyskinesia-like behaviors of grimacing, movements of the tongue and lips, and sudden involuntary gestures. More recent studies of first-episode psychotic patients have also identified disorders of movement prior to the onset of neuroleptic treatment. Although typical neuroleptics are beneficial for many psychotic patients, they also produce troublesome side effects of extrapyramidal syndromes (EPS). These disorders of akathisia, dystonia, and parkinsonism occur in the majority of patients and are a common reason for noncompliance and relapse. EPS produce both motor (objective) and mental (subjective) symptoms that must be distinguished from other disorders. Examples include differentiating akathisia from psychotic agitation as well as parkinsonian bradykinesia and bradyphrenia from the primary negative symptoms of psychosis. Progress has been made with clozapine and risperidone, but they have their own dose-limiting side effects. New and novel agents such as olanzapine, sertindole, and quetiapine are even further advances because they all show good efficacy and encouragingly low EPS liability that is not significantly different from placebo. Thus, the treatment of psychotic illnesses will improve because of far less drug-induced motor dysfunction, though signs of EPS may not completely disappear from the clinical arena because some of these motor disorders may be intrinsic to the psychotic process.

No. 41B
THE LINK BETWEEN EXTRAPYRAMIDAL SYMPTOMS AND NEGATIVE DEFICITS

William T. Carpenter, Jr., M.D., *Department of Psychiatry, MD Psychiatric Research Ctr, PO Box 21247, Baltimore MD 21228*

SUMMARY:

Kraepelin described avolitional pathology as one of the two core maladies of dementia praecox. More recently conceptualized as negative symptoms, these symptoms account for substantial long-term morbidity in some patients, and effective treatment is not yet documented. However, negative symptoms (e.g., flat affect, low drive, poverty of speech, and anhedonia) occur in most patients with schizophrenia and have several causes. Anhedonia may be secondary to depression, social withdrawal may be in response to psychosis, and paranoid guardedness may cause poverty of speech.

Neuroleptic drugs induce anhedonia in animals and humans. The effect of neuroleptic drugs on negative symptoms during the treatment of schizophrenia is complex. During acute treatment, reduction in negative symptom ratings parallels reduction in psychosis. In the longer term, sustained negative symptoms are often observed despite a robust antipsychotic response, and dose reduction strategies are associated with better negative symptom course despite increased psychosis. Neuroleptic treatment increases risk of depression and, therefore, anhedonia and low drive. However, the most direct negative symptom effects observed with neuroleptic drugs are linked with extrapyramidal effects. Akinesia, for example, results in ratings of restricted affect and psychomotor retardation. Therapeutic approach depends on differential diagnosis of the cause of secondary negative symptoms.

No. 41C
IS THE INCIDENCE OF TARDIVE DYSKINESIA RELATED TO THE INCIDENCE OF EXTRAPYRAMIDAL SYMPTOMS

William M. Glazer, M.D., *Mass General Hospital, Harvard Univ. School of Med., Beach Plum Lane, Menemsha MA 02552*

SUMMARY:

It is now 25 years since Crane posed the hypothesis that TD is more likely to occur in patients who experience early EPS. This presentation will review indirect and direct evidence for and against this hypothesis. Current knowledge would argue for a clinically significant relationship. Given this view, the presenter will discuss the role of the new generation of antipsychotic medications in the etiology of TD.

No. 41D
THE EFFECT OF EXTRAPYRAMIDAL SYMPTOMS ON COGNITION IN THE ELDERLY

Dilip V. Jeste, M.D., *Department of Psychiatry, Veterans Affairs Medical Cntr., 3350 La Jolla Village Drive, San Diego CA 92161-0001;* Jonathan P. Lacro, Pharm.D., Michael P. Caligiuri, Ph.D., Julie A. Gladsjo, Ph.D., Jovier Evans, Ph.D., Jane S. Paulsen, Ph.D.

SUMMARY:

Background: Conventional or typical neuroleptics produce extrapyramidal symptoms (EPS), and in high doses may cause cognitive impairment. Elderly patients are particularly susceptible to both of these side effects and are likely to develop them at much lower doses than younger adults. Relatively little research has been done on the relationship of EPS to cognitive impairment associated with neuroleptic use, especially in older patients.

Methods: We will review the published studies and present data from our ongoing investigations. We have assessed psychopathology, EPS, and cognition in more than 400 middle-aged and elderly psychiatric outpatients treated with typical neuroleptics (usually haloperidol or thioridazine) in a longitudinal prospective study. In a small sample of patients, we have examined the effects of newer atypical antipsychotics.

Results: Compared with the typical neuroleptics, the atypical ones are associated not only with a lower risk of EPS, but also with greater global cognitive improvement. These drugs, however, need to be used in much lower amounts in the elderly than the doses commonly prescribed for younger adults.

Comment: The mechanisms underlying the cognitive effects of antipsychotics are unclear. Nonetheless, the importance of such cognitive effects is highlighted by our finding that the best statistical predictor of functional status in the older psychotic patient is the degree of cognitive deficit.

No. 41E
THE SPECTRUM OF EXTRAPYRAMIDAL SYMPTOMS IN CHILDREN AND YOUNG ADULTS

Judith H.L. Rapoport, M.D., *Child Psychiatry Branch, Nat'l Inst. of Mental Health, 9000 Rockville Pike, 10 6N-240, Bethesda MD 20892-0001;* Sanjiv Kumra, M.D., Leslie K. Jacobsen, M.D.

SUMMARY:

Children and adolescents with chronic neuroleptic therapy are at risk for parkinsonism, tardive dyskinesia, and akathisia, with reported rates reported higher (Wolf and Wagner, 1993) and lower (Green, 1995) than for adults. These data are complicated by variation in reported adult rates (Baldessarini, 1974) and nonpsychotic diagnoses of children given antipsychotic agents.

As part of NIMH comparison studies of typical and atypical neuroleptics, neuroleptic-induced tardive dyskinesia and withdrawal dyskinesias were measured at baseline, after a four-week drug-free period (n = 28), and after six weeks treatment with clozapine (n = 26), haloperidol, and benztropine (n = 11), and olanzapine (n = 5) using the Abnormal Involuntary Movement Scale (AIMS). Abnormal movements emerging during previous treatment or drug withdrawal phases, and abnormal movements appearing during clozapine, olanzapine, or haloperidol treatment were rated by clinical judgment and by AIMS (Schooler and Kane, 1982).

Dyskinesias were noted in 14 (50%), eight males and six females, (mean age 14.5 [+/–2 yrs], and mean neuroleptic exposure of 25+/–16 months). Of these, one had preexisting and one a treatment emergent dyskinesia on haloperidol, while 12 (86%) had withdrawal dyskinesias. Subsequent treatment with Haldol improved only 2/6 (33%) cases, while open or blinded six-week treatment with clozapine produced complete improvement in eight of 10 cases (80%). Thus, clozapine appears effective for treatment of dyskinesias in schizophrenic children.

REFERENCES:

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2. Crane GE: Pseudoparkinsonism and tardive dyskinesia. *Arch Neurol* 27:426-430, 1972.
3. Jeste DV, Gladsjo JA, Lindamer LA, Lacro JP: Medical comorbidity in schizophrenia. *Schizophrenia Bulletin* 22(3):413-430, 1996.
4. Kumra S, et al: Childhood-onset schizophrenia: double-blind clozapine-haloperidol comparison. *Arch Gen Psychiatry*, in press.

INDUSTRY SUPPORTED SYMPOSIUM 42—NEW CLINICAL APPROACHES FOR TREATING ANXIETY AND DEPRESSION: THE TREATMENT OF AGITATION AND DEPRESSION IN THE ELDERLY
Bristol-Myers Squibb

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM
See page 293—Industry Supported Symposium 25.

No. 42A
ADVANCES IN THE TREATMENT OF AGITATION IN THE ELDERLY PATIENT

Stuart C. Yudofsky, M.D., *Dept of Psych & Behav Sci, Baylor College of Medicine, One Baylor Plaza, Houston TX 77030*

SUMMARY:

Dr. Yudofsky will present assessment and treatment strategies for agitation in older adults. He will review epidemiology and differential diagnosis of agitation in elderly patients and will present a new objective rating scale for the assessment of agitation, called the Overt Agitation Severity Scale. Agitated behavior is more prevalent in elderly patients with organic brain disorders. Because these older adults are more sensitive to the central nervous system side effects of medications, agitation is difficult to treat optimally while maintaining patient alertness and minimizing cognitive problems. The management of agitation with pharmacologic agents, including serotonin-specific drugs, anticonvulsants, and beta-blockers, will be reviewed.

No. 42B
NEW APPROACHES TO THE MANAGEMENT OF LATE-LIFE DEPRESSION

George T. Grossberg, M.D., *Department of Psychiatry, St. Louis University Med. Sch., 1221 South Grand Bouelvard, St. Louis MO 63104-1016*

SUMMARY:

The spectrum of mood disorders, ranging from major depression to dysthysia to subsyndromal depression, is quite common in later life. The prevalence of clinically significant depression is particularly high among the medically ill, hospitalized elderly (20%-40%), and those in nursing homes (12%-20%). In addition, the risk of suicide is higher in older adults, particularly those older than 75.

Safe, effective treatment of mood disorders in older adults, particularly older than 75 with multiple medical problems often requires novel approaches. Though the tricyclics desipramine and nortriptyline have been past mainstays of therapy, older patients can often not tolerate these agents secondary to their anticholinergic, autonomic, or cardiac toxicities. Consequently, the selective serotonin reuptake inhibitors (SSRIs) have moved to the forefront of geriatric depression treatment. However, the SSRIs need to be used carefully since anorexia, weight loss, anxiety, and insomnia have been reported. Some SSRIs may also adversely affect blood levels of other medications through inhibiting various cytochrome P450 isozymes. Increasingly, newer antidepressants such as nefazodone and bupropion are being used. At times, psychostimulants or ECT may be indicated. When appropriate, psychotherapy combined with pharmacotherapy is superior to pharmacotherapy alone.

This paper will focus on newer antidepressants in late-life mood disorders, with an emphasis on dosing, side effects, and duration of treatment.

REFERENCES:

1. Kunik ME, Yudofsky SC, Silver JM, Hales RE: Pharmacologic approach to management of agitation associated with dementia. *J Clin Psychiatry* 55(2, suppl): 13-17, 1994.
2. Webster JM, Grossberg GT: The new antidepressants and the elderly psychiatric patient. *Psychiatric Times*, Vol. 12, No. 10, pp. 40-41, 1995.

INDUSTRY SUPPORTED SYMPOSIUM 43—BIPOLAR MIXED STATES: THE CLINICAL FRONTIER
Supported by Abbott Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM
See page 294—Industry Supported Symposium 26.

No. 43A
A BROADER DEFINITION OF MIXED STATES

Giulio Perugi, M.D., *Institute of Psychiatry, Via Roma 67, 56100 Pisa, Italy;* Laszlo Gyulai, M.D., Allan Gottschalk, M.D.

SUMMARY:

We attempted to validate mixed bipolar states deriving from the concepts of Kraepelin and the Vienna School and defined as sustained instability of affective manifestations of opposite polarity in the setting of marked emotional perplexity. We compared 143 mixed state patients so defined with 118 DSM-III-R manic patients. Mixed states were predominant in the history of index mixed patients who were more likely to have attempted suicide; manic episodes were more common in the history of the index manic patients who had more episodes. Two-thirds of both groups arose from a dysregulated baseline temperamental dysregulation, which in manics was largely hyperthymic, and in mixed patients both hyperthymic and depressive. Of our 143 mixed states, only 54% met the DSM-III-R criteria for mixed states (which conformed to "dysphoric mixed mania"); of the remaining, 17.5% could be described as "mixed agitated psychotic depressive states" with irritable mood and flight of ideas; and 26% as "unproductive-inhibited manic" with fatigue and indecisiveness. The family history and course of these "non-DSM-III-R" mixed states were essentially similar to DSM-III-R mixed states. These data favor the European approach to mixed states over the grossly underinclusive DSM-III-R and DSM-IV criteria.

No. 43B
THE CLINICAL MANAGEMENT OF MIXED STATES

Alan C. Swann, M.D., *Department of Psychiatry, Univ Texas Mental Sci. Inst., 1300 Moursund Avenue, Room 270, Houston TX 77030*

SUMMARY:

The treatment of patients experiencing episodes of combined depressive and manic features (mixed states) has high stakes. These episodes tend to be more severe and complicated than purely depressive or manic episodes and carry a high risk of suicide. In addition to depressive and manic symptoms, patients in mixed episodes are severely anxious and overaroused. Evidence accumulated over the last 20 years, from both open and controlled studies, consistently shows mixed manias to be relatively refractory to lithium treatment. Interestingly, at least one study found lithium treatment to improve depression but not mania in mixed states. Information about response to other antimanic treatments has been scarce until recently. A large controlled study found that depressive symptoms during mania predicted a poor response to lithium but did not alter response to divalproex. Studies with newer "atypical" neuroleptics are promising in terms of potential antimanic effectiveness, but generally have focused on refractory mania in general rather than mixed states. A study of patients with severe manic episodes suggested that single pharmacologic treatments were rarely effective in mixed states, and that patients not responding to combined pharmacologic treatments had a robust antimanic response to ECT. Based on these results, we will discuss the treatment of mixed states in terms of a rational approach to known biological characteristics of these patients and development of a treatment algorithm.

REFERENCES:

1. Swann AC, Bowden CL, Morris D, et al: Depression during mania: treatment response to lithium or divalproex. *Arch Gen Psychiatry,* in press.
2. Kraepelin E: *Manic-Depressive Insanity and Paranoia.* Edinborough, ES Livingstone, 1921.

INDUSTRY SUPPORTED SYMPOSIUM 44—ANXIETY DISORDERS: IDENTIFYING THE CRITICAL CHALLENGES
Supported by Roerig Division/Pfizer, Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM
See page 295—Industry Supported Symposium 27.

No. 44A
FACING THE CHALLENGE: SELF-HELP AND ADVOCACY

Jerilyn Ross, M.A., *Ross Center for Anxiety, 4545 42nd Street, NW, Ste. 311, Washington DC 20016*

SUMMARY:

In spite of the fact that anxiety disorders are the most prevalent mental health problem in the United States, affecting more than 26 million Americans and costing in excess of $46 billion a year, anxiety disorders continue to be minimalized, trivialized, misdiagnosed, and mistreated. Although in recent years tremendous strides have been made in understanding the causes and nature of anxiety disorders, as well as the development of new treatments, huge gaps in knowledge, dissemination of information, and access to care still exist.

The Anxiety Disorders Association of America (ADAA) responds to an average of 60,000 information requests a year from the public. Many who write and call ADAA describe the devastating impact their disease has had on their life and the difficulty of being taken seriously and/or finding effective treatment. Since 1980, through its network of self-help groups, a dedicated board of directors and scientific advisory board, several thousand consumer and professional members and high visibility with the national media, ADAA has been advocating for more research, destigmatization, and better access to care.

This presentation will focus on how consumers, clinicians, and researchers are working together to bring forth the message that anxiety disorders are REAL, SERIOUS, and TREATABLE, and improve the quality of life of those suffering from these disorders.

No. 44B
ANXIETY IN THE PRIMARY CARE SETTING

Roger G. Kathol, M.D., *Department of Psychiatry, University of Iowa, 200 Hawkins Drive, Iowa City IA 52242-1009*

SUMMARY:

Anxiety is seen in many patients with medical illness. It can occur as a primary anxiety disorder, in association with another psychiatric illness, be caused by medications, or be related to an organic disorder. If anxiety is primary, then the behavioral/emotional syndrome can be treated the same way that anxiety patients without a medical illness are treated. If anxiety is related to another psychiatric illness, then primary treatment depends on the coexisting psychiatric illness. If anxiety is caused by a medication or substances that the patient is taking, such as cold preparations or excessive caffeine, discontinuation of the offending agent is advised. If anxiety is related to medical illness, it could be due to the stress or change necessitated by the illness or a direct result of physiologic changes from the illness itself. In the first instance, support and/or short-term psychotherapy can be helpful. In the latter, treatment of the medical condition should alleviate symptoms without the need for anxiety-specific intervention. When anxiety persists in patients with chronic medical illness, even when thought to be related to the stress of the illness, then anxiety-specific therapy, such as medication and/or psychotherapy, should be considered. In the primary care setting, differentiating among the various causes of anxiety can be difficult. It requires attention to medical and psychiatric components of the patient's history and a physical assessment. Sometimes laboratory testing is indicated. Once the etiology is narrowed down, the clinician can be more comfortable that the specific approach to the patient is likely to lead to improvement. Treatment will not only alleviate symptoms but also decrease the functional impairment associated with it.

REFERENCES:

1. Stoudemire A: Epidemiology and psychopharmacology of anxiety in medical patients. *J Clin Psychiatry* Vol 7 (Suppl. 7); 64-72, 1996.

INDUSTRY SUPPORTED SYMPOSIUM 45—WOMEN'S MENTAL HEALTH IN THE 1990S: TOWARD AN INTEGRATED APPROACH
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM
See page 295—Industry Supported Symposium 28.

No. 45A
WHO COMES TO AN EATING DISORDERS SCREENING?

David B. Herzog, M.D., *Department of Psychiatry, Harvard Medical School, 15 Parkman Street, EDU 725-ACC, Boston MA 02146*

SUMMARY:

Eating disorders such as anorexia nervosa (AN), bulimia nervosa (BN), and binge eating disorder (BED) constitute a significant public health problem. Approximately 5% of college-age females suffer from anorexia or bulimia, and another 15% manifest substantially disordered eating attitudes and behaviors consistent with the diagnosis, eating disorder not otherwise specified (EDNOS).

The first-ever National Eating Disorders Screening Program was held in February 1996. The program consisted of the following: viewing an educational videotape, completing a self-report screening questionnaire, weighing (optional), and meeting with a counselor to discuss the need for further assessment. Preliminary results from 409 schools returning a total of 9,059 questionnaires showed that 91% of the participants had no previous diagnosis of or treatment for an eating disorder; however, 75% met guideline criteria for further professional evaluation and 1% met criteria for an urgent referral. Descriptive data regarding those who participated will be provided.

Early identification programs for eating disorders can be successful. However, further research is necessary to develop a valid screening instrument. More and better-organized resources are necessary to facilitate early intervention.

No. 45B
A NATIONAL SCREENING PROGRAM FOR EATING DISORDERS: ETHNICITY, GENDER AND REPORTED SYMPTOMS

Anne E. Becker, M.D., *Department of Psychiatry, Massachusetts General Hospital, One Fruit Street, Boston, MA 02114*

SUMMARY:

(See above No. 45A)

REFERENCES:

1. Drewnowski A, Yee DK, Kurth CL, Krahn DD: Eating pathology and DSM-III-R bulimia nervosa: a continuum of behavior. *Am J Psychiatry* 151:1217-1219, 1994.

INDUSTRY SUPPORTED SYMPOSIUM 46—CHALLENGE: MAKING THE MOST OF THERAPY WITH ATYPICAL ANTIPSYCHOTICS
Supported by Janssen Pharmaceutica and Research Foundation

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM
See page 296—Industry Supported Symposium 29.

No. 46A
COST-EFFECTIVENESS: NEW VERSUS OLDER ANTIPSYCHOTIC MEDICATIONS

Richard J. Wyatt, M.D., *Dept. of Neuropsychiatry, Nat'l Inst Mntl Hlth/St. Eliz., 2700 ML King Jr Ave SE, Rm 536, Washington DC 20032*

SUMMARY:

Of the noncommunicable illnesses, the neuropsychiatric disorders are responsible for the greatest global burden of disease. In fact, only communicable respiratory, perinatal, and diarrhea diseases are more costly. Ultimately, prevention of neuropsychiatric disorders will best decrease the losses attributable to them; in the interim, ways of reducing costs must be found in treatment for these illnesses. For many of these disorders, psychotropic medications are the safest and most cost-effective treatments, and they have the widest acceptance. While the newer antipsychotic medications tend to be more expensive, they are often better tolerated by patients and may be more effective. Since they cause fewer side effects, patients should be more willing to take them early in their illness and, once on them, more likely to sustain their use. Are these greater front-end costs a good long-term investment? The greatest direct cost associated with schizophrenia and manic-depressive illness is that of hospitalization.

To the degree that the new antipsychotic medications can decrease hospitalization, they will be of immediate economic value. If their comparative tolerability also allows them to decrease long-term morbidity, they may prove to be of even greater value, both economically and in the social/psychological sense.

REFERENCES:

1. Wyatt RJ, Henter I, Leary M, Taylor E: An economic evaluation of schizophrenia-1991. *Social Psychiatry and Psychiatric Epidemiology* 30:196-205, 1995.

INDUSTRY SUPPORTED SYMPOSIUM 47—NOVEL ANTIPSYCHOTICS: OUTCOMES, COST-EFFECTIVENESS AND QUALITY
Supported by Zeneca Pharmaceuticals Group

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

The participant should be able to recognize the clinical efficacy profile of the new-generation antipsychotic medications, the pharmacoeconomics and cost-effectiveness of this class of drugs, and the psychosocial outcomes and quality of life in medicated psychotic patients.

No. 47A
SEROTONIN-DOPAMINE ANTAGONIST: CLINICAL EFFECTS

Diana O. Perkins, M.D., *Department of Psychiatry, Univ of NC School of Medicine, CB 7160, Neurosciences Hosp., Chapel Hill NC 27599*

SUMMARY:

A new generation of antipsychotics, dubbed "atypical" in part due to their decreased risk of inducing extrapyradimal side effects (EPS), are either in development or available in the U.S. The "atypical" serotonin-dopamine antagonists (SDAs) clozapine, risperidone, olanzapine, sertindole, seroquel, and ziprasidone will be discussed. This presentation will consider the potential improved effectiveness of these SDAs in the treatment of schizophrenia and related psychotic disorders, including their efficacy in treating positive symptoms and overall tolerability due to improved side-effects profiles. Negative symptoms may be primary to the underlying schizophrenic disease process or secondary to antipsychotic medication side effects. Data will be presented related to the potential of SDAs to minimize the risk of secondary negative symptoms and to treat primary negative symptoms. Other side effects of the "typical" antipsychotics will be compared with those of the SDAs. Finally, the potential impact of SDAs on clinical management of patients in both acute and chronic phases of their illness will be considered.

No. 47B
RECENT PHARMACOECONOMIC STUDIES OF ANTIPSYCHOTIC USE

Henry A. Nasrallah, M.D., *Department of Psychiatry, Ohio State University, 1670 Upham Drive, Columbus OH 43210-1252*

SUMMARY:

Schizophrenia is a very costly brain disease. The estimated direct and indirect annual costs of schizophrenia in the United States are $34 billion.

The costs of antipsychotic medications represent only 5%-10% of the direct costs of schizophrenia. The new generation of novel antipsychotics costs significantly more than the first generation drugs, which have been used for over 35 years. However, there are now several studies showing that novel antipsychotics are in fact cost-effective, that is, they generate savings that exceed their cost. The improved efficacy in positive and negative symptoms as well as the relative infrequency of EPS side effects and better compliance with novel antipsychotics appear to reduce the direct and indirect costs of schizophrenia.

Pharmacoeconomic studies have shown that 1) hospital days are significantly reduced by clozapine, risperidone, and sertindole, 2) life span increases by about six years in clozapine-treated patients, and 3) the frequency for physician, nursing, and social work services is reduced with risperidone.

Studies with the latest novel antipsychotics such as olanzepine, seroquel, and ziprasidone are underway and are expected to show similar trends. These pharmacoeconomic studies indicate that advances in antipsychotic pharmacotherapy (improved efficacy and reduced adverse effects) may not only improve compliance, functioning, and quality of life in schizophrenia, but may also reduce the total costs of this severe and disabling psychiatric brain disorder.

No. 47C
UPDATE ON MEASURES OF PSYCHOSOCIAL OUTCOME

Anthony F. Lehman, M.D., *Department of Psychiatry, University of Maryland, 645 West Redwood Street, Baltimore MD 21201*

SUMMARY:

Advances in the neurosciences, concerns about cost containment, and growing consumer advocacy are creating new hopes and challenges for the development of more effective and cost-effective treatments for persons with psychotic disorders. Using the development of new antipsychotic agents for the treatment of schizophrenia as a prototype, this presentation examines the assessment of outcomes of treatments for these patients. Psychotic disorders exert a broad range of negative effects on patients' lives, thus demanding a broad view of outcomes to assess the effectiveness of alternative pharmacotherapies. The outcomes of interest cover the clinical, rehabilitative, humanitarian, and public welfare domains. Most of our knowledge about the efficacy of antipsychotic agents focuses on improvements in the positive symptoms of schizophrenia. However, better antipsychotic medications must show advantages beyond symptom suppression. We need to know not only whether alternative medications offer advantages in these other outcome dimensions, but also how they interact with psychosocial treatments to enhance outcomes, how effective they are with patients in usual practices settings, and how cost-effective they are relative to other treatments.

No. 47D
RECENT FINDINGS IN THE ASSESSMENT OF QUALITY OF LIFE AMONG PATIENTS WITH SCHIZOPHRENIA

A. George Awad, M.D., *Department of Psychiatry, Toronto Univ/ Clarke Institute, 250 College Street, Toronto ON M5T 1R8, Canada;* Lakshmi N.P. Voruganti, M.D., Ronald Heslegrave, Ph.D.

SUMMARY:

The issue of subjective tolerability of antipsychotic medications in the treatment of schizophrenia has been increasingly recognized in recent years, not only in clinical practice but also in research and in clinical trials of new antipsychotics. Clinicians have frequently observed that some of their patients experience a change in subjective

state after a few doses of an antipsychotic. Complaints range from "feeling like a zombie" to inability to think straight and the notion that the medications are worsening their condition. Subjective tolerability to antipsychotic medications has been linked to a number of important clinical outcomes relevant to the management of schizophrenia. Data will be presented to implicate such phenomena in compliance, clinical outcome, prediction of response, quality of life, and suicidal behavior. Recent data indicate that negative subjective responses to antipsychotic medications may be the missing link in comorbid substance abuse. In a recent study, we examined the intercorrelation between negative subjective tolerability and several, clinical indices. Lower subjective tolerability correlated significantly with high positive symptom score on the Positive and Negative Syndrome Scale (r = 0.31), general psychopathology (r = 0.34), depression (r = 0.37), insight (r = 0.52), and total PANSS score (r = 0.32); higher score on the Hillside Akathisia scale (r = 0.35); as well as total neuroleptic dose (r = 0.51).

The measurement of subjective tolerability will be reviewed, and our data will be discussed relative to the development of new antipsychotics.

No. 47E
ADVANCES IN THE PHARMACOTHERAPY OF SERIOUS MENTAL ILLNESS IN THE ERA OF MANAGED CARE

Rodrigo A. Munoz, M.D., *Univ. of California, San Diego, 3130 5th Avenue, San Diego CA 92103*

SUMMARY:

Early success in the treatment of psychoses with phenothiazines led clinicians to evaluate nonsomatic strategies for the rehabilitation of chronic patients. Their efforts led to the development of new approaches to schizophrenia with family interventions, therapeutic communities, marital therapy, and cognitive therapy. Knowledge about social factors in the course of schizophrenia produced studies of expressed emotions, social skills training, vocational rehabilitation, case management, and integrative community treatment.

The incorporation into the community of a person who has been chronically ill represents challenges that are not different from those posed by people with chronic physical illnesses, people separated from their group or their place of work for long periods, or people forced to relocate because of economic changes. This presentation explores the use of family, social, and community interventions developed for the treatment of patients with schizophrenia in the last decade.

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2. Meltzer HY: Cost-effectiveness of clozapine treatment. *Journal of Clinical Psychiatry* Monograph Series 14:16-17, 1996.
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INDUSTRY SUPPORTED SYMPOSIUM 48—SCHIZOPHRENIA: CHARTING A COURSE THROUGH ILLNESS
Supported by Roerig Division/Pfizer, Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

To demonstrate knowledge of the life-long course of schizophrenia, incorporating new findings; to recognize which phases of illness are critically important to evaluate new vs. older antipsychotic treatments and psychosocial interventions across course of psychotic illness.

No. 48A
ANTECEDENTS OF SCHIZOPHRENIA ADDRESSING EARLY RISK FACTORS

Professor Robin M. Murray, *Institute of Psychiatry, Kings College Hospital, De Crespigny Park, London SE5 8AF, United Kingdom;* Mary Cannon, M.B., Peter Jones, M.B., Jim Van Os, M.D., Russell A. Ku, Ph.D., Janet Munro, M.B.

SUMMARY:

The mothers of 70 schizophrenics, 28 patients with bipolar disorder, and 100 normals were interviewed concerning their childhood function. Preschizophrenics had shown greater impairment than controls both in sociability and in school adjustment and achievement; bipolars also showed impairment but to a lesser degree. There was a linear relationship in schizophrenics between birth weight and childhood social adjustment. Thirty-four adult schizophrenics who had earlier been seen at a child psychiatry clinic had shown similar deficits and a lower IQ than expected. The latter is consistent with birth cohort studies that also show low IQ to be a risk factor for schizophrenia. These studies also show delayed milestones, difficulties in play, and language problems in preschizophrenics, but also to a lesser extent in females with chronic affective disorder.

No. 48B
PRODROMAL INTERVENTION: A REALISTIC GOAL

Patrick D. McGorry, Ph.D., *Psychiatry, University of Melbourne, c/o EPPIC 35 Poplar Road, Parkville Victoria 3052, Australia;* Alison R. Yung, M.B.

SUMMARY:

Objective: While the focus for early intervention in psychotic disorder has been largely on first-episode psychosis (FEP), this may still be too late. Positive symptoms generally occur late in the denouement of these illnesses; however, extensive decline in functioning may have already occurred and is associated with other severe forms of risk.

Method: A framework is outlined for extending preventive intervention earlier into the prepsychotic period linked to a broader early intervention program for FEP. This involves a focus on young people who already meet criteria for high risk of early transition to psychosis based on a combination of state and trait risk factors.

Results: Very high early transition rates (>40%) have already been observed along with significant levels of symptoms and disability. The influence of biological (MRI), psychological (candidate precursor symptoms and neurocognitive variables), and psychosocial (life events, SES, cannabis usage) variables on the prediction of risk of subsequent psychosis will be considered.

Conclusion: The feasibility of defining and intervening with young people at very high risk of early transition to psychosis is demon-

strated. The data support a greater focus on the phase of illness prior to the onset of first psychotic symptoms.

No. 48C
ADOLESCENT SCHIZOPHRENIA: CHARACTERISTICS AND TREATMENT

S. Charles Schulz, M.D., *Department of Psychiatry, Case Western Reserve University, 11100 Euclid Avenue, Cleveland, OH 44106*

SUMMARY:

Schizophrenia is a heterogeneous illness, but by studying first-episode, drug-naive, schizophrenic patients, certain of the confounds of previous studies can be eliminated. First-episode patients are relatively homogeneous in their stage of illness, free of the effects of prior drug exposure, and can be followed prospectively over the critical early stages. We studied 118 first-episode schizophrenic patients up to five years, assessing both clinical and biological parameters both before and after undergoing standardized treatment. Of particular interest and the focus of this presentation is their treatment response and outcome. Fifty-two percent of the sample were male, 41% were Caucasian, 79% had never been married, and 62% had at least some college education. The mean age at study entry was 25.2 years with the mean weeks of psychiatric and psychotic symptoms prior to study entry of 143.5 and 71.5 weeks, respectively. At baseline, patients were very ill with a GAS of 27.1.

At one year, 86.4% had remitted with a mean time to recovery of nine weeks, and out of these only 36% did not relapse again. Patients who stopped their medication were five times more likely to relapse than patients who remained on medication. We noted a clear pattern of decreasing responsiveness to treatment over subsequent episodes of illness. A number of specific clinical and biological correlates of treatment response were found and will be discussed. More recently, we had also had a cohort of 23 first-episode patients who received clozapine as a first-line treatment and their outcome will also be discussed. Overall, the data demonstrate that despite substantial symptomatic improvement after the first episode, psychosocial, occupational, and global functioning were impaired in many patients at follow-up. Whether different treatments such as clozapine change this outcome has yet to be determined.

No. 48D
BEYOND ACUTE PSYCHOSIS: DEFICIT AND MOOD SYMPTOMS

David G. Daniel, M.D., *Washington Clin. Rsch. Center, 6404-P Seven Corners Place, Falls Church VA 22044;* Fuad Issa, M.D., Mary R. Lee, M.D.

SUMMARY:

In schizophrenia, deficit symptoms and depression often persist after successful neuroleptic treatment of delusions, hallucinations, and other "positive" symptoms. Despite their negative impact on reintegration into society and quality of life, deficit symptoms and depression are often unrecognized and untreated. Differential diagnosis includes secondary effects of positive symptoms, neuroleptic-induced deficit syndrome, neuroleptic-induced parkinsonism, sedation, medical illness, and psychological factors. Although the phenomenology of deficit symptoms and depression may overlap, their clinical course, pathophysiology, and treatment differ. Their pathophysiology may include imbalances in dopaminergic, glutaminergic, serotonergic, and noradrenergic systems. Their resistance to conventional neuroleptic treatment has inspired target-symptom-based strategies employing neuroleptic reduction, antiparkinsonian agents, stimulants, antidepressants, and psychotherapy. More recently, optimism has been engendered by "atypical" serotonin-dopamine antagonist (SDA) antipsychotic agents. The theoretical and empirical basis, practical clinical applications, and limitations of available SDAs in the treatment of deficit symptoms and depression in schizophrenia will be discussed. In addition, novel agents under development that combine actions considered to have potential for both antipsychotic and antidepressant activity will be presented.

No. 48E
LONG-TERM MANAGEMENT OF SCHIZOPHRENIA

Steven G. Potkin, M.D., *Department of Psychiatry, Univ of CA Irvine Medical Cntr, 101 City Drive South Route 88, Irvine CA 92717*

SUMMARY:

The key to the long-term successful treatment for patients with schizophrenia is prevention of relapse. Lack of compliance with antipsychotic medication is the major factor in psychotic relapse. New data suggest that psychotic relapses may have a cumulative effect and accentuate a downhill course. A frequent reason for patients discontinuing antipsychotic medication is the occurrence of uncomfortable pseudo-Parkinsonian symptoms, akathisia, and other side effects. Compliance can be enhanced by selecting agents with characteristics most likely to reduce patient-specific side effects. A model using receptor affinities will be presented to rationally select the optimal neuroleptic treatment with the fewest side effects for each patient. Optimizing dose, slow titration, and rational use of adjunctive agents are important factors in maintenance long-term pharmacological treatment. Providing psychoeducation to patients and their families, with emphasis on medication compliance, identification of early signs of illness, and problem-solving techniques, are important aspects of maintenance. Flexibility to intervene when necessary with community-based programs, such as Assertive Community Treatment, can be useful especially when medication compliance is at issue. A rehabilitation model, combined with optimal psychopharmacology, is the key to successful maintenance treatment.

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2. Yung AR, McGorry PD, McFarlane CA, et al: Monitoring and care of young people at incipient risk of psychosis. *Schizophr Bull* 22:283-303, 1996.
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INDUSTRY SUPPORTED SYMPOSIUM 49—TREATMENT-RESISTANT SCHIZOPHRENIA: MEETING THE THERAPEUTIC CHALLENGE
Supported by Novartis Pharmaceuticals Corporation

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be able to: 1) diagnose treatment-resistant schizophrenic patients; 2) recognize factors which contribute to the development of treatment-resistance; 3) demonstrate cost-effectiveness of drug therapy in treatment-resistant patients; and 4) to demonstrate suicide risks.

No. 49A
ANTIPSYCHOTIC NONRESPONSE: DEFINITION AND CONTRIBUTING FACTORS

Jean-Pierre Lindenmayer, M.D., *Department of Psychiatry, NYU School of Medicine, 60 Remsen Street, Brooklyn NY 11201-3453*

SUMMARY:

While 75% to 85% of schizophrenic patients experience significant improvement after antipsychotic treatment during their first episode, 10% to 30% of these patients will subsequently go on to partial or complete treatment resistance. These patients present a major challenge to clinical, social, and financial resources of the mental health delivery system. The number of nonresponders varies according to the definition used and to the time of observation in the course of illness (initial vs. subsequent treatment resistance). This presentation will attempt to explore and refine the definition and incidence of antipsychotic nonresponse using a multidimensional framework of schizophrenic psychopathology and will examine underlying pathogenic factors that may contribute to nonresponse. Given our better understanding of five independent, but coexisting components of schizophrenic psychopathology, an expanded concept of nonresponse will be presented that specifies partial or complete resistance in the positive, negative, cognitive, anxiety-depression, and excitement domains. While positive and excitement symptoms respond fairly effectively to typical antipsychotics, negative, cognitive, and depression symptoms respond much less well and can contribute to debilitating social deficits. Further, underlying factors contributing to resistance in these five different domains will be explored. They include (1) medication noncompliance, (2) pharmacokinetic factors, (3) pharmacodynamic factors, and (4) psychosocial factors. The impact of these factors on the different domains of treatment outcome will be discussed.

No. 49B
THE EFFICACY AND COST-EFFECTIVENESS OF CLOZAPINE

Dennis S. Charney, M.D., *Department of Psychiatry, Yale University, 25 Park Street, New Haven CT 06519;* Robert A. Rosenheck, M.D., Joyce Cramer, Weichun Xu, Ph.D., Jonathan Thomas

SUMMARY:

A multicenter, randomized, double-blinded clinical trial was undertaken to evaluate the efficacy and cost-effectiveness of clozapine compared with a standard treatment, haloperidol. The cohort of 423 patients had not only failed to respond to adequate trials of at least two standard antipsychotic medications at appropriate dose, but had also been hospitalized for 30 to 364 days in the previous year. The population was clearly defined as high resource users for whom a clozapine treatment might provide improvement in symptomatology as well as reductions in direct and indirect costs. After randomization, patients were followed for one year whether or not they continued to take the assigned treatment. Data collection throughout the study included measures of symptomatology (PANSS, BPRS, CGI, GAS), quality of life (QOLS, QLI), adverse effects, and service utilization (VA and non-VA). Estimating the cost of clozapine as approximately $6,500 annually for a typical dose of 400-500 mg/day plus required clinical care, the clozapine group would have to spend 22 fewer days in hospital to recoup the cost of medication, assuming that all other costs are equal. The findings of the study regarding costs, positive gains in employment, and quality of life will be discussed.

No. 49C
MORTALITY IN CURRENT AND FORMER USERS OF CLOZAPINE

Lee L. Lanza, M.P.H., Felix M. Arellano, M.D., *Staff Epidemiologist, Epidemiology Resources Inc., 1 Newton Executive Park, Newton Lower Falls, MA 02162;* Alexander M. Walker, D.P.H., Kenneth J. Rothman, D.P.H.

SUMMARY:

Although clozapine (Clozaril) causes fewer extrapyramidal side effects than other antipsychotics, its indication is commonly limited to schizophrenia that is not responsive to other therapies, owing to the occurrence of agranulocytosis. To place the risk of agranulocytosis into a wider context of the drug's effects on mortality, we compared rates of various causes of death in 67,072 current and former clozapine users.

A national registry containing data on white blood counts in users of clozapine in the United States made it possible to ascertain deaths, which we categorized according to underlying causes and recency of clozapine use. We calculated death rates standardized by age, sex, and race.

Mortality was lower during current clozapine use than during periods of nonuse. Mortality from suicide was decreased in current clozapine users by comparison with past users (rate ratio - RR - of 0.18, 95% confidence interval of 0.10, 0.30). During clozapine use there were elevations in mortality rates for less common causes of death, including pulmonary embolism (RR compared to past clozapine use for current exposure 5.0; 95% CI 0.91 to 106), and respiratory disorders (RR = 3.0; 95%CI 0.81 to 19). Clozapine reduced mortality in schizophrenics, mostly by decreasing suicide rates. Several less common causes of death were elevated in clozapine users, albeit with wide confidence intervals. The risk of suicide in patients who discontinued clozapine for medical reasons (i.e., low WBC) increased after discontinuation to the same extent it did in those whose discontinuation may have been due to resistance to clozapine therapy. The advantage of clozapine therapy to current users was not attributable to a transient worsening of suicide risk immediately upon discontinuation of therapy.

No. 49D
SWITCHING ANTIPSYCHOTIC DRUGS: ADVANTAGES AND PRECAUTIONS

Herbert Y. Meltzer, M.D., *Department of Psychiatry, Psych Hosp at Vanderbilt Univ, 1601 23rd Ave. South, Ste. 306, Nashville TN 37212*

SUMMARY:

The introduction of clozapine, followed by risperidone and now olanzapine and sertindole, has resulted in switching many patients from a typical neuroleptic drug to one of these agents. It is clear that switching from one typical neuroleptic drug to another rarely conveys clinical advantages with the exception that the side-effect profile may be more favorable in a given patient, e.g., fewer extrapyramidal side effects or less hypotension. Switching patients to clozapine from typical neuroleptic drugs has been accomplished without major incident. Stopping the typical neuroleptic before starting clozapine is recommended. Further study about switching from the newer agents to clozapine is needed. Stopping clozapine may be associated with a higher rate of relapse than stopping typical neuroleptic drugs. Some patients who relapse under these circumstances may respond less well to the agents they are subsequently given than would be the case if they were switching from another drug. Evidence will be presented that it is desirable to start treatment with a second agent before stopping clozapine when possible, and then slowly tapering clozapine. The relapse rates when stopping the newer

atypical antipsychotic drugs require further study. The mechanism of the relapse following clozapine withdrawal will be discussed.

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2. Meltzer HY, Cola PA: Pharmacoeconomics of clozapine: a review. *Journal of Clinical Psychiatry*, 55 (Suppl B): pp. 161-165, 1994.
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4. Tune L, et al: Dopamine D2 receptor estimates in schizophrenia: a positron emission tomography study with C-N-methylspiperone. *Psychiatry Research* 49:219-37, 1993.

INDUSTRY SUPPORTED SYMPOSIUM 50—PRACTICAL ADVANCES IN THE MANAGEMENT OF ALZHEIMER'S DISEASE
Supported by Bayer

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should have a greater knowledge of new developments in genetics, pathobiology, diagnosis, current treatment strategies, and how to apply these findings in a changing managed care marketplace.

No. 50A
NEUROBIOLOGY AND GENETICS OF ALZHEIMER'S DISEASE

Murray A. Raskind, M.D., *Department of Psychiatry, VA Puget Sound Medical Center, 1660 S. Columbian Way, 116A, Seattle WA 98108*

SUMMARY:

Recent advances in the neurobiology and genetics of Alzheimer's disease (AD) have improved prospects for developing rational treatments for this devastating disorder. Substantial evidence suggests involvement of a neurotoxic form of beta amyloid protein in the pathophysiology of AD. The presynaptic cholinergic deficit of AD may contribute to AD progression by enhancing the metabolic pathway that processes amyloid precursor protein (APP) to neurotoxic beta amyloid. This phenomenon may underlie the retrospective observation that AD patients treated with a high dose of a cholinesterase inhibitor manifested slower disease progression as measured by time to nursing home placement. Genetic studies of AD families have uncovered etiologic mutations on chromosome 14 (S-182 gene), chromosome 1 (STM-2 gene), and in the APP gene on chromosome 21. In addition, the apolipoprotein E gene allele type substantially determines risk of developing AD. Specifically, the type 4 allele of apolipoprotein E accelerates onset of AD. The clearest relation between a mutation and expressed AD pathobiology involves the rare chromosome 21 APP gene mutations that affect production of beta amyloid. Intensive studies are underway to determine how the other AD mutations and the apolipoprotein E allele variations affect formation of the extraneuronal senile plaques and intraneuronal neurofibrillary tangles found in AD brain tissue and ultimately affect the neuronal degeneration of AD.

No. 50B
EARLY DETECTION AND TREATMENT STRATEGIES

Gary W. Small, M.D., *Department of Psychiatry, UCLA Neuropsychiatric Inst., 760 Westwood Plaza, Los Angeles CA 90024-8300*

SUMMARY:

New treatments for Alzheimer's disease (AD) are more likely to slow the disease's gradual progression than to reverse existing neuronal damage. Thus, identifying persons with mild cognitive complaints before they develop the full dementia syndrome will facilitate antidementia treatments before extensive brain damage develops. The discovery of the apolipoprotein E-4 (APOE-4) allele as a major risk factor for AD offers promise of assisting in early AD detection, particularly when such genetic assessments are combined with neuroimaging biomarkers. Positron emission tomography (PET) studies show that middle-aged persons with mild memory complaints and APOE-4 have lower parietal metabolism than those without this genetic risk, and such metabolic patterns may predict cognitive decline. Although useful, such measures only indicate general neuronal function. A promising strategy for disease-specific monitoring is *in vivo* imaging of beta-amyloid or Aβ, the principal component of the amyloid plaque, which is a neuropathological hallmark of AD. Recent findings suggest that initial Aβ deposition occurs before AD symptoms are observed clinically and may be an early marker of disease progression when combined with APOE genotyping. Development of radiolabeled, small molecule probes for Aβ could provide a means for disease-specific monitoring in conjunction with PET imaging. Such approaches would be useful for monitoring novel antidementia treatments designed to inhibit Aβ aggregation of amyloid fibrils. This presentation will review how such detection strategies can complement novel treatment approaches.

No. 50C
MANAGEMENT OF DEPRESSION IN DEMENTIA

Ira R. Katz, M.D., *Department of Psychiatry, University of Pennsylvania, 3600 Market Street, Room 812, Philadelphia PA 19104*

SUMMARY:

Management of depression among patients with dementia is important to reduce excess disability and caregiver burden and to improve the quality of life of both patients and their families. Although there are concerns about the limits of diagnostic information derived from patient reports and about the lack of specificity of symptoms related to apathy, the literature strongly supports the validity of depressive syndromes (major and minor) as components, complications, or comorbidities of Alzheimer's disease and other dementias. The evidence to support the efficacy of antidepressant medications in major depression associated with dementia is, at present, scant. Available data, however, suggest that current clinical practice should be governed by the hypothesis that treatment in patients with dementia should follow the same guidelines that apply in other frail elderly people; clinicians must ensure the adequacy of treatment while avoiding cardiac, peripheral autonomic, and central anticholinergic side effects. Further research is needed to evaluate the specificity of treatment responses and to evaluate the longer-term use of agents such as stimulants. For patients with both major and minor depression, psychosocial treatment in which caregivers are trained to act as therapists appears promising. Thus, depression among patients with dementia should trigger active interventions.

No. 50D
PSYCHOSIS AND DEMENTIA: OPTIMIZING CLINICAL RESPONSE

Pierre N. Tariot, M.D., *Department of Psychiatry, Monroe Community Hospital, 435 East Henrietta Road, Rochester NY 14620*

SUMMARY:

Half or more of patients with dementia exhibit agitation and/or psychosis at some point during the course of their illness. The treatment of these signs and symptoms ideally entails identification and alteration of physical, environmental, social, and psychiatric factors. Optimizing sensory input, environmental modification, education of caregivers, and therapeutic activity programs are examples of nonpharmacologic approaches that can effectively reduce some signs and symptoms of this nature. For those that remain, empirical administration of pharmacologic agents may be appropriate. One approach is to inventory the specific behaviors and develop a "therapeutic metaphor," i.e., subtype the agitated behaviors according to the presence of target symptoms likely to be responsive to specific classes of medication. This presentation will review available evidence regarding the efficacy and safety of somatic therapies for agitation and psychosis in dementia, including antipsychotics, antidepressants, anticonvulsants, benzodiazepines, cholinesterase inhibitors, and others.

No. 50E
NEW TREATMENTS FOR COGNITIVE IMPAIRMENT

Lon S. Schneider, M.D., *Department of Psychiatry, University of Southern CA, 2011 Zonal Avenue, HMR-101, Los Angeles CA 90033*

SUMMARY:

By the latter half of 1997 physicians will have available a variety of efficacious medications to treat Alzheimer's disease. There will be a range of cholinesterase inhibitors representing an emerging differential pharmacology. They can be classified into three groups: (1) reversible, competitive inhibitors (e.g., tacrine and donepezil), (2) pseudo-irreversible inhibitors (e.g., ENA 713 and physostigmine), and (3) irreversible inhibitors (e.g., metrifonate). In addition to their inhibitory characteristics, these medications vary with respect to other pharmacodynamic effects (e.g., selectivity for acetylcholinesterase and even subtype of acetylcholinesterase) and pharmacokinetic effects (e.g., distribution, metabolism, excretion, duration of action, dosing, etc). Since cholinesterase inhibitors have not been compared directly, physicians will need to consider these effects when making treatment decisions. It is likely that patients may respond differentially as well. Much information will be learned as these medications are used in clinical practice.

Concurrently there will be several potential therapeutic options that may influence the progression of neuronal degeneration or slow cognitive or functional decline. Although empirical results are meager, antioxidants have attracted considerable interest; and both basic and observational research suggest that marketed cholinesterase inhibitors may have long-term effects. Furthermore, antioxidants are available on the market both as food supplements and for other medical indications. Therefore, physicians are faced with new and complex challenges and opportunities with respect to AD pharmacotherapy.

No. 50F
TREATING DEMENTIA IN A CHANGING MEDICAL MARKETPLACE

Gary L. Gottlieb, M.D., *Administration, Friends Hospital, 4641 Roosevelt Boulevard, Philadelphia PA 19124*

SUMMARY:

Over the past several years, increased penetration of managed care has changed the health care delivery marketplace. In a number of markets, penetration of managed care among Medicare recipients has reached 30%-35%. The process of service delivery in these environments is radically different from that supported by indemnity Medicare. Comprehensive assessment, the use of expensive diagnostic tools, interdisciplinary treatment teams, and the availability of psychiatric services may be affected adversely by managed care mandates.

This presentation will focus on the changing health care delivery marketplace and its effects on the treatment of patients with Alzheimer's disease and other dementias. Additionally, several model approaches to care and a research agenda for the treatment of patients with dementia and their families in a managed care environment will be offered.

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LECTURES

LECTURE 1
APPI/APA's MANFRED S. GUTTMACHER AWARD LESION OF THE WILL: DIAGNOSIS AND CRIMINAL RESPONSIBILITY IN 19TH CENTURY ENGLAND

Joel P. Eigen, Ph.D., *The University of Pennsylvania, Gerhart House, Franklin and Marshall, Lancaster, PA 17604*

SUMMARY:

Historians of psychiatry often consider the formulation of the McNaughtan Rules to have been a legal exercise designed to reposition insanity on cognitive, rather than volitional grounds. Legal anxiety regarding pre-McNaughtan medical testimony had centered on the introduction of concepts such as moral insanity, monomania, and "lesion of the will," which were thought to expand both the range of possible debilitating states that could call for acquittal, and the professional authority and influence of the specialist as well. This lecture explores a series of cases heard at London's Central Criminal Court, the Old Bailey, ten years after McNaughtan, in an effort to gauge the court's success in maintaining the criterion of an "inability to know right from wrong" as the (only) legitimate grounds for an insanity plea. Three trials are examined in detail to answer the following questions. How effectively did the reinforcement of the cognitive standard stressing knowing right from wrong limit the medical specialists' re-introduction of states of volitional impairment that argued for a loss of self control even while consciousness was retained? What strategies did medical witnesses adopt to confront legal questioning that insisted on answers to the "right or wrong" criterion? How did these techniques continue a pattern exhibited by medical specialists earlier in the century to establish a professional niche in the courtroom?

REFERENCES:

1. Goldstein J: *Console and Classify: The French Psychiatric Profession in the Nineteenth Century.* Cambridge University Press, Cambridge, MA, 1987.
2. Eigen JP: Delusion in the Courtroom: The Role of Partial Insanity in Early Forensic Testimony. *Medical History* 35:24-49, 1991.

LECTURE 2
THE BIOLOGY OF PTSD

Rachel Yehuda, Ph.D., *Traumatic Stress Studies Program, Mount Sinai School of Medicine, Bronx Veterans Affairs, 130 W. Kingsbridge Road, New York, NY 10468*

SUMMARY:

Studies over the last decade have demonstrated distinct neuroendocrine, cognitive and neuroanatomic differences in trauma survivors with PTSD compared to trauma survivors without PTSD. In most cases, the biologic differences observed in PTSD are different from those seen in other psychiatric disorders that co-occur or share symptoms with PTSD, such as major depression. A salient example of this are findings of hypothalamic-pituitary-adrenal alterations in PTSD which have repeatedly demonstrated that levels of the stress hormone cortisol are actually lower in both the acute and chronic aftermath of trauma in survivors with PTSD compared to trauma survivors without PTSD. This presentation will summarize recent biological findings in PTSD and consider their treatment implications. It will be emphasized that trauma exposure alone does not likely account for the biologic changes observed in PTSD, since: 1) many individuals who are exposed to trauma never develop, or fully recover from, this disorder; and 2) that many of the biologic changes in trauma survivors with PTSD are different than those that occur in response to stress. Accordingly, recent evidence for the presence of biologic risk factors for PTSD will also be discussed.

REFERENCE:

1. Southwick SM, Yehuda R, Charney DS: Neurobiological alterations in Posttraumatic Stress Disorder: A Review of the Clinical Literature. In: Fullerton CS, Ursano RJ (eds), *Acute and Longterm Responses to Trauma and Disaster.* American Psychiatric Press, Washington, DC, 1996.

LECTURE 3
APA'S OSKAR PFISTER AWARD LECTURE BELIEF IN PSYCHIC LIFE

Ana Maria Rizzuto, M.D., *75 Gardner Road, Brookline, MA 02146-4523*

SUMMARY:

When psychiatrists discuss belief, they focus on belief as content, on what people believe about their personal lives, this world, and the transcendent world. These concrete beliefs are the result of broad psychic activities engaged in an effort to make sense of every aspect of human experience. Believing, as a psychic action, is a ubiquitous process and a function present since the beginning of life. The function of believing is an indispensable component of psychic life. The modalities and contents of believing evolve with the changing needs of the developing psyche and of the transformations of external life.

Believing is a function connected with the indispensable need to maintain at least a minimally viable sense of self. In an optimal situation, believing offers integrated views of self and others in the context of concrete life circumstances. Believing, as a complex psychic activity, avails itself of all psychic abilities and defensive processes. Thus, all acts of belief are composite psychic elaborations intended to maintain an acceptable location and perception of one's self in the context of existing realities. This manner of conceptualizing believing holds for diverse beliefs from infantile convictions to scientific and religious beliefs. Believing is not opposed to knowing but complementary to it.

REFERENCE:

1. Rizzuto AM: *The Birth of the Living God. A Psychoanalytic Study.* The University of Chicago Press, 1979.

LECTURE 4
APA's SIMON BOLIVAR AWARD LECTURE CULTURE, HEALTH AND QUALITY OF LIFE

Juan E. Mezzich, M.D., *Professor of Psychiatry and Head, Division of Psychiatric Epidemiology, Mount Sinai School of Medicine of the City University of New York, Box 1230 Fifth Avenue and 100th Street, New York, NY 10029-6574*

SUMMARY:

Culture informs our understanding and experience of health and life. Recently, building on maturing cross-cultural research and stimulated by a growing multiculturality in the general population, innovative contributions to the cultural framework of DSM-IV were prepared by a NIMH Work Group. Following this, developments are emerging to enhance the cultural validity and sensitivity of health assessment, from the identification of mental problems in primary care to the appraisal of quality of life.

REFERENCE:

1. Mezzich JE, Kleinman A, Fabrega H, Parron DL (eds): *Culture and Psychiatric Diagnosis: A DSM-IV Perspective.* American Psychiatric Press, Washington, DC, 1996.

LECTURE 5
THE ANATOMY OF PREJUDICES

Elisabeth Young-Bruehl, Ph.D., *409 W. Stafford Street, Philadelphia, PA 19144*

SUMMARY:

This lecture, organized into three parts, will offer, first, a survey statement about the key assumptions that have governed social scientific studies of prejudice since the end of the Second World War. It will then present an approach to the understanding of prejudices—in the plural, not the singular—that is based on psychoanalytic characterological theory. It will sketch three ideal types of prejudiced people and indicate the basic content of their characteristic prejudices. Obsessional types hold prejudices which resemble antisemitism, that is, they are directed at groups considered clannish, infiltrating of the prejudiced person's society, poisonous or germ-infected, wiley and intellectual; hysterical types are racists, in the sense that they are prejudiced against a group that is conceived as lower, darker, more sexual, primitive. Sexism is a prejudice only partially compassed by psychoanalytically informed feminist theory. This lecture offers a critique of that theory and proposes a theory of narcissistic characterological prejudice. In the third part of the lecture, some of the implications of this approach to prejudices for coalition building among oppressed groups are explored.

REFERENCE:

1. Young-Bruehl E: *The Anatomy of Prejudices.* Harvard University Press, Boston, MA, 1996.

LECTURE 6
THE 1997 NATIONAL DRUG CONTROL STRATEGY: ENGAGING THE MEDICAL COMMUNITY

General Barry R. McCaffrey, *Director, Office of National Drug Control Policy, Executive Office of the President, Washington, DC 20503*

SUMMARY:

The purpose of this address is two-fold—to broaden understanding of the 1997 National Drug Control Strategy and to challenge psychiatrists to lead the medical profession in recognizing and treating substance abuse problems.

The National Drug Control Strategy organizes a collective effort to achieve its common purpose of reducing illegal drug use and its consequences in America. The strategy provides general guidance and specific direction to the efforts of the more than fifty Federal agencies involved in the struggle against illegal drugs and substance abuse. Further, this strategy offers a common framework to state and local government agencies, to educators and health care professionals, to law enforcement officials and community groups, and to religious organizations, mass media, and the corporate community to build a unified American counterdrug effort.

Engaging the medical profession is a vital thrust of the National Drug Control Strategy. Physicians and other health care professionals play an essential role in reducing the use of alcohol, tobacco, and other drugs, especially among our youth. Efforts aimed at education, prevention, and treatment must be led by capable, caring, and involved health professionals working closely with parents and other concerned adult caregivers. As experts in human emotions and behavior, psychiatrists are uniquely qualified to lead the medical profession in its efforts to effectively address the challenges posed by drug abuse and addiction.

LECTURE 7
DISAVOWAL AND THE MERELY UNHAPPY

Arnold I. Goldberg, M.D., *122 South Michigan Avenue, Suite 1305B, Chicago, IL 60603*

SUMMARY:

Using the concept of disavowal which is defined as the separation from and denial of a certain aspect of reality, this paper compares its presence both in the field of psychiatry as well as in a specific form of psychopathology. In psychiatry this manifests itself in the separation of the "merely unhappy" from the "truly sick." This is considered to be a separation that distorts our field. It is further seen in the separation of pharmacologic therapy from psychotherapeutic effort. This separation both distorts and harms both our field and our patients.

The Narcissistic Behavior Disorders are presented as examples of severe disavowal, here termed "vertical splitting," in which one sector of the personality behaves realistically while another engages in a variety of pathologic behaviors such as the perversions, the additions and the delinquencies. These forms of disavowal allow for the co-existence of such pathology alongside of normal behavior. As long as the split is maintained treatment remains ineffective.

In these behavior disorders one must aim for integrating the personality or healing the split. So too in psychiatry we must attend to our divisiveness and integrate our field.

REFERENCE:

1. Goldberg A: *The Problem of Perversion.* Yale University Press, New Haven, CT, 1995.

LECTURE 8
WILLIAM C. MENNINGER MEMORIAL CONVOCATION LECTURE

LECTURE 9
OUR SCIENTIFIC REVOLUTION IN PSYCHIATRY: PITFALLS AND CAVEATS

David J. Kupfer, M.D., *Thomas Detre Professor and Chair, Department of Psychiatry, Director of Research, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213-2593*

SUMMARY:

Advances in basic and clinical neurosceince have fueled the expectation that the major psychiatric disorders, including affective disorders and schizophrenia, will soon be understood in molecular terms and new treatments designed accordingly. Despite this enthusiasm, researchers and clinicians alike need to be aware of current pitfalls in these expectations. For example, the affective disorders remain a heterogenous group of conditions for which we still await a decisive "genetic" breakthrough. Acknowledging the rapid changes that have recently taken place in our therapeutic endeavors with the affective disorders, our list of critical questions concerning etiology and course of disorder has actually increased in number. It would be useful to outline the key etiologic and treatment determinants that still need to be elucidated, to show their potential relationships, and to demonstrate the role that new interdisciplinary approaches, such as developmental neurobiology, can play in setting the research agenda for the next decade. In an era of limited resources and an unlimited horizon, such strategic goals would be useful to define. I would argue that they must represent a carefully thought through mix of clinical and basic science achievements. We cannot neglect the need to improve therapeutic options for these patients who are currently suffering and who, without effective treatment, may not live to see the molecular genetic revolution bear fruit. Yet, when carefully planned and

executed treatment trials can add to our knowledge about etiology of both disorder and episode, pre-clinical studies must be informed by what we are learning clinically and basic brain science, likewise, is most likely to yield significant breakthroughs when it is informed by in-depth knowledge of disorder manifestation. Now that we have been given scientific tools unimaginable a quarter century ago and have learned how to use them with considerable skill, the true challenge is to put these tools to the most productive use possible.

REFERENCE:

1. Kupfer DJ, Frank E: The Role of Psychosocial Factors in the Onset of Major Depression. In: *Proceedings of the Conference "The Integrative Neurobiology of Affiliation"* sponsored by Georgetown University, held March 14-17, 1996, Washington, DC. Annals of the *New York Academy of Sciences*, (in press).

LECTURE 10
PSYCHIATRY IN A NEW KEY: ASSURING THE FUTURE OF OUR PROFESSION

Miles F. Shore, M.D., *Malcolm Wiener Center for Social Policy, 450B Taubman Building, 79 John F. Kennedy Street, Cambridge, MA 02138*

SUMMARY:

For psychiatry to survive as a profession, psychiatrists must move beyond "brainless psychiatry," and "mindless psychiatry" and learn to function as members of the "encompassing mental health profession." To do so, they must establish legitimacy by offering deeper understanding of all aspects of the field, and proficiency in exploring and intervening in complex problems. In addition to expertise in the biological and psychosocial aspects of mental disorders, psychiatrists must prepare themselves for leadership roles in organized systems of care by understanding organizational dynamics, and learning how to function as effective leaders, responsible for the work of others. They must lead by building a group of dedicated, skilled individuals who are able to work together constructively. Training in psychiatry must be reorganized in both its content and its style to fulfill these essentials if psychiatry is to have a future in the reorganized health care system.

REFERENCE:

1. Greenlick MR: Educating Physicians for the Twenty-First Century. *Academic Medicine* 70:179-185, 1995.

LECTURE 11
APA'S BENJAMIN RUSH AWARD LECTURE FOR BETTER OR WORSE: INTERPERSONAL RELATIONSHIPS AND INDIVIDUAL OUTCOME

Jerry M. Lewis, M.D., *2750 Grove Hill Road, P.O. Box 270789, Dallas, TX 75227*

SUMMARY:

This presentation will explore the interpersonal perspective on both the development and course of individual psychopathology and on the processes of growth and maturation. The theoretical relevance and growing empirical support for the importance of several common dyadic processes that influence outcome in infant-mother attachment behaviors, marital relationships, and the psychotherapeutic alliance will be reviewed.

The interpersonal perspective outlined in this presentation will emphasize the importance of systems theory, the balance of separateness and connectedness in dyadic systems, the concept of subjective reality, and the joint construction of life narratives.

The presentation will draw heavily on the author's experience as an individual, couples and family therapist and his 30 years of research investigating the characteristics of healthy families and effective marriages.

The implications of the interpersonal perspective for clinical work will be noted, particularly as it applies to how problems are defined and whether the focus of intervention can most helpfully be the individual, couple or family.

REFERENCE:

1. Lewis JM: *Marriage as a Search for Healing: Theory, Assessement and Therapy.* Brunner/Mazel, New York, NY, 1997.

LECTURE 12
APA'S PATIENT ADVOCACY AWARD LECTURE MEDIA MADNESS: PUBLIC IMAGES OF MENTAL ILLNESS

Otto F. Wahl, Ph.D., *Department of Psychology, George Mason University, Fairfax, VA 22030*

SUMMARY:

From movies such as *Psycho* to *Silence of the Lambs* and *Seven*, from television shows such as *Kojak, Melrose Place* and *ER*, in addition to books, music, cartoons and advertising, images of mental illness are being presented to a vast audience. These omnipresent portrayals, unfortunately, tend to be insensitive, inaccurate, and stigmatizing. The lecture will examine the prevalence, nature and impact of these depictions, using numerous visual examples from a wide variety of media. It will demonstrate the inaccuracies and unfavorable stereotypes advanced by media depictions and discuss the damaging consequences of such stereotypes: stigma, loss of self-esteem, reluctance to seek, accept or reveal psychiatric treatment, discrimination, and restriction of opportunity. In addition, current efforts to combat negative stereotypes in the media and to encourage more accurate and sympathetic attention to mental illnesses will be described.

REFERENCE:

1. Wahl OF: *Media Madness: Public Images of Mental Illness.* Rutgers University Press, New Brunswick, NJ, 1995.

LECTURE 13
THE NEUROBIOLOGY OF READING AND DYSLEXIA

Sally E. and Bennett Shaywitz, M.D., *Yale University, School of Medicine, Department of Pediatrics, LMP 3089, PO Box 208064, New Haven, CT 06520-8064*

SUMMARY:

Why some very bright people should experience difficulties in learning to read has puzzled and intrigued scientists for the century since the first description of dyslexia. Advances of both a conceptual and a technological nature have now provided a model of reading and reading difficulties and a tentative architecture for the functional organization of brain for reading. Epidemiologic studies carried out within a longitudinal framework provide a conceptual model that places reading and reading disability as part of the same continuum and allows all that has been learned about reading to be applied to the study of dyslexia. Data also indicate that the disorder affects 15-20% of the population, that boys and girls are equally affected and that the disorder is persistent. A growing consensus implicates the linguistic system, in particular the phonologic component, as central to understanding reading and dyslexia. Within this model, a circumscribed, lower level deficit in phonological processing impairs rapid word identification. Higher level cognitive and linguistic functions (semantics, syntax, reasoning, concept formation) involved in comprehension are not affected. The phonologic deficit represents an encapsulated deficit surrounded by intact, often considerable, higher order cognitive abilities; this model provides an explanation of why

some extremely bright dyslexic individuals can achieve at the highest levels (law, medicine, literature). Advances in imaging technology now make it possible to study the neural circuitry of reading in intact children and adults. Initial studies using functional magnetic resonance imaging (fMRI) localize the component cognitive processes in reading, and indicate that phonological processing is generally highly lateralized (left inferior frontal gyrus) in males and represented bilaterally in females. Furthermore, brain activation patterns obtained during fMRI predict particular reading strategies.

REFERENCES:

1. Shaywitz S: Dyslexia. *Scientific American* 275(5):98-104, 1996.
2. Shaywitz BA, Shaywitz SE, Pugh KR, Constable RT, Skudlarski P, Fulbright RK, Bronen RA, Fletcher JM, Shankweiler DP, Katz L, Gore JC: Sex Differences in the Functional Organization of the Brain for Language. *Nature* 373(6515):607-609, 1995.

LECTURE 14
URBAN MENTAL HEALTH CARE: CHALLENGES AND OPPORTUNITIES

Professor Norman Sartorius, M.D., *Departement de Psychiatrie, Hopitaux Universitaires de Geneve, 16-18 Bd de St Georges, 1205 Geneve*

SUMMARY:

In less than 30 years more than 80% of the world's population will be living in cities. Many of these will be of very large size and most of them will be in Third World countries. It is highly probable that the health problems of these cities will be similar to those seen in any megalopolis in developing countries today—ranging from the breakdown of communal services to the erosion of culture, psychosocial problems (e.g., violent behaviour) and diseases of the homeless. Health problems in cities of industrialized countries are also likely to grow, particularly in their poorer areas.

Primary health care defined in the Alma Ata Conference was the strategy proposed in the 1970's for the provision of health care to the majority of the world's population then living in rural areas. The strategy of primary health care is still adapted to urban life: yet, no other specific, coherent and comprehensive set of principles, proposals for action and political agendas have been formulated to date. It is urgent and possible to develop a strategy for the improvement of health in cities. Psychiatrists and other mental health workers could have an important role in this process.

The presentation will review the current situation and some of the trends of urban health development. On the basis of this review a set of priority actions will be proposed.

LECTURE 15
TARGETING AGRESSIVE AND ADDICTIVE BEHAVIOR USING SEROTONIN RECEPTOR KNOCKOUT MICE

Rene' Hen, Ph.D., *Associate professor, Department of Neurobiology and Behavior, Columbia University College of Physicians & Surgeons, 722 West 168th Street PI Annes, Room 729, New York, NY 10032*

SUMMARY:

Disorders of impulse control have been associated with deficits in the central serotonin system. Using technology for targeting and manipulating specific genes, we have generated mutant mice lacking individual serotonin (5-HT) receptor subtypes to investigate which of the 15 known 5-HT receptors might be involved in impulse control. Mice lacking 5-HT1B receptors develop, feed and breed normally but display a number of behavioral differences compared to their wild type litter mates. The 5-HT1B knockout mice are more active when placed in a novel environment; both males and females are more aggressive in a resident intruder aggression test; the mutant mice acquire cocaine self administration faster than the wild type mice and consume more alcohol; in an operant learning test, the knockouts respond faster than the wild types. The decreased latency to attack in the aggression test and the shorter latency to respond in the self administration paradigm as well as in the food reward choice task, point towards an increased impulsiveness in the knockout mice. The other observed phenotypes might be related to the fact that impulsiveness is often associated in humans with hyperactivity, aggressive behavior, suicide and drug abuse. We are currently studying the possibility that mutations in the 5-HT1B gene might underlie conditions such as childhood hyperactivity, susceptibility to drugs of abuse and impulsive violence.

REFERENCE:

1. Hen R: Mean Genes. *Neuron* 16:17-21, 1996.

LECTURE 16
A LIFE IN MOODS

Kay Redfield Jamison, Ph.D., *Professor of Psychiatry, the Johns Hopkins University, School of Medicine, 2745 Brandywine Street, NW, Washington, DC 20008*

SUMMARY:

The lecture will focus upon several different areas: twenty years of research, teaching, and clinical practice in the field of mood disorders, especially manic-depressive illness; the role of mood disorders and extreme mood states in the lives and works of writers and artists; and, the experience of the lecturer's more than thirty years of manic-depressive illness in herself and in her family. The difficulties of functioning within a professional world—especially one with clinical privileges and teaching responsibilities—while at the same time experiencing episodes of mania and severe depression will also be discussed. So, too, will the consequences of having written and lectured about these issues in public settings. The advantages and disadvantages of treating and studying an illness that is of personal as well as professional interest will be presented, as will the issues of dealing with impaired physicians and others in the public trust.

Finally, the regrets and pleasures of living a life in moods will be reviewed.

REFERENCES:

1. Goodwin, FK, Jamison KR: *Manic-Depressive Illness.* Oxford University Press, New York, NY, 1990.
2. Jamison KR: *Touched With Fire: Manic Depressive Illness and the Artistic Temperament.* Free Press Macmillan, New York, NY, 1993.
3. Jamison KR: *An Unquiet Mind: A Memoir of Moods and Madness.* Alfred A. Knoff, New York, NY, 1995.

LECTURE 17
APA'S SOLOMON CARTER FULLER AWARD LECTURE

David Satcher, M.D., Ph.D., *Director, Center for Disease Control, 1600 Clifton Road, Mail Stop 14, Atlanta, GA 30333*

LECTURE 18
MENTAL HEALTH CARE IN THE NEXT MILLENNIUM: WHAT DOES THE FUTURE HOLD?

Steven M. Mirin, M.D., *Medical Director Designate, American Psychiatric Association, 1400 K Street, NW, Washington, DC 20005*

SUMMARY:

Growing pressure to reduce the cost and manage the delivery of mental health care has fostered the spread of managed care, capitated reimbursement, and the development of integrated delivery systems. As these trends evolve corporations, not clinicians and patients, are increasingly controlling where, how, and by whom mental health care is being delivered. Reconfiguration of the mental health care delivery system is also shaping estimates of the future need for psychiatrists and placing federal support for psychiatric training in jeopardy. These developments have profound implications for individual psychiatrists, the patients they serve, and for our profession.

As we prepare to enter the next millennium, the effectiveness of organized psychiatry in addressing these issues will have a profound impact on the role of psychiatrists practicing in both institutional and community settings, and on the level of federal support for psychiatric training and research. This lecture will focus on some of the key initiatives that organized psychiatry can pursue to confront these trends in an effort to ensure a brighter future for our patients, their families, and our profession.

REFERENCE:

1. Mirin SM, Sederer LI: Mental Health Care: Current Realities, Future Directions. *Psychiatric Quarterly* 65(3), 1994.

LECTURE 19
PSYCHIATRIC REFLECTIONS ON THE RIGHT TO DIE

Louis Jolyon West, M.D., *760 Westwood Plaza, Los Angeles, CA 90024*

SUMMARY:

The "right to die" is being discussed in venues ranging from the theater to the hospital; from the legislature to the cathedral; from the classroom to the police station. Broadly considered, the topic included: 1) refusal of vital medical care; 2) termination of life-sustaining medical care; 3) euthanasia; and 4) assisted suicide. Inevitably, psychiatric considerations are prominent in these discussions. For example, scenarios for physician-assisted suicide (such as the Dutch model) require that a determination be made as to whether or not the patient is depressed. If he is not depressed, he can be helped to commit suicide. But, if he is found by a psychiatrist to be depressed, he cannot be assisted. What then? Should the psychiatrist cure the patient's depression so that he can be put to death?

Another aspect of this model is that the candidate for physician-assisted suicide must be suffering from a mortal illness, preferably one causing great pain or disability. However, a normal person might be expected to experience some depression under these conditions. How much depression would be too much? How much would be too little? These and many other questions emerge from inspection of the "right to die" controversy from the psychiatric point of view. It is that perspective which this paper will address.

REFERENCE:

1. West LJ: Reflections on the Right to Die. In: Leenars AA (ed.), *Suicidology.* Jason Aronsen, Inc., Northvale, NJ, 1993.

LECTURE 20
APA'S ADOLF MEYER AWARD LECTURE
THE DEVELOPMENTAL AND PHYSIOLOGICAL BASIS OF SCHIZOPHRENIC SYMPTOMS

Professor Robin M. Murray, M.B., *President, Association of European Psychiatrists, Department of Psychological Medicine, Institute of Psychiatry, De Crespigny Park, London SE5 8AF, England*

SUMMARY:

Recent research demonstrates that early onset schizophrenia has its origins in neurodevelopmental impairment. In familial cases, this appears secondary to a genetic defect in the control of the development of normal cortical asymmetry. In other cases, early environmental hazards appear to play a role: for example, perinatal hypoxia may result in increased ventricular size and decreased hippocampal volume; prenatal exposure to viral infections such as influenza also conveys an increased risk of later schizophrenia. We postulate that the dysplastic neural network which is established results in pre-schizophrenic children showing delayed milestones, lower I.Q., anxiety and poor peer relations; minor psychomotor and language problems are particularly common. However, it is not clear whether these abnormalities are an intrinsic part of the schizophrenic process or are instead risk factors for it (i.e. whether schizophrenics are "doomed from the womb" or whether a cascade of risk factors is necessary, each amplifying the deviance until the psychosis develops). Recent functional imaging studies suggest that auditory hallucinations result from a mislabelling by the patient of their own 'inner speech' as external voices, and that this is consequent upon dysfunctional connectivity between the frontal and temporal centres of the brain. It is perhaps not surprising that a disorder of 'inner speech' should be particularly common in those who as children had difficulty in acquisition of language skills.

REFERENCE:

1. Damasio AR: *Descartes' Error: Emotion, Reason and the Human Brain.* Grosset/Putnam, New York, 1994.

LECTURE 21
MANAGEMENT OF HIV INFECTION FOR THE YEAR 1997

J. Allen McCutchan, M.D., *Professor of Medicine, UCSD, 2760 Fifth Avenue, Suite 300, San Diego, CA 92103*

SUMMARY:

Recent developments in the epidemiology, pathogenesis, clinical manifestations (with emphasis on neurology and psychiatry), and management of HIV infection will be reviewed. The impact of new technologies for measuring HIV in plasma and of new therapies (protease inhibitors and non-nucleoside RT inhibitors) dramatically changes the outlook for patients. Intensive therapy leading to total suppression of viral replication for several years might theoretically eliminate all HIV from patients. Studies to examine this possibility have been started recently.

The new era of antiretroviral therapy is reflected in lower incidences of opportunistic infections and tumors, hospitalization, and death in the U.S. and Europe. The durability of these responses may be limited by development of resistance to the new drugs which is more likely if compliance is poor. Several new psychosocial problems have emerged as patients realize that long-term survival is now a probability. Patients who have neglected their finances and careers find they may now face the long-term consequences.

Both neurocognitive impairment and psychiatric morbidity and mortality remain important problems in HIV-infected patients and may become more prevalent as survival improves. Understanding of barriers to effective treatment such as non-compliance with antiretroviral medications has emerged as an important issue on which psychiatric research should be focused. Overall, the need for psychiatric care and research has been increased as recent treatment advances turn HIV infection into a more chronic condition.

REFERENCE:

1. Williams WM, Whalley AS, Comacchio RM, Rosenberg J, Watta RA, Isenberg DA, McCutchan JA, Morrow WJ: Correlation Between Expression of Antibodies to Histone H2B and Clinical

Activity in HIV-infected Individuals. Clin Exp Immunol 104:18-24, 1996.

LECTURE 22
TRANSLATING SCHIZOPHRENIA RESEARCH INTO PATIENT ADVANTAGE

Carol A. Tamminga, M.D., *Maryland Psychiatric Research Center, P.O. Box 21247, Baltimore, MD 21228*

EDUCATIONAL OBJECTIVE:

To enlighten participants on the advances of schizophrenia research in all areas of study: diagnosis, genetics, in vivo imaging, drug treatments, psychosocial interventions and neurosciences, and to inform them of how these advances work to the advantage of patients.

SUMMARY:

Advances in schizophrenia research are occurring in all areas of its study: diagnosis, genetics, *in vivo* imaging, drug treatments, psychosocial interventions, and in the relevant basic neurosciences. Within each scientific area, findings are being avidly pursued and enthusiasm is at its highest in the last century. Yet the translation of the findings within any area to other scientists, other clinicians, consumers, and the interested public has been lagging. In this talk, I will present clinical and preclinical data from our laboratory with implications for understanding schizophrenia. Specifically, we have used the effect of phencyclidine (PCP) on immediate early genes (IEG) expression in rat brain to successfully suggest the localization in human brain (normal and schizophrenic) or regional cerebral blood flow (rCBF) changes with ketamine and the correlation of these rCBF changes with psychotic symptoms. We have compared ketamine-induced mental status changes and associated rCBF alterations between normal and schizophrenic persons to identify brain areas related to psychosis. In addition, we have compared normal and schizophrenic persons in these areas while performing a mental task to understand regional functional differences in schizophrenia with mental activity. In these paradigms, schizophrenic persons demonstrate abnormalities in rCBF in anterior cingulate cortex; moreover, different kinds of shcizophrenic manifestations look different on rCBF. This observation has led us to examine the anterior cingulate for effects of antipsychotic drugs and for changes in postmortem tissue. Particular effort will be devoted to articulating the implications of these data for the function and treatment of persons with this illness. The application of these findings to antipsychotic drug development, to CNS localization of clinical symptoms, and potentially to long-term rehabilitation will be made. The importance of strategies to facilitate the translation of these kinds of research findings to other audiences will be emphasized.

REFERENCE:

1. Tamminga CA: Gender and Schizophrenia. *J Clinical Psychiatry* (in press), 1996.

LECTURE 23
APA's SEYMOUR D. VESTERMARK AWARD LECTURE
THE THREE Rs OF PSYCHIATRIC EDUCATION

Jonathan F. Borus, M.D., *Professor of Psychiatry, Brigham and Women's Hospital, 75 Francis Street, Boston, MA 02115*

SUMMARY:

To prepare psychiatrists for the changing practice environment of the 21st century, we must rethink the "Three Rs" of psychiatric education: reading (the learning process), 'riting (the teaching process), and 'rithmetic (funding the educational enterprise).

Reading, the prototypic method of gaining new knowledge, must be supplemented by active learning strategies including small group, problem-oriented learning, supervised clinical encounters with a multitude of patients in different settings, and interactions with computer databases and other technologic learning tools. Writing as a method of conveying knowledge must be joined by new faculty teaching roles including on-site, contemporaneous supervision and demonstration of efficient ways to assess and treat patients, direct evaluation and feedback of the clinical learner's performance, and constructive mentoring of trainees in effective ways to convey ideas through teaching and publishing. The changing arithmetic of diminished financial rewards, fewer students entering psychiatry, and decreased funding for psychiatric education should focus our efforts on fostering the unique helping skills of psychiatrists, collaborating with non-psychiatric physicians and alerting payors, insurers, and health system administrators to the "value" which integrated health and mental health care can add to improving quality and controlling health costs.

REFERENCE:

1. Borus JF: Teaching and Learning Psychiatry. *Academic Psychiatry* 17(3):3-11, 1993.

LECTURE 24
APA's ADMINISTRATIVE PSYCHIATRY AWARD LECTURE
PSYCHIATRIST AS DIRECTOR IN THE PUBLIC MENTAL HEALTH SYSTEM

Stuart B. Silver, M.D., *Mental Hygiene Administration, 201 West Prestor Street, Baltimore, MD 21201*

SUMMARY:

Maryland requires that the Director of the Mental Hygiene Administration be a psychiatrist, but few of the daily challenges tap clinical skills directly. The task is one of prioritization, strategy, tactics, and delegation—of getting each of thousands of individual employees to produce their best efforts towards achieving the treatment and program goals.

Being a **psychiatrist** gives one a head start on understanding something about mental illness, about listening, about interpreting, about being respectful of others, about not intruding on people's work, about being an agent of frustration while trying to help.

As a **physician** one has learned to process enormous amounts of data in a short time to reach decisions with far-reaching effects and to tolerate the tenuousness of this process. It is an advantage to have some understanding of the workings of the human body; the linkage of mental process and physiology, to experience illness–causing death, and to learn to accept a high level of accountability for events over which one has limited influence.

Psychiatry the discipline, permeates all aspects of public mental health; but psychiatrists' individual roles are variable. Psychiatrists have skills which would give them an advantage, but that will not be enough. Very few of these jobs **must** have a psychiatrist at the helm. We have to earn them in a competitive marketplace and to discharge these responsibilities **well** when we have the opportunity.

REFERENCE:

1. Talbott JA, Hales RE, Keill SL: *Textbook of Administrative Psychiatry*. American Psychiatric Press, Washington, DC, 1992.

LECTURE 25
RECURRENT UNIPOLAR MAJOR DEPRESSION IS A LIFELONG ILLNESS THAT REQUIRES LIFELONG TREATMENT?

Martin B. Keller, M.D., *Brown University, Mary E. Zucker Professor and Chairman, Department of Psychiatry and Human Behavior, Butler Hospital, 345 Blackstone Blvd., Providence, RI 02906*

SUMMARY:

The past 15 years have witnessed phenomenal scientific progress in our understanding of the long-term course and treatment of recurrent unipolar major depression. The prevailing belief in 1997 is that most patients suffering from recurrent unipolar major depression should be treated with a regimen of maintenance antidepressant pharmacotherapy, with or without adjunctive psychotherapy, for a minimum of three to five years, or for the remainder of their lives. This is in dramatic contrast to the dominant teaching in the mid-1980's, which was to treat most patients with recurrent unipolar major depression with antidepressant medication for four to six months after recovery from an episode of depression and to then taper them off medication. Remarkably, despite current recommendations, less than 10% of patients suffering from depression in the United States today receive the proper medication in sufficient duration and dosage.

This presentation will critically evaluate the longitudinal prospective naturalistic research, and controlled randomized neuropsychopharmacologic continuation and maintenance clinical trials published in the past 15 years that are the basis for recommending long-term, if not lifelong treatment, for recurrent unipolar major depression.

The goal will be to critique the validity of the evidence for recommendations about long-term and lifelong treatment and to suggest future research to resolve unanswered questions, including addressing the reasons why depression remains such a vastly undertreated illness.

REFERENCE:

1. NIMH/NIH: Consensus Development Conference Statement. Mood Disorders: Pharmacologic Prevention of Recurrences. *Am J Psychiatry*, 142(4):469-476, 1985.

MEDIA PROGRAM

1: LEAVING LAS VEGAS

EDUCATIONAL OBJECTIVES:

At the conclusion of this film, the participant should be able to recognize the destructive effects of progressive alcoholism on a person's sense of self as well as the dynamics of intimate relationships affected by alcoholism and emotional neediness.

PROGRAM DESCRIPTION:

Leaving Las Vegas is a graceful, unrepentant portrait of an alcoholic in the end stages of self-destruction and of the depressing yet graceful relationship that surrounds that end.

Nicolas Cage as Ben Sanderson is a Hollywood screenwriter whose alcoholism has affected the loss of relationship with his wife and child, his job and his friends. He burns his belongings and drives to Las Vegas planning to drink himself to death.

While there, he meets Sera (Elizabeth Shue), a prostitute whom he initially engages for money, though because of the effects of alcohol, Sanderson's attempt to have sex is a failure. When Sera loses her pimp, Uri (Julian Sands), she and Ben begin a relationship to keep loneliness at bay. She promises never to ask him to stop drinking and he promises he will never ask her to stop hooking.

This couple's love is a "moving, depressing tale in which love redeems but does not save." Directed by Mike Figgis, who also wrote the score and played the keyboard and trumpet on a wonderful, moody soundtrack, the film is an uncompromising picture about alcoholism and "two wounded, desperate, marginal people and how they create for each other a measure of grace." It won Cage a best-actor Oscar for his performance.

2: VIDEO CASEBOOK OF PSYCHIATRY

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be able to use the *Video Casebook of Psychiatry* to enhance his/her teaching of psychopathology and psychiatric diagnosis.

PROGRAM DESCRIPTION:

This *Video Casebook of Psychiatry* contains eight video cases that illustrate a variety of common psychiatric diagnostic categories. Each case is approximately 4–10 minutes in length, and should contain enough information to arrive at a specific DSM-IV diagnosis. The video cases have been taken from the *Pass the Boards!* set of videotapes that have been used by thousands of psychiatrists preparing for their oral board examination. These video cases can be used for a variety of purposes: They will be useful for teachers who wish to illustrate certain forms of psychopathology and arrive at specific psychiatric diagnoses consistent with the DSM-IV. A specific targeted audience is teachers of undergraduate and graduate students studying psychology. They will also be useful for the students who may wish to have the diagnoses "come to Life" on video so as to illustrate the psychopathology about which they have read in the textbooks. They will remain of value to professionals studying for their specialty examinations, such as the psychiatry boards where half of the oral examination involves an examination on material contained in a videotape of a patient. An additional suggested use of the videotape is to illustrate interviewing techniques that demonstrate how to elicit historical information important in establishing a diagnosis. *The Video Casebook of Psychiatry* comes with a manual that includes a brief summary of the patient's history followed by a discussion of the psychopathology and the diagnosis.

3: ETHNOCULTURAL PSYCHOTHERAPY

EDUCATIONAL OBJECTIVES FOR TWO VIDEOTAPES:

At the conclusion of this presentation of videotapes three and four, the participant should be able to describe patient behaviors that the clinician faces in real-world clinical settings.

PROGRAM DESCRIPTION:

Two psychotherapy videotapes were selected from a psychotherapy videotape series by the American Psychological Association. The goal of each videotape is to present an unrehearsed session that captures the theoretical approach and clinical style of the particular psychotherapist. Toward this end, a number of steps were taken to ensure that both the therapist and the client were anchored, conceptually and experientially, in the clinical material, each other, and previous sessions. First, therapists provided the type of patient, problem, and presentation with which they typically work. Second, a client profile was developed that included demographic data., clinical history, and presenting problem, precipitating event, and other background information.

The videotaped session will demonstrate ethnocultural psychotherapy which was developed by Lillian Comas-Diaz and Frederick M. Jacobsen in order to integrate human diversity into clinical practice. This eclectic approach acknowledges the concept of self as an internal ethnocultural representation. The recognition, recovery, and use of the client's strengths constitute central tenets in this framework.

4: COGNITIVE-BEHAVIOR THERAPY

PROGRAM DESCRIPTION:

Jacqueline B. Persons, Ph.D. is featured as the therapist on this videotape. Dr. Persons provides clinical and research training to psychologists and psychiatric residents and conducts research on cognitive processes underlying depression and anxiety and on case conceptualization in cognitive-behavior therapy. This psychotherapy approach emphasizes the use of case conceptualization to guide the therapist's use of standard cognitive-behavioral interventions. A case formulation includes a description of the patient's overt problems as well as hypotheses about some of the core beliefs (schema) that drive and maintain both the overt problems and the patient's mode of responding to and coping with the overt problems. This psychotherapy approach will be demonstrated in this documentary.

5: BOYZ IN THE HOOD

PROGRAM DESCRIPTION:

Boyz in the Hood is a powerful drama about coming of age in black, urban America and marks the feature film-writing and directing debut of 23-year-old John Singleton. It tells a poignant story about the community where Singleton was raised, of three friends growing up in South Central Los Angeles neighborhoods, and of street life where friendship, pain, danger, and love combine to form reality.

6: PSYCHOTIC DISORDERS

7: ANXIETY DISORDERS

8: MOOD DISORDERS

EDUCATIONAL OBJECTIVES FOR ALL THREE TAPES:

At the conclusion of this presentation, the participant should be able to identify and discuss the new diagnostic issues related to the three psychiatric diagnoses presented in the videotapes.

PROGRAM DESCRIPTION FOR ALL THREE:

This series of three clinical programs reveals additions and changes from DSM-III-R to DSM-IV for mood, psychotic, and anxiety disorders. Each videotape focuses on a particular area of psychiatric diagnosis and contains enactments of three outstanding clinicians' actual patient interviews. Nancy C. Andreasen, M.D., Andrew H. Woods Professor of Psychiatry, University of Iowa College of Medicine, is the interviewer for *Psychotic Disorders;* Andrew E. Skodol II M.D., Associate Professor of Clinical Psychiatry at the College of Physicians and Surgeons of Columbia University, is the interviewer for *Anxiety Disorders;* and Ellen Frank, Ph.D., Professor of Psychiatry and Psychology at the University of Pittsburgh School of Medicine, is the interviewer for *Mood Disorders.* Each videotape begins with an introductory discussion between the clinician and the moderator. The clinician then conducts three 10-minute psychiatric diagnostic interviews. Following each interview, the clinician and the moderator discuss the taped segments and comment on issues illustrated during the interviews. Including how the DSM-IV diagnostic criteria were utilized in the interview, how diagnostic markers were elicited, and how interpersonal issues and diagnostic markers were identified. The interviews use reference data to examine conclusions reached during the patient interviews. Each tape also demonstrates good interviewing techniques and highlights the development of a positive doctor/patient relationship.

9: BELLE DE JOUR-BUNEL

PROGRAM DESCRIPTION:

Acclaimed actress Catherine Deneuve stars in this 1967 film as a woman who leads a secret double life of a prostitute by day and a caring, nurturing wife by night. Luis Bunuel directed this emotional look at the sensuality and love a woman expresses to both her clients and husband.

10: LITTLE ITALY

PROGRAM DESCRIPTION:

An eclectic collection of characters and personal anecdotes are the highlights of this rewarding gem of a documentary. Poignant tales of immigration and assimilation; memories of tender mothers with indomitable spirits; and the music, art, and food of Italian-American culture are vividly recounted by men and women who grew up in the Little Italys of North Beach in San Francisco and the Arthur Avenue section of the Bronx, including such personalities as August Coppola, Diane di Prima, Lawrence Ferlinghetti, and Chazz Palminteri. By tackling thorny questions about ethnic identity with candor, passion and pride, the Italian-Americans of Little Italy pay tribute to their forbears and lovingly acknowledge how the traditions of a rich and unique culture have informed their lives.

11: STOLEN GROUND

PROGRAM DESCRIPTION:

In this 45-minute documentary six Asian-American men describe how racism has impacted their lives. Through these seldom-seen portraits of so-called "model minority's" lives, the men share their pain, anger, and struggle for acknowledgment.

They talk poignantly and sometimes angrily about the lack of positive media images of Asian men and of their desire for whites in America to become more aware and "unconditionally accept" the experiences that Asian-Americans have had. They talk of their need to endure to survive in this country, of overachieving, of the stereotypes they face and disparaging remarks they hear, of the experiences of gay Asian-Americans and of at the risks they face when they confront the racism in today's society. They talk about the need to get rid of racism; to "not let racism slide anymore, to call people on it." There is resolve to confront racism against Asian-Americans to join as allies with others fighting against racism.

12: RESTLESS MINDS, RESTLESS KIDS

PROGRAM DESCRIPTION:

Attention-deficit/hyperactivity disorder is the most commonly diagnosed neurobehavioral problem in childhood and adolescence. Various workers have suggested that as many as one in 10 American youngsters may have symptoms (principally inattention, distractibility, and psychomotor hyperactivity) severe enough to impair normal social and academic development. Untreated, ADHD is often associated with school or vocational difficulties, substance abuse, affective disorders, antisocial behavior, or other significant psychological disability. Despite an extraordinarily large research base documenting ADHD as a neuropsychiatric disorder that responds to appropriate treatment, public and even professional controversy surrounds ADHD. A spirited debate cyclically appears in the media regarding the prevalence and treatment approaches to the disorder. In *Restless Minds, Restless Kids,* Drs. C. Keith Conners and John S. March, both specialists in childhood externalizing and internalizing disorders, discuss the state-of-the-art approach to diagnosing and treating ADHD. They are joined on tape by four mothers of ADHD-affected children who share their experiences, especially the effects of this disorder on family life. *Restless Minds, Restless Kids* was produced in broadcast style, and is appropriate for a wide ranging-audience, from medical students to parent support groups.

13: THE TROUBLE WITH EVAN

PROGRAM DESCRIPTION:

As early as age 4, Evan was exhibiting serious behavior problems. Now at age 11, he has been caught drinking beer, smoking, stealing money, and committing arson. His parents and teachers cannot control him and fear that he is on a criminal path.

With the family's permission, cameras were placed in Evan's home to record three months of painful and intimate moments of family conflict. The footage details intense verbal and emotional abuse of Evan, revealing that Evan's troubles can be traced back to his parents. We see the raw emotions of an enraged father, as he yells, cuffs, swears at his son, and tells him he is no longer part of the family. Rarely have scenes like this been captured on camera.

Intercut with these scenes of family strife are excerpts of therapy sessions of five young offenders at a juvenile correction center. Their

memories of emotional abuse have much in common with Evan's experience.

14: ADDICTED TO SPEED

PROGRAM DESCRIPTION:

This is a short documentary about the growing problem of adolescents and driving at a high rate of speed.

15: THE COLOR OF FEAR

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should be able to identify areas in which racism has directly affected him/her and those around him/her; empathize with others, both minority and non-minority, about the toll of racism; and feel more empowered to raise issues of racism at home and at work.

PROGRAM DESCRIPTION:

The Color of Fear is a film about the state of race relations in America, as experienced and described by eight men of African, Asian, Latino, and European descent. One by one the men reveal the pain and anguish that racism has caused them. Out of these confrontations and struggles toward understanding and trust emerges an emotional and insightful portrayal of the type of discussion most of us fear, but hope will happen sometime in our lifetime.

16: COMPUTERIZED MEDICAL RECORDS IN PSYCHIATRY

Gerald Segal, M.S., *New York State Psychiatric Institute, 722 West 168th Street, Unit 18, New York, NY 10032.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the following issues regarding psychiatric electronic medical records: methods of accessing information; aiding quality control; providing patient information security; and exchanging information with other systems.

PROGRAM DESCRIPTION:

Integral to the success of psychiatric health care delivery is the development of electronic medical records. A psychiatric electronic medical record system should encompass the special attributes of psychiatric treatment and be relevant to research, which plays an important role in the improvement of clinical care. An electronic medical record system must also be able to share medical data effectively within the home institution and have the ability to communicate medical information to systems in the city, state, national and international arenas. At the same time, proper security must by provided to maintain patient confidentiality. These requirements present a challenge to the developer and user.

17: COMPUTERIZED RECORD KEEPING IN PSYCHIATRY

Theron C. Bowers, Jr., M.D., *10600 Fondren 217, Houston, TX 77096;* Rick Marinko.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize barriers to establishing a computer-based record-keeping system as well as recognizing benefits and areas for using a clinical electronic database system in a psychiatric practice.

PROGRAM DESCRIPTION:

Although the computer is a common tool in many psychiatric practices, its use remains confined to primarily administrative jobs such as billing and scheduling. Since they are in a cognitive based specialty with a primary task of collecting and evaluating patient information, electronic database management has numerous potential benefits for psychiatrists in all areas of practice. This presentation will explore issues regarding computerized clinical database management in psychiatric practices.

This program will examine potential barriers and challenges to maintaining electronic records. The presentation will also illustrate the benefits and goals of an efficient computerized clinical system by demonstrating a patient-tracking computer program based on a relational database. Using this program, we will show the basic requirements of a patient-tracking system, such as records of progress notes, mental status examinations, and medications. We will also demonstrate more advanced and specialized features such as tracking a patient's progress and monitoring medication side effects.

18: FROM DANGER TO DIGNITY: A FIGHT FOR SAFE ABORTION

PROGRAM DESCRIPTION:

From Danger to Dignity: A Fight for Safe Abortion weaves together two parallel stories: the evolution of underground networks that helped women find safe abortions outside the law, and the intensive efforts by activists and legislators who dedicated themselves to legalizing abortion. Archival footage brings history alive by documenting the actions of those who broke the silence and challenged the laws.

19: SOUTH ASIANS AND DOMESTIC VIOLENCE

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize cultural factors underlying why South Asian women stay in abusive situations; identify why the classic model for understanding domestic violence may not apply to South Asian women; and make culturally appropriate interventions.

PROGRAM DESCRIPTION:

In the past 20 years, the battered women's movement in the U.S. has been successful in raising public awareness about domestic violence and in establishing a nationwide network of shelters for survivors. However, women of color, including South Asian women, continue to be significantly underrepresented at service agencies for battered women.

Through interviews with Indo-American survivors of domestic violence as well as several staff members of a South Asian crisis Line, this video elucidates some of the cultural factors that correlate with spousal abuse in the South Asian community. To provide culturally competent diagnosis and treatment, clinicians must take into account the following issues that are salient for South Asian women: arranged marriage as a permanent alliance of families; protecting family/cultural group from outsiders; saving family from shame within cultural group; importance of social/familial duties and responsibilities over individual rights; religious/spiritual paradigms (e.g. law of karma); severe social stigma attached to divorce.

20: RAPE BY ANY NAME

PROGRAM DESCRIPTION:

A woman is raped every six minutes in the United States. Acquaintance rape constitutes more than 60 percent of all rapes, yet it is

rarely reported and difficult to prosecute. *Rape by Any Name*, a powerful documentary, explores this complex issue. Weaving the stories of three acquaintance rape survivors with the views, attitudes, biases, and understandings of experts and professionals, as well as with those of ordinary people, including high school and college students, it exposes a number of underlying beliefs that heighten the divisiveness surrounding acquaintance rape. Also included is a very effectively staged mock trial based on a real case of acquaintance rape. The discussions in this video raise hard questions about how different elements of our society play into the problem: male and female socialization, inadequate legal recognition, and assumptions about the victim's culpability. *Rape by Any Name* is an excellent resource for exploring this pervasive and complicated issue.

21: ROUND EYES IN THE MIDDLE KINGDOM

PROGRAM DESCRIPTION:

Round Eyes in the Middle Kingdom is a documentary that tells the story of the Caucasian residents of China from the 1930s to the present. It follows a family of Westerners who fled China as the revolution spread in 1949 but focuses on one Caucasian man who stayed, a Russian Jew who joined Mao's revolution and decided to become a Chinese citizen. Why Israel Epstein joined the communist revolution that forced most foreigners to flee, why he remains in China after five years of solitary confinement in the 70s, and what his life is like today as China's leading foreign journalist are central questions this film answers. As a personal documentary, *Round Eyes* is narrated by a film maker who was born in China but taken to America at age 10. Compelled to understand the motives of a man who was his father's closest friend, he returns 45 years later to discover Epstein's fate, to make his film, and to reconcile his own comfortable, colonial childhood with the famines and suffering that led to the Chinese revolution in the first place.

22: SUZANNE BONNAR: THE BLACKSBURG CONNECTION

PROGRAM DESCRIPTION:

Suzanne Bonnar was the first black baby to be born in a small seaside town on the west coast of Scotland. Her mother lived near an American military base and fell in love with her father, an African-American serviceman. She had not seen her father since she was two years old, and was brought up in an all-white community.

Twenty-six years later, longing to meet her father, she contracted with an organization that specializes in uniting families of servicemen. Her unique and moving voyage of discovery began in a railroad station in London where, for the first time as an adult, she met her father.

Together with her father she journeyed to South Carolina to meet her extended family, including three half brothers she never knew existed. Suzanne felt immediately at home with her black family as they welcomed her into their lives. In Scotland she was known as a blues singer with a powerful, vibrant voice. Now, in a stirring scene, we see her singing in a Southern church with all the fervor that spiritual music inspires.

23: NONE OF THE ABOVE

PROGRAM DESCRIPTION:

None of the Above is a documentary about people of mixed racial heritage based on the film maker's own search for identity and community. Erika Surat Andersen, whose mother is (Asian) Indian and father is Danish American, explores her "own personal hangup" by finding others in the same ambiguous category. Through her journey into the multiracial world, we are given an inside view of the emotional reality of what it's like to be racially unclassifiable in a society obsessed with race.

We meet Leslie, a young woman of Native-American, African, and European ancestry; Curtiss, whose mother is Japanese and father is African American; and Henrietta, whose family has been mixed for at least six generations and defies all categorization. The film maker's openness about her own experience makes this film emotionally compelling and particularly relevant in today's multicultural society.

24: OUT OF MY MIND

PROGRAM DESCRIPTION:

Out of My Mind is an intimate portrait of 23-year-old John Cadigan, the film maker's brother who became seriously mentally ill while he was an art student at college. Soon after his first psychotic break John asked his sister, the film maker and his primary caretaker, to document his story. Filmed over three years, the siblings narrate the story of painful deterioration despite various therapies.

Rarely has the family experience of the early stages of schizophrenia been articulated so clearly. John's acute self awareness and his intense art work make him the ideal subject. He describes what it is like to be labeled psychotic, to become catatonic, and to feel like part of your mind is working against you. Day to day, John struggles with a steady stream of paranoid and violent thoughts.

John continues to battle his illness, which has now been diagnosed as schizoaffective disorder. Obtaining an accurate diagnosis, medical benefits, and housing were part of the arduous process of searching for help. Despite multiple hospitalizations he tries to lead as normal a life as possible, relying on the love and support of his family.

25: BACK FROM MADNESS: THE STRUGGLE FOR SANITY

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to appreciate the complexities of biological psychiatry.

PROGRAM DESCRIPTION:

Back From Madness provides a view of the world of insanity that few ever see, a world that is not traditionally dealt with in television. It is a chronicle of four psychiatric patients and contexualizes their present-day treatments with footage gathered from the archives of the American Psychiatric Association and the Netherlands Institute for Mental Health. The film follows each individual for one-to-two years, from the time they arrive at Harvard's Massachusetts General Hospital and affiliated Erich Lindemann Mental Health Center. On one level, it's a film about psychiatric treatment at a great medical center. On another level, it's about the patients and the inner strength that is required of them as they search for some relief from their insanity.

The film was made to provide an accurate document of psychiatric treatments and secondly to depict the plight of patients in clear, albeit sometimes painful, detail. The film suggests that severe mental illnesses like schizophrenia, bipolar disorder, obsessive compulsive disorder, and severe unipolar depression are due, in large measure, to a biological dysregulation of the brain. The film also documents the great struggle faced by patients, their families, and their doctors. A struggle that is most difficult in light of the lack of clear-cut

remedies, the social stigma, and blame associated with the illnesses and the diminishing resources available for the mentally ill.

26: JOE PASS IN CONCERT

PROGRAM DESCRIPTION:

Joe Pass (1929-1994) was called "The Art Tatum" of the guitar for his dazzling combination of virtuosity and harmonic invention. It was only during the last 15 to 20 years of his career that his genius was recognized as an acoustic guitarist. His uniqueness can be best appreciated when he plays by himself—when you can witness his blazing technique and delight in the multiplicity of his themes and counterpoint. His solo performance sounds like a blending of an entire trio or quartet.

This recording presents an uninterrupted solo concert in Europe where he is considered to be "American standards." You will recognize all of the tunes, but you will be surprised and delighted by what Joe Pass hears and conveys.

27: STAN GETZ: VINTAGE JAZZ

PROGRAM DESCRIPTION:

"The Lush Life—Jazz and Addiction. Stan Getz." For so many years Stan Getz was at the top of the jazz polls for his tenor saxophone playing, yet was abusing alcohol and narcotics almost continuously. How could he be so drugged and inebriated and out of control one day, and then go on to perform a series of beautiful, balanced, and creative masterpieces the next? We will discuss this question, as well as the music itself, after viewing a video (1983) of Stan Getz playing standard jazz and bossa nova pieces for which he was renowned. The quartet includes Victor Lewis (drums), Marc Johnson (bass), and Jim McNeely (piano).

28: BEDSIDE CLINICAL DATABASING: USING THE HAND-HELD, PEN-ENTRY COMPUTER

James J. Strain, M.D., *Department of Psychiatry, Mt. Sinai Medical Center, 1 Gustav Levy Place, New York, NY. 10029;* Jeffrey S. Hammer, M.D., George Fulop, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to enter, process, and print data for the medical record that includes clinical observations, narrative, and literature pertinent to a particular patient's record.

PROGRAM DESCRIPTION:

More effective methods of collecting, documenting, and recording clinical data are required in the medical/surgical setting. The notes need to have more pedogogic value as well as legibility. A software package for a hand-held computer with pen-entry capacity which follows a protocol, has been developed for the psychiatric setting.

This software system allows accurate documentation and mandates key variables that must be included, e.g., employment, education, and previous illnesses, and decreases the collection time by 75 percent. In addition, a legible, computer-generated medical record chart note is automatically printed. In addition, letters to the referring physician, family, and insurance carrier, as well as the production of the patient record on a diskette in a text file can be provided to the patient at the close of the consultation. Pertinent literature selected from the database can augment the chart notes and serve as an additional pedogogic tool. This system has been field tested in 30 international sites and is available in Spanish.

29: GAF REPORT: COMPUTER-ASSISTED GAF ASSESSMENT

Michael B. First, M.D., *New York State Psychiatric Institute, 722 West 168th Street, Unit 74, New York, NY 10032;* Steven Stein, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be familiar with how a decision tree can be used to facilitate the making of an accurate GAF rating and how the GAF Report implements the decision-tree logic.

PROGRAM DESCRIPTION:

The GAF Report is a Windows-based expert system that assists a clinician in making a rating on Global Assessment of Functioning Scale (DSM-IV Axis V). Its increasing importance in determining eligibility for, and level of, care has made an accurate well-documented GAF rating essential. The first step is to select the time frame (e.g., lower level last week, highest past year). The second step is to narrow the GAF to a specific 10-point range by presenting questions that follow the algorithmic logic of a decision-tree designed to make a rating using in the minimum number of questions. The answers to the questions continually set an upper limit to the GAF rating until the final 10-point range is determined. For each question, precise definitions of terms as well as illustrative examples are provided. The process concludes with the user selecting the final GAF rating according to provided guidelines. By making multiple ratings over time, the GAF Report is used as means of tracking a patient's clinical progress. The GAF Report documents each rating with a detailed report containing the clinical evidence supporting the rating as well as an explanation of why a lower rating was not justified.

30: CONSULTANT FOR THE MEDICAL TREATMENT OF DEPRESSION

David N. Osser, M.D., *Department of Psychiatry, Harvard Medical School, 74 Fenwood Road, Boston, MA 02115;* Robert D. Patterson

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to demonstrate software that offers psychopharmacology consultation on patients with various kinds of depression: major, dysthymic, delusional, and bipolar I, II, and rapid cycling/mixed depression; and to promote recognition of the value of this medium for training, improving the consistency and effectiveness of patient care, and for outcome research.

PROGRAM DESCRIPTION:

This is an expert system for the medical treatment of depression. It is programmed in HTML language. The enclosed files require an Internet browser such as Netscape 2.0 or Microsoft Navigator in order to be viewed.

This program is a virtual psychopharmacology consultant: it asks the consultee questions about a patient and then, when enough information is supplied, displays detailed recommendations. Most question screens have "help" sections with definitions, criteria, differential diagnosis, or related advice. "Comment" screens appear at crucial points with additional explanations. References are numerous and are found on each screen. The consultee can go back and change previous answers to explore what the program recommends for other situations. With the advantages of HTML, there are links to accessory information for the prescribing clinician including tables of drug costs, cytochrome enzyme interactions, dosing instructions for adequate trials of specific drugs, and suggested strategies for tapering off old medications and starting new ones.

Users on the Internet can check to see when changes and additions to the algorithm have occurred, and click on links to see the changes

immediately. They can send comments and critiques to the developers at any time. All instructions for use are on screen.

31: ROSA PARKS: THE PATH TO FREEDOM

PROGRAM DESCRIPTION:

It has been only 40 years since the fateful day that Mrs. Rosa Parks refused to give up her seat on the bus, yet the chain of events that she set in motion has changed the world forever. In honor of this anniversary, Kingberry Productions (which produced *The Freedom Train*) has compiled a biography of this dynamic but quiet woman, whose demand for her civil rights led to the social changes of the 1960s. This documentary contains an overview of the events that took place in Montgomery, Alabama: Mrs. Parks' arrest, the bus boycott, and the segregation laws that were finally overturned. It also tells the story of the Rosa Parks that few people know—the former seamstress whose life continues to be committed to social justice for all people.

32: FICTION AND OTHER TRUTHS: A FILM ABOUT JANE RULE

PROGRAM DESCRIPTION:

This film profiles the life and work of novelist, essayist, teacher, and political activist Jane Rule. Blending interviews with archival footage and dramatic evocation's of Rule's writings, the documentary examines the author's lifelong interest in the intricacies and complexities of human relationships and communities, her continuing involvement in the struggle against censorship, and her conviction that we must all be able to live and love truthfully. The film traces Rule's formative years in the U.S., her move to Canada during the McCarthy era with her lifelong companion Helen Sonthoff, the sensational impact of the 1964 publication of her first (and openly lesbian) novel, *The Desert of the Heart,* (filmed 20 years later as *Desert Hearts*), her outspoken defense of *The Body Politic* newspaper throughout its many years of legal harassment, and her important contributions to the public debate about sexuality and representation. In recounting Rule's four decades of creative writing and political activism, the film allows us to share the evolution of her art and thought and the development of sexual, political, and ethical principles that are necessary for any compassionate and enlightened society.

33: OUT FOR A CHANGE

PROGRAM DESCRIPTION:

This important documentary explores the devastating emotional impact homophobia has on all women athletes, regardless of their sexual orientation. It features interviews with college athletes, coaches, students, and administrators; NCAA officials; and prominent professional athletes including Martina Navratilova and Zina Garrison-Jackson. The video shows how fears of being labeled a lesbian or a "dyke" prevent many young women from even participating in athletics. It also demonstrates that homophobia is a political tool used to retain male control over the multibillion-dollar women's sports industry. Produced by Dee Mosbacher.

34: OLD BAGS CLUB

PROGRAM DESCRIPTION:

A woman abandoned by her husband in middle-age for someone younger often has the sense that her future has been stolen from her. After long years of marriage, the prospect of being alone can be terrifying. When Sally Moon, an English aristocrat, discovered that her husband was flagrantly cheating with a much younger woman, her first reaction was to take spectacular revenge. Her mischief made local headlines.

Then she founded the Old Bags' Club for the legions of women worldwide, like herself, on the slow path back to self-esteem. Wary of male companionship, many have rediscovered the kinship they felt with other women before their marriage. These women share a determination not to be victims no matter how tough things get. *Old Bags' Club* is an inspiring and sometimes humorous look at women who share a common marital disaster.

35: DEPRESSION AND MANIC DEPRESSION

PROGRAM DESCRIPTION:

Depression affects over 17 million Americans each year. And it has been estimated that only one-third of them get any treatment, largely because of stigma and fear. That lack of treatment results in a high number of suicides, making this illness as fatal as any other illness and a serious epidemic. This program explains the disease through the experiences of several people, including CBS reporter Mike Wallace; psychiatrists and author of a book on her life with manic depressive illness, Dr. Kay Redfield Jamison; artist Lama Dejani; and State Department official Robert Boorstin. An overview of medications and therapy and a list of resources are also provided.

36: BEYOND STIGMA

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation the participant, should be able to discuss stigma and the role psychiatry should take to extinguish it; and to create an appropriate treatment milieu for compassionate ECT.

PROGRAM DESCRIPTION:

ECT's effectiveness has been documented in the psychiatric literature, yet the treatment is underutilized. Often its life-saving potential is not made available to patients because of the adverse stigma associated with the procedure. This videotape follows a patient and her family through ECT treatment. Her family is present throughout, including during the procedure itself. The patient and her family concur regarding the effectiveness of ECT and comment how this setting has made it more psychologically positive and less stigmatizing.

This video concludes that it is a simple matter for treating psychiatrists to undertake physical and structural changes in the treatment setting. It demonstrates the benefits and ease of family involvement. These changes argue forcefully for extinguishing the stigma that has plagued ECT for 40 years. These concepts should open a new epoch in which the providers of ECT are viewed as merciful, kind, and caring professionals while sacrificing neither skill nor adherence to ethical standards.

37: HARBOR OF HOPE

PROGRAM DESCRIPTION:

Harbor of Hope is narrated by Susan Sarandon and is a film that explores the essential role hope plays in healing. Produced by a young mother who was struggling with a devastating and progressive disease, this woman reached out to others who were living with AIDS, cancer, and MS to find some sense of hope and understanding. This video follows her journey into the darkest of places as well as to the discovery of one's belief system and the power of healing

one's own body. Now two years later, this same mother has stopped the progression of the disease and continues to heal.

38: BODY, MIND AND SPIRIT

PROGRAM DESCRIPTION:

A presentation of the National Institute for Healthcare Research exploring the link between spirituality and good health. Patients tell their own stories of recovery and improved health through the power of combined faith with medicine. Nationally recognized scholars, clinical research specialists and healthcare professionals share their findings and views on the relationship between spirituality and health.

39: PSYCHOTHERAPY IN THE HOLLYWOOD CINEMA

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe typical portrayals of psychotherapy in the movies; understand how movie portrayals affect the public's view of psychotherapy; and be aware of the ways in which movie portrayals of psychotherapy affect the treatment of patients.

PROGRAM DESCRIPTION:

In this session, a number of film clips will be shown that illustrate the way that Hollywood movies have portrayed the psychotherapy process. These films range from the 1930s to the 1990s. The portrayals rarely match what psychiatrists know to be a typical psychotherapy session. Screenwriters and directors have constantly struggled with ways to make psychotherapy more entertaining and more cinematic, and the results are often hilarious but also may be confusing to the public.

40: SOUTH CENTRAL LOS ANGELES: INSIDE VOICES

PROGRAM DESCRIPTION:

This is a powerful documentary that honestly and directly exposes issues of prejudice, racism, and class as they effect multicultural communities. Filmed by people living and working in the areas affected by the L.A. riots, it is a vivid portrayal of the complex urban tapestry where violence and hope live side by side. It has been broadcast all over the world to critical acclaim. Activist filmmaker Maxi Cohen decided the weapon of choice among the protagonists should be a video camera with which to film their lives. Their honest voices and strong images bring out issues of race and class with compassion.

41: FRANTZ FANON: BLACK SKIN, WHITE MASK

PROGRAM DESCRIPTION:

Frantz Fanon: Black Skin, White Mask explores for the first time on film on of the most influential theorists of the 20th century's anti-colonial movements. Fanon's two major works, *Black Skin, White Mask* and *The Wretched of the Earth*, were pioneering studies of the psychological impact of racism on both colonized and colonizer. Jean-Paul Sartre hailed Fanon as the figure "through whose voice the Third World finds and speaks to itself." This innovative film biography restores Fanon to his rightful place at the center of contemporary discussion around post-colonial identity.

Frantz Fanon (1925-1961) was born in Martinique into a lower-middle-class family of mixed-race ancestry and received a conventional colonial education. When he went to France to fight in the Resistance and receive his psychiatric training, Fanon's assimilationist illusions were destroyed by the specter of racism. The European intellectual tradition, he recalls, "had at first been a liberation returning me to a likeness I thought I had lost. By taking me out of the world, it returned me to it. But at the point I began to rise, I stumbled. The Other, with gestures and looks, fixed me in my place."

42: BEYOND IMAGINATION

Kemal Sagduyu, M.D., *Department of Psychiatry, University of Missouri, 600 East 22nd Street, Kansas City, MO 64108;* Zyed. Jaffri, M.D.

EDUCATION OBJECTIVE:

At the conclusion of this session, participants should be familiar with the background and basics of the Internet. They will be able to log-on to the Internet and browse efficiently. They will learn resources available to them on the Internet and learn how to utilize them effectively for academic and teaching purposes.

PROGRAM DESCRIPTION:

The Internet has great potential in psychiatric education, clinical care, research, and administration. Individuals and organizations will need to learn the basics of the Internet resources and make necessary and adjustments to maximize the usefulness of these resources.

Although brief, technical introductions were made into the Internet in previous years at the APA Annual Meetings, there still is need for more detailed explanations with live demonstrations to maximize learning. The purpose of this multimedia presentation will be to demonstrate downloading/uploading files, e-mail, news groups, Internet phone, and peer-to-peer networking. This will be followed by a demonstration of the televideo conference. Publishing activities available on the Internet followed by a step-by step demonstration of forming a Website publication will also be shown.

43: THE PHYSICAL CAUSES OF MENTAL ILLNESS

PROGRAM DESCRIPTION:

Introduced by NIMH Acting Director, Rex Cowdry, M.D., the video offers a glimpse into exciting NIMH-supported research bringing new hope to the one in 10 sufferers of mental illness in America. Abnormalities in the brain can now be seen. Stunning animations of brain circuits thought to be involved in mental illnesses like schizophrenia and obsessive-compulsive disorders show that these disorders have physical causes.

44: OUT OF THE SHADOWS AND INTO THE LIGHT: FROM STIGMA TO UNITY

PROGRAM DESCRIPTION:

This video reaches out to minorities and families of all people with mental illness, seeking to bring mental illness into the light of reason. Effective coping skills are discussed, stressing the importance of support groups and the National Alliance for the Mentally Ill.

45: FAMILIES COPING WITH MENTAL ILLNESS

PROGRAM DESCRIPTION:

This videotape shows people talking about their experiences with the mental illness of family members. It conveys, as no textbook can, their struggles and their wisdom. One theme is the profound importance of respectful, informative, and sensitive professional response—and its too frequent absence. Professionals in training

should see this tape. It is a powerful learning tool, particularly for social workers and others attempting to help families cope with mental illness. Many professionals, unfamiliar with what families experience, want more guidance in their relationships with families of their patients. Students in a variety of health professions will find the insights eye-opening.

46: A BRUSH WITH LIFE

PROGRAM DESCRIPTION:

A Brush with Life is a compelling and powerful portrait of Diane, a gifted artist struggling to free herself from mental illness through her art. The film, codirected by Martin Duckworth and Glen Salzman, was shot over two years at Montreal's largest psychiatric hospital, where an innovative art therapy studio was established for a small number of patients. For Diane, the studio was a door leading out of hell. The year she spent there dramatically changed her life. Diane discovered a way to liberate her inner self and to deal with multiple personality disorder brought on by a childhood of abuse. The ebb and flow of Diane's struggle invites the viewer to question his or her own insight into the delicate balance of the human condition. With haunting images and empathy, *A Brush with Life* is a moving portrait of an exceptional individual's search for well-being.

47: THE TEN COMMANDMENTS OF COMMUNICATING WITH PEOPLE WITH DISABILITIES

PROGRAM DESCRIPTION:

The key message of this video is to "lighten up" when communicating with people with disabilities. Even though the narrator has cerebral palsy, the video uses humor appropriately. By using him as host, the message is clearly conveyed that we can competently interact with people with disabilities just as we learn to interact with anyone. The humor extends to showing the video outtakes at the end and continues the learning point by showing persons with disabilities behaving in the same way anyone else would when recognizing bloopers. The 10 tips/commandments: 1. Speak directly to the person rather than through a companion or interpreter; 2. Always offer to shake hands when introduced; 3. Always identify yourself and others who may be with you when you are with someone who is blind; 4. If you offer assistance, wait until the offer is accepted and you receive instructions from the person; 5. Treat adults as adults; 6. Do not hang or lean against someone's wheelchair or cart or distract a working animal; 7. Listen attentively when talking with people who have difficulty speaking. Don't pretend to understand; 8. Place yourself at eye level when speaking with someone in a wheelchair; 9. Tap a person who is deaf on the shoulder or wave your hands to get their attention; 10. Don't be embarrassed if you use a common expression that may relate to a persons disability, such as "I see."

48: FUNNY, YOU DON'T LOOK SICK

PROGRAM DESCRIPTION:

An intimate documentary self-portrait, told with humor and compassion, of Susan Abod, a young woman living with chronic fatigue immune dysfunction syndrome (CFIDS) and multiple chemical sensitivities (MCS), or environmental illness. Susan describes in detail the nature of her illness (often disparagingly referred to as the "yuppie flu"), illustrates her daily routine, and gives us a guided tour of her environmentally "safe" apartment. Comments from Susan's numerous doctors and a visit with her CFIDS support group offer further insights in this illuminating, firsthand report on a baffling, late 20th century disease.

49: WHO OWNS MY LIFE?

PROGRAM DESCRIPTION:

This moving documentary has generated widespread public debate over the bioethical issue of doctor-assisted suicide, illegal in North America. It follows Sue Rodinguez, an attractive young mother, in her battle with ALS, amyotrophic lateral sclerosis. This disease was destroying her nervous system, causing her pain, and would ultimately lead to death by suffocation. This death, in her own words, was a "gruesome and unfair way to go." She made up her mind that when things became intolerable, she would commit suicide.

In Canada suicide is legal. However, Sue knew she would lose the physical ability to end her life as she became increasingly handicapped. With the support of the Right to Die Society, she and her lawyer mounted a legal challenge that quickly made her a symbol of the right to die cause.

This documentary goes behind the scenes to portray a gracious yet determined woman who allowed her personal pain to become public. Her case was debated and appealed before the Supreme Court of Canada. Although the plea lost by a narrow margin of 5 to 4, Sue had the satisfaction of putting the issue of how and when and who controls the way we die on the public agenda. In 1994, Sue had a peaceful, although illegal, doctor-assisted death.

50: FINDING AND USING SOFTWARE GEMS FROM THE INTERNET

Marvin J. Miller, M.D., *1315 West 10th Street, Indianapolis, IN 46202*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant, should be able to locate mental health software on the Internet, download it to his or her own computer, and test it out for use in clinical practice.

PROGRAM DESCRIPTION:

The Internet provides for easy distribution of mental health software in addition to the more widely known features of providing discussion groups, professional journals, literature searches, consumer education, advertising, and education for professionals.

Powerful search engines allow rapid location of software around the world on the World Wide Web. Many of the Internet access services provide a browser so that a clinician can travel throughout the Internet easily. Some free browsing services are available to clinicians through Physicians Online. After locating a piece of software with potential interest, it is a very rapid process to download this to the individual's own computer. The software then usually needs to be unpacked and set up. It then needs to be evaluated for suitability to intended tasks and for evidence of utility. After suitable evaluation the software can often provide a distinct additional dimension in the evaluation of a psychiatric patient. Many pieces of software have distinct clinical value and are not suitable for commercial marketing. This type of software can be shared easily across the Internet.

51: TOUCH OF EVIL

PROGRAM DESCRIPTION:

Touch of Evil starring Charlton Heston and Orson Welles, also directed by Orson Welles, is the smoky, sleazy, and powerful story of a narcotics officer and his bride who fall under the spell of a corrupt and fascinating sheriff in a seedy Mexican-American border

town. The conflicts of ethics and morality between the narcotics officer and the sheriff set the stage for a most perverse confrontation of good and evil, conscience and corruption: a labyrinthian journey into a nether world where the law is the criminal. The genius of Orson Welles is immediately apparent in the film's opening sequence, an uninterrupted, three-minute tracking shot that establishes the relationships of major characters, the perilous nature of the environment, and the incident that is the catalyst of the narrative. *Touch of Evil* is considered by many film historians to be the end piece of the film noir movement.

52: ADVENTURES IN THE GENDER TRADE: A CASE FOR DIVERSITY

PROGRAM DESCRIPTION:

Kate Bornstein, writer and performer, was born a man. This documentary presents her frank account of her journey from unhappy boy into liberated transsexual lesbian. Interspersed with her satiric night club act called "Hidden: A Gender," are the stories of a wide range of people who refused to have their identity defined by whether they were born male or female.

We are thus presented with a spectrum of colorful gender anomalies: drag queens, transsexuals, cross-dressers, and those who refuse to be categorized. They want the right to be not "male" or "female," but whatever they choose in between. Why, they ask, must we have a bipolar gender system, when some other cultures can accommodate diversity?

53: THE BLANK POINT: WHAT IS TRANSSEXUALISM?

PROGRAM DESCRIPTION:

Examines the widely misunderstood nature of transsexuals—people who psychologically identify with the opposite sex and undergo reassignment surgery—and offers meaningful insights into this rare condition. The program focuses on two male-to-female transsexuals and one female-to-male transsexual. The subjects candidly discuss their old identities, the transition to their new lives, and the scientific and psychological processes that enable them to change genders.

54: PSYCHIATRY RESIDENTS' USE OF INTERNET RESOURCES

Waguih William IsHak, M.D., *Department of Psychiatry, New York University Medical Center, 550 First Avenue, NB 20N11, New York, NY 10016*; Tal Burt, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participants should be able to recognize the key functions of the Internet in education including e-mail use, education mailing lists, and web sites dedicated to learning and teaching.

PROGRAM DESCRIPTION:

Psychiatry residents use Internet resources mainly for education and communication. There is a growing number of psychiatry-related sites on the World Wide Web and a growing number of psychiatry residents using them. Computer skills will enable residents to keep updated with the latest advancements in the field, participate in discussions concerning new developments and patient-care issues, and communicate with other colleagues around the country and around the world. These residents could become an integral part of the psychiatric political arena and join the health care debates at a time when their informed and educated opinion is most needed. Psychiatry resources on the Internet can be divided into five domains: text, e-mail, news groups, software, and interactive resources. With the help of a computer that is directly connected on-line and a projector, the skills required for navigating the Internet will be taught and a number of resources exemplifying each of the above five domains will be explored in real time. Participants will have the opportunity to acquire skills, ask questions, and participate in a debate about the future role of computers in psychiatric education.

55: ANATOMY OF DESIRE

PROGRAM DESCRIPTION:

What makes us gay? straight? Bisexual? Is sexual orientation a lifestyle choice, as many insist? Or is scientist Simon LeVay correct when he argues that a part of the brain determines sexual orientation? These and other issues are examined in this provocative documentary on the long-standing debate, as well as science's history of attempting to define, control, and sometimes even eradicate, same-sex desire. Incisive interviews with leading historians, psychiatrists, and writers are blended with rare archival footage to illuminate the growing debate on the origins of sexual orientation.

56: GAY LIVES AND CULTURAL WARS

PROGRAM DESCRIPTION:

Gay Lives and Culture Wars is a thoughtful look at gay and lesbian youth and their relationships with their families, set against the harsh propaganda being delivered by the religious right. Combining interviews of grown children and their parents with footage tracing Oregon's anti-gay rights measures, the video illustrates the pain and tragedy that results from prejudice. By showing young people telling their personal stories about coming to terms with their sexual identity, the video refutes common myths and misinformation spread about the gay and lesbian community. This work also shows the range of difficulties experienced by parents of gay and lesbian youth as they learn to accept their children's sexual orientation. It stresses that the support of the family is crucial to the survival of gay and lesbian youth. This piece reaches out to people who don't know much about what it is like to be lesbian or gay and puts a human face on the stereotypes promoted out of ignorance and fear of the unknown.

57: GAY CUBA

PROGRAM DESCRIPTION:

Gay Cuba takes a candid look at one of Cuba's most controversial human rights issues: the treatment of gay and lesbian people in Cuba since the Cuban Revolution of 1959. This documentary from journalist and photographer Sonja de Vries takes the viewer through three decades of conflict and transformation, providing insight into Cuban culture and society rarely seen. With a dynamic cast of characters, including a radio show host, a union leader, a drag queen, and a musician, *Gay Cuba* shows us the personal experiences of family, society, and political institutions. Gay and lesbian Cubans tell their stories of police harassment and gay-positive psychologists, accounts of expulsion from political organizations and election to political leadership, while stunning archival footage provides a telling historical context.

SESSION 31 (FOLLOWING MEDIA NUMBER 57) SUICIDE THEMES IN ROCK MUSIC

Keith Cheng, M.D., *Department of Adolescent Psychiatry, Emanuel Hospital, 3001 North Gantenbein Avenue, Portland, OR 97227.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize that rock music reflects some of society's current and past cultural norms and attitudes regarding suicide, demonstrate the knowledge of common suicidal-themes in rock music; and be aware of possible associations between rock music and youth suicide.

PROGRAM DESCRIPTION:

This media presentation is composed of 18 songs with suicidal themes. Eight songs will be shown on videotape and 10 songs will be played on compact disc. Suicidal feelings are explicitly expressed in these rock music works, with the following common themes: 1) unrequited love or romance failure; 2) existential angst; 3) being a victim of abuse or neglect; 4) drug/alcohol abuse; 5) assisted suicide; 6) pathologic grief; 7) self-endangering behavior; 8) antisuicide pleas. The first song in the collection is "Gloomy Sunday" from the jazz era. Billie Holiday's rendition is an example of a precursor to suicidal themes in rock music today. The following 17 songs presented in chronologic order represent various rock music categories. They include works by Simon & Garfunkel, Elton John, The Police, Pink Floyd, Ozzy Osbourne, Suicidal Tendencies, Depeche Mode, Megadeath, Metallica, Pearl Jam, 10,000 Maniacs, Nirvana, R.E.M., S.O.D., Pete Droge, Self, and the Suicide Machines. There is a preponderance of heavy metal and alternative rock included in the program, as these two genres of rock music seem to be the most common preferences for suicidal youth.

58: NO PLACE LIKE HOME

PROGRAM DESCRIPTION:

This brilliant documentary explores eight months in the life of a broken family in Seattle and powerfully depicts the cycles that keep families tied to poverty and violence from one generation to the next. The film focuses on a young girl, Barbara, who lives with her mother, brother, and sister in homeless shelters and cheap motels. They spend their days stretching welfare checks and shuttling between shelters while they wait for public housing and a future that never seems to arrive. Barbara's mother recounts a childhood of abuse and violence and a period of imprisonment as an adult. As Barbara tells *her* story—trying to make sense of a legacy of domestic violence, poverty, and abandonment—she emerges as the primary target of her own anger. At age 10, she's "tired of moving, tired of packing...tired of everything." She speaks dispassionately of being beaten by her father, of homelessness and the fears it engenders, of her mother's prison time. Her eerie calm belies the dangers she faces, and it is clear that her home is only the latest in a long series of losses. Her resignation, her acceptance of the unacceptable, is heartbreaking. The film makes no pretense of providing easy answers, but it clearly shows, through the eyes of one young girl, what the crucial questions are.

59: TROUBLESOME CREEK: A MIDWESTERN

PROGRAM DESCRIPTION:

Jeanne Jordan and Steven Ascher's chronicle of a crisis on Jordan's family farm in southwest Iowa plays, in Jordan's words, "like a *Reader's Digest* condensed version of the farm crisis." Jordan's parents owe large amounts of money from their yearly operating loans and, despite years of business, have been labeled a "troubled" account by the new, corporate owners of the bank. The family makes the hard decision to auction their belongings in a gamble to pay off the bank and save the land. With a chatty, first-person narration, Jordan surrounds the auction at the center of the film with a patchwork of facts, personal details, corrections of misconceptions about modern farm life, colorful family anecdotes, and comparisons to Hollywood Westerns. Her moving evocation of her childhood and sympathetic depiction of her stoic, poker-faced father combine with exquisite images of the Iowa countryside's cornfields and stormy skies to give weight to the potential loss of a way of life that teeters on the brink of oblivion. Troublesome Creek skillfully balances the personal and the universal. It succeeds as both a vivid illustration that the economic realities behind the farm crisis are far from gone and a lovingly stitched memory quilt to protect against the cold.

60: CRISIS OF CARE

PROGRAM DESCRIPTION:

Crisis of Care is a positive solutions oriented documentary examining the mental health delivery system for children and their families. The program provides a clear and comprehensive blue print for action. Focusing on services that emphasize prevention, early intervention, and interagency collaboration. A broad continuum of service options for children with emotional disturbance and their families is described and presented. The documentary's primary voice comes from children, parents and front line care givers.

61: THIEVES OF CHILDHOOD

PROGRAM DESCRIPTION:

One researcher makes a conservative estimate that 20 percent of women and 7 percent of men have been molested as children. How does this happen? Why is this happening and who are the culprits that are stealing the innocence, trust, and security of our children? In *CNN Presents...Thieves of Childhood,* CNN's medical unit correspondent Rhonda Rowland looks for answers to these and other disturbing questions about this major public health epidemic—child molestation.

In this one-hour in-depth documentary, Rowland speaks with experts, sex offenders, and child victims. The program begins by looking into the background of a child molester. Is it a genetic defect or is it a learned behavior caused by some problem during their childhood? Rowland searches for answers to why adults molest children. The program concludes with a look at intervention, prevention, and social responsibility. Rowland delves into ways experts are attempting to stop child molestation. What actions can be taken for intervention and prevention and how much responsibility society bears for not stopping this epidemic are issues that she also explores.

62: PATHER PANCHALI

PROGRAM DESCRIPTION:

Satyajit Ray is by far India's greatest filmmaker and, with Renoir and De Sica, one of the supreme masters of humanist cinema. The hallmarks of Ray's style are simplicity and subtlety. Made with extraordinary clarity, his films can be enjoyed by working-class audiences in his native Bengal, yet on closer examination reveal inexhaustible layers of psychological insight and evocative symbolism. His naturalistic, understated approach was unprecedented in an Indian cinema based on theatrical bombast. No director has displayed a comparable genius for quiet moments—those charged stillnesses that reveal infinitely more than any amount of melodramatic sound and fury. Ray achieved a synthesis that integrates Western concepts of realism and psychology into an Eastern framework of dualism and spirituality, enabling him to make films both essentially Indian and broadly universal. *Pather Panchali* Ray's first film was voted one of the ten greatest films of all time in the 1992 Sight and Sound poll. This dense mosaic of village life introduces Apu's dreamy father, fretful mother, and tempestuous older sister, with the child Apu a wide-eyed observer. Beautifully balancing the prosaic and

poetic, it depicts harsh poverty and childhood raptures with unsentimental compassion.

63: THE ART OF BEING HUMAN: A PORTRAIT OF FREDERICK FRANCK

PROGRAM DESCRIPTION:

This is an inspirational portrait of the artist Frederick Franck, author of *The Zen of Seeing.* Born on the border of Holland and Belgium, where both World Wars began, Franck has seen first hand the horrors of modern warfare. Living now in upstate New York, his life's work—through painting, sculpture, and books—has been to help people see the humanity in others, so that they will not be able to tolerate or be involved in violence towards others. It's a message with particular significance in the wake of Bosnia, Rwanda, and Oklahoma City.

64: TIBOR JANKAY: THE ART OF SURVIVAL

PROGRAM DESCRIPTION:

This charming film documents the life of a 94 year-old Hungarian born artist who used his artistic skills to survive the Holocaust. In one instance, Tibor escaped death using a sculptor's chisel to dig a hole in the bottom of a train bound for Auschwitz. Although he suffered during the war years, when it was over he was ready to start a new life in a new country. His irrepressible nature drew him towards Venice, California where he painted exuberant images of love and beauty. Among the threads running through Tibor's life is a widower, he found new friendships among young artists, inspiring them with his incredible survival stories and philosophy of forgiveness.

65: AFRICAN-AMERICAN ARTISTS: AFFIRMATION TODAY

PROGRAM DESCRIPTION:

This project investigates the historical influence and continuing significance of African-American art and culture and the ways in which five contemporary artists have tapped the spiritual and social underpinnings of black American life. This video features Lois Mailou Jones, Fred Brown, Keith Morrison, Sam Gilliam, and Leroy Almon speaking on camera about their work and their early decisions to become artists. A 40-page study guide relates key works of art from the National Museum of American Art's African-American collection to themes in history and social studies and to literature written by African Americans. A 208-page reference book, *Free Within Ourselves,* highlights 31 artists and their work represented in the museum's collections. Twenty slides provide visuals for reference and reinforcement of information learned.

66: CELLULOID CLOSET

PROGRAM DESCRIPTION:

Based on Vito Russo's pioneering history and directed by the team responsible for the Oscar-winning documentaries *The Times of Harvey Milk* and *Common Threads. The Celluloid Closet* is a sexy, funny infuriating, and instructive overview of a hundred years of largely inadequate depictions of homosexuals in Hollywood movies. Clips from 120 films are lucidly and wittily presented, covering not just the obvious highlights but also rarities and eyebrow-raising second looks. The are accompanied by sometimes sardonic and often movingly personal commentary from sympathetic Hollywood insiders (such as Whoopi Goldberg, Tom Hanks, Susan Sarandon) and skeptical gay spectators (including Susie Bright, Quentin Crisp, Harvey Fierstein), the latter group reliving both the sting of insulting stereotypes and the hunger with which crumbs of self-recognition were appropriated and consumed. The survey covers the "sissy" stereotypes of the 1930s (as well as the still provocative androgyny of Marlene Dietrich and Greta Garbo), the heavily disguised gay characters of the restrictive Hays Code period (*Rebecca, Rebel with a Cause,* etc.), and the dubious emergence of screen homosexuals as suicidal neurotics and vicious predators in the 1960s and 1970s. The unsteady progress toward more positive images is illustrated by such landmarks as *The Boys in the Band, Cabaret,* and *The Color Purple,* and the film ends on a warily triumphant note with the recent surge of unapologetically gay-themed indies. Neither narrowly sectarian nor toothlessly diplomatic, *The Celluloid Closet* is good history, good politics, and good entertainment.

67: LIVING FULLY UNTIL DEATH

PROGRAM DESCRIPTION:

This is an inspirational account of three people, faced with terminal illness, who find courage and new meaning while living their final months. Their willingness to face and deal with the unknown has lessons for people of all ages.

68: TIRED OF LIVING, FEARED OF DYING

PROGRAM DESCRIPTION:

Dutch doctors are now legally able to accede to a patient's request for medical help so that they can die with dignity and without pain when their sufferings have become unbearable. This remarkable film follows seven people who have registered a request for euthanasia when they judge the time to be right.

Each patient talks about the reasons for choosing this way of death and tries to define the specific trigger that will cause him or her to decide when the time has come to ask the doctor for the lethal injection. Members of their families add their own comments, and five doctors with experience in the practice of euthanasia speak eloquently about the ethical questions and the practical problems that euthanasia poses for them. By the end of the film, several of the subjects had died without expressing apprehension or regret about their decision.

MEDICAL UPDATES

1. SLEEP DISTURBANCE IN THE ELDERLY

Sonia Ancoli-Israel, Ph.D., *Professor, Department of Psychiatry, UCSD, Director, Sleep Disorders Clinic, Veterans Affairs Medical Center 3350 La Jolla Village Drive, San Diego, CA 92161*

EDUCATIONAL OBJECTIVES:

Participants will understand the following: 1) what the elderly report about their sleep disturbances; 2) what happens to sleep with age; 3) changes in sleep seen in aging due to a decrease in the ability to sleep; 4) the main contributing factors to the sleep disturbances seen in the elderly; and 5) the best approaches for treating sleep disturbances in the elderly.

SUMMARY:

Complaints of sleeping difficulties increase with age with over 50% of older adults reporting regular problems with sleep. The increase in daytime sleepiness suggests that it is the ability to sleep that decreases with age rather than the need to sleep that decreases. Therefore sleep complaints in the elderly are not part of the normal aging process. In the elderly, sleep complaints are usually secondary to circadian rhythm changes (advanced sleep phase), to specific sleep disorders, such as sleep disordered breathing and periodic limb movements in sleep, medical illness, psychiatric illness, medication use and dementia.

Insomnia is a complaint of trouble falling or staying asleep. It is best treated with good sleep hygiene techniques and behavioral therapies, although appropriate use of pharmacological therapy can also be recommended. Sleep apnea is a disorder of respiratory cessation and is characterized by excessive daytime sleepiness. Periodic limb movements in sleep is a disorder of leg jerks which disrupt sleep. It can be characterized both by complaints of insomnia and complaints of excessive daytime sleepiness. The symptoms of many of these disorders are similar; therefore, a good sleep history and an objective sleep evaluation are necessary for an accurate diagnosis to be made.

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2. CUSHING'S SYNDROME

Gordon N. Gill, M.D., *Chairperson, Faculty of Basic Biomedical Science, School of Medicine, UCSC, 9500 Gilman Drive, La Jolla, CA 92093-0650*

EDUCATIONAL OBJECTIVES:

The objectives of this presentation are to review the: 1) varied signs and symptoms, which bring patients with Cushing's syndrome to medical attention; 2) diagnosis and treatment; and 3) the recovery period: steroids withdrawal syndrome and depression.

SUMMARY:

While uncommon, Cushing's disease exhibits protean manifestations including prominent psychological disturbances. Once considered, precise diagnosis is possible using firstly, biochemical measurements that include 24-hour urine-free cortisol, resistance to normal feedback inhibition using dexamethasone suppression studies and anatomical localization using petrosal sinus sampling for ACTH-dependent Cushing's disease. Appropriate therapy depends on the etiology, but in most cases the primary therapy is surgical. Following successful management of Cushing's disease, a characteristic set of signs and symptoms occur that constitute the steroid withdrawal syndrome. These require supportive and adjunctive management strategies. While Cushing's disease is uncommon, iatrogenic Cushing's syndrome due to high dose glucocorticoid therapy is much more common and many of the same principles apply to symptom management during the active phase of glucocorticoid excess and to the withdrawal phase. Prominent among the manifestations of Cushing's disease are psychological disturbances. Less well recognized, but quite prominent are depressive symptoms that occur during the steroid withdrawal syndrome and in the recovery phase from exposure to high glucocorticoids.

REFERENCES:

1. Cushing's Syndrome. *New England J Med* 332:791-803, 1995.
2. Tyrrell JB: Glucocorticoid Therapy. In: *Felig P, Baxter J, Frohman LA (eds) Endocrinology and Metabolism*. McGraw Hill 3rd Edition, 1995.

3. BRONCHIAL ASTHMA

Stephen J. Wasserman, M.D., *Professor and Chair, Department of Medicine, UCSD Medical Center, 402 Dickinson Street, San Diego, CA 92103*

EDUCATIONAL OBJECTIVES:

The attendance will, at the end of the conference, be able to identify the major causes of asthma, to distinguish its immunologic and non-immunologic manifestations, to evaluate and comprehend the inflammatory cascades which lead to its expression, and to have a full understanding of the current approaches to diagnosis and treatment.

SUMMARY:

Asthma is an important respiratory condition which affects at any one time approximately 5% of the population. Recently, there has been an increase in both the morbidity and mortality of asthma. Important insights into the manifestations of this disorder have lead us to the understanding that the fundamental problem in asthma is that of a unique form of pulmonary inflammation, characterized by lymphocytes and eosinophil infiltration of the airway, leading to bronchial hyperreactivity to nonspecific stimuli. Current concepts of lymphocyte biology and cytokine synthesis suggests that a unique lymphocyte subpopulation, TH2, participates and controls this inflammatory response. Therapeutic decisions, then, should be made towards controlling the inflammation. In this regard, the recognition of the need for inhaled anti-inflammatory drugs, including steroids or chromalin-like drugs, should be the cornerstone of therapy in all but the mildest of asthmatics. Additionally, the appropriate of beta-adrenergic agonists by inhalation and of newer therapeutic agents and their appropriate niches in asthma will be discussed.

REFERENCES:

1. Bigby TD, Wasserman SI: Asthma. In: Stein JH (ed) *Internal Medicine*, 4th ed. Mosby, St. Louis, Mo, 1994.
2. Matheson DA: Asthma in Adults: Diagnosis and Treatment. In Middleton EE (ed) *Allergy Principles and Practice*. Mosby, St. Louis, MO, 1993.

4. THYROID DISORDERS

Wolfgang Dillmann, M.D., *Professor, Department of Medicine, UCSD, 9500 Gilman Drive, La Jolla, CA 92093-0618*

EDUCATIONAL OBJECTIVES:

To alert the participants to similar signs and symptoms occurring in thyroid diseases and psychiatric diseases. Appropriate laboratory testing should be undertaken to diagnosis hyper- and hypo-thyroidism and treatment of those conditions leads frequently to an amelioration of psychiatric symptoms.

SUMMARY:

Psychiatric diseases like paranoid schizophrenia and bipolar disorders can result in signs and symptoms which also occur in patients with thyroid disorders, especially hyper and hypothyroidism. In patients with severe hyperanxiety states, a decreased cognitive ability and decreased capability to abstraction can frequently be noted. Patients with apathetic hyperthyroidism frequently present with symptoms of depression. Appropriate diagnosis using specific labatory values like free- T and TSH for the diagnosis of thyroid disorders is, therefore, important in patients with mental and dood abnormalities. Hypothyroid patients show symptoms and signs compatible with depression, disorganized agitation, and have poor memory. Probably overall 5% of patients with hypothyroidism exhibit mental symptoms. In the depressed patients, in the initial phases, thyroxine levels are frequently increased. Specific attention should be paid to patients who have postpartum thyroiditis resulting in depression. It also has to be noted that lithium carbonate has anti-thyroid effects and can lead to hypothyroidism which further worsens a depressed state. Replacement of patients with severe hypothyroidism and depression can lead to a worsening of psychiatric symptoms and result in the induction of manic excitement. Children with the rare resistance to thyroid hormone syndrome have an increased incidence of the attention deficit syndrome which seems to respond well to thyroid hormone replacement.

REFERENCES:

1. Perrild H, Hansen JM, Arnung K et al: Intellectual Impairment After Hypothyroidism. *Acta Endocrinol* 112:185, 1986.
2. Bauer MS, Whybrow PC: Throid Hormones and the Central Nervous System in Affective Illness: Interactions That May Have Clinical Significance. *Integr Psychiatry* 6:75, 1988.

NIMH WORKSHOP

Co-Sponsored by the National Institute of Mental Health and the APA Office of Research

SUCCESSFUL GRANTWRITING FOR FEDERAL RESEARCH GRANTS: UNDERSTANDING THE GRANTMAKING PROCESS

Co-Chairpersons: Harold Alan Pincus, M.D., and Steven Hyman, M.D.

Participant: Peter Jensen, M.D.

EDUCATIONAL OBJECTIVES:

To gain an understanding of the process for applying for research grants at the NIMH, and the skills for developing federal research grant applications.

SUMMARY:

This workshop is designed to clarify the grantmaking process for psychiatrists contemplating applying for NIMH, NIDA, or NIAAA, or other federal grants. During the first half of the workshop, participants will present a practical, hands-on approach to and description of successful grantwriting, describing aspects of successful grant applications, ways to avoid pitfalls, and the general grant process at these institutions. The second half of the workshop presents successful recipients of federal grants and allows them to provide their insights and advice as they present case studies from their successfully funded research projects.

REFERENCES

1. Kennedy, C, Steinberg, J: Successful Research Grant Applications in *Research Funding and Resource Manual.* Washington, DC, American Psychiatric Press, Inc., 1995.
2. Kennedy, C, Steinberg, J: Preparing Successful Research Grant Applications in *Psychiatric Research Report*, 7:3, September 1992.

PRESIDENTIAL SYMPOSIUM

THE DOCTOR-PATIENT RELATIONSHIP: THE CRUCIBLE OF PSYCHIATRIC CARE

Chairperson: Harold I. Eist, M.D.

Participants: Allan Tasman, M.D., Howard E. Book, M.D., Jennifer A. Katze, M.D., Denise M. Nagel, M.D., Roger Peele, M.D.

SUMMARY:

This symposium will address the central relationship which governs psychiatry's clinical work. The panel will begin with an overview of the doctor-patient relationship (DPR) and why it is crucial to successful clinical activities. We will discuss how to develop DPR in time-limited therapy. In this era of third party intrusions, means of protecting this relationship will be explored. The DPR in psychopharmacologic treatment will also be discussed. Finally, closing comments will be provided by the APA President.

RESEARCH ADVANCES IN PSYCHIATRY

RESEARCH ADVANCES IN PSYCHIATRY: AN UPDATE FOR THE CLINICIAN

*Chairperson:*Herbert Pardes, M.D.
*Co-Chairperson:*Sidney H. Weissman, M.D.
*Participants:*Jack Gorman, M.D., Nancy C. Andreasen, M.D., Ph.D., Ellen Frank, Ph.D., Elliott Gershon, M.D.

EDUCATIONAL OBJECTIVES:

The participant will become familiar with new advances in research, especially those covered at the 1997 Annual Meeting. In addition, participants will learn about new research in anxiety disorder, schizophrenia, treatment of depression and genetics.

SUMMARY:

Disseminating information in a timely fashion about advances in new research is critical to the practice of clinicians. This session will not only highlight the topics that are being covered at the 1997 Annual Meeting, but will attempt to give participants some notion of the national priorities in research.

REFERENCES:

1. Dickstein LJ, Riba MB, Oldham JM (eds): *Review of Psychiatry Volume 15*, Washington, DC, American Psychiatric Press, Inc., 1996.
2. Dickstein LJ, Riba MB, Oldham JM (eds): *Review of Psychiatry Volume 16*, Washington, DC, American Psychiatric Press, Inc., 1997.

REVIEW OF PSYCHIATRY

PART I OF THE REVIEW OF PSYCHIATRY

COGNITIVE THERAPY

Chairperson: Jesse H. Wright, M.D.
Co-Chairperson: Michael E. Thase, M.D.

1. **Anxiety Disorders: Cognitive Approaches**
   David M. Clark, D, Phil., Adrian Wells, Ph.D.
2. **Substance Abuse Disorders: A Cognitive-Behavioral Approach**
   Michael E. Thase, M.D.
3. **Personality Disorders: Cognitive Approaches**
   Judith S. Beck, Ph.D.
4. **Eating Disorders: Cognitive-Behavioral Treatment**
   James E. Mitchell, M.D., Carol B. Peterson, Ph.D.
5. **Chronic and Severe Mental Disorders: Cognitive Therapy**
   Janine Scott, M.D., F.R.C. Psych., Jesse H. Wright, M.D.

EDUCATIONAL OBJECTIVES:

This session will provide an update on new clinical developments and research in cognitive therapy. Participants will be able to identify the basic features of the cognitive therapy approach to anxiety disorders, substance abuse, characterological problems, eating disorders, and chronic and severe mental conditions. In addition, the participant will be able to discuss the current status of empirical research on the efficacy of cognitive therapy for these disorders.

SUMMARY:

Cognitive therapy procedures have now been developed for a wide array of psychiatric illnesses. Treatment strategies for depression were outlined by Beck over 30 years ago, and an extensive research effort has documented the efficacy of cognitive therapy for this disorder. More recently, cognitive therapists have described innovative methods for treating anxiety disorders, substance abuse, characterological problems, eating disorders, and chronic and severe mental conditions. This update focuses on several of the newer applications of cognitive therapy.

The cognitive therapy methods developed for this diverse set of disorders share a number of common features including a collaborative-empirical therapeutic relationship, a problem oriented approach, and an emphasis on reversing both cognitive and behavioral pathology. However, specific modifications of therapy techniques have been required to address the special features of different clinical conditions. For example, cognitive therapy of personality disorders is based upon a comprehensive theory of personality in which characteristic patterns of pathological beliefs and compensatory behavioral strategies are identified for each type of characterological disturbance. Cognitive therapy for bipolar disorder is geared toward facilitating pharmacotherapy by enhancing compliance, teaching coping strategies, and increasing the patient's understanding of the illness. The cognitive therapy approach to anxiety disorders is designed to reduce the heightened sense of personal vulnerability, distorted cognitions about control and/or self-efficacy, and habitual patterns of avoidance usually observed in such patients.

Each of the presentations in this update describes the conceptual framework for treatment, outlines basic therapeutic methods, and reviews available research on cognitive therapy for commonly encountered mental disorders. The strong empirical tradition of cognitive therapy suggests that there will be continued evolution and testing of this treatment approach.

REFERENCES:

1. Clark DM, Salkovskis PM, Hackman A, et al: A Comparison of Cognitive Therapy, Applied Relaxation and Imipramine in the Treatment of Panic Disorder. *Br J Psychiatry* 14:759-769, 1994.
2. Garner DN, Rockert W, Davis et al: Comparison of Cognitive-Behavioral and Supportive-Expressive Therapy for Bulimia Nervosa. *Am J Psychiatry* 150:37-46, 1993.
3. Kingdom D, Turkington D: The Use of Cognitive Behavior Therapy with Normalizing Rationale in Schizophrenia. *J of Nerv and Men Dis* 179:207-211, 1991.
4. Wright JH, Beck AT: *Cognitive Therapy. In: Hales RE, Yudofsky SC, Talbott JA (eds), American Psychiatric Press Textbook of Psychiatry,* Second Edition 1083-1114. American Psychiatric Press, Inc., Washington, DC, 1004.

PART II OF THE REVIEW OF PSYCHIATRY

REPRESSED MEMORIES

Chairperson: David Spiegel, M.D.

6. **Trauma and Memory**
   Lisa D. Butler, PH.D., David Spiegel, M.D.
7. **Memory, Repression and Abuse: Recovered Memory and Confident Reporting of the Personal Past**
   Kevin M. McConkey, Ph.D.
8. **Intentional Forgetting and Voluntary Thought Suppression: Two Potential Methods for Coping with Childhood Trauma**
   Wilma Koutstaal, Ph.D., Daniel L. Schacter, Ph.D.
9. **Perspectives on Adult Memories of Childhood Sexual Abuse: A Research Review**
   Linda M. Williams, Ph.D., Victoria L. Banyard, Ph.D.
10. **Repressed Memories in Patients with Dissociative Disorder: Literature Review, Controlled Study and Treatment Recommendations.**
    Philip M. Coons, M.D., Elizabeth S. Bowman, M.D.

SUMMARY:

We review the large empirical literature relevant to the currently polarized debate about repressed memories and discuss problems in generalizing from laboratory findings to clinical phenomena. While cognitive research with normal subjects suggests that negative emotion tends to enhance memory for central (but not peripheral) details, there is clinical evidence of significant memory disturbance in trauma survivors. Several of the cognitive psychological explanations for traumatic amnesia are examined, emphasizing critical features that are often not addressed. We also describe cognitive laboratory demonstrations of memory alteration and implantation in normal subjects and outline some of the limitations of these effects relative to claims made about them. We propose that these findings are consistent with a mechanism of dissociation to explain traumatic amnesia and recovered memories and may well be viewed as evidence in support of it. In conclusion, we urge caution in extrapolating from experimental research to the clinical situation.

PART III OF THE REVIEW OF PSYCHIATRY

OCD ACROSS THE LIFE CYCLE

Chairperson: Michele T. Pato, M.D.
Co-Chairperson: Gail Steketee, Ph.D.

11. **OCD in Children and Adolescents**
    Joseph V. Penn, M.D., John March, M.D., M.P.H.

12. OCD in Adults
Michele T. Pato, M.D., Carlos N. Pato, M.D.

13. OCD in Later Life
C. Alec Pollard, Ph.D., Cheryl N. Carmin, Ph.D.

14. Course of Illness in OCD
Jane Eisen, M.D., Gail Steketee, Ph.D.

15. OCD in Pregnancy and the Puerperium
Susan F. Diaz, M.D., Lynn Grush, M.D.

EDUCATIONAL OBJECTIVES:

This session is designed to give the practicing psychiatrist up-to-date information on the treatment of Obsessive-Compulsive Disorder throughout the life cycle. Particular emphasis will be placed on both similarities and differences in treatment depending on the age of the patient, be they 5 or 65. Special attention will be given to the longitudinal course of the disorder as well as special life cycle issues like pregnancy in patients with OCD.

SUMMARY:

There has been much progress in the diagnosis and treatment of OCD in the past 20 years. This progress was, in part, fueled by the ECA study which revealed OCD to be far more common than had been suspected from previous reports, with a 2.5% lifetime prevalence. However, with this new knowledge of it's prevalence has also come the realization that for many OCD is a life-long illness with periods of exacerbation and remission but rarely cured. Each of these discussants will deal with the unique aspects of diagnosis and treatment that may arise in dealing with a patients suffering with OCD at different stages in their life. This will include special considerations in providing both pharmacologic and behavioral treatments in each age group: children/adolescents, adults and older adults. In the discussion of issues in the longitudinal course of illness, special emphasis will be placed on what work still needs to be done in predicting course and outcome. The final discussion will be on the special situation of patients with obsessive compulsive disorder with either the onset or worsening of their symptoms in the perinatal period. This will reinforce what will be emphasized by the other discussants, namely that periods of stress, whether it be positive or negative, will often worsen OCD symptoms.

REFERENCES:

1. Karno M, Golding J, Sorrenson S, Burnam M: The Epidemiology of Obsessive Compulsive Disorder in Five U.S. Communities. *Arch Gen Psych* 45:1094-1099, 1988.
2. March J, Leonard HL, Swedo SE: Obsessive Compulsive Disorder *In: March J (ed) Anxiety Disorders in Children and Adolescents.* NY Guilford Press, 251-275, New York, NY, 1995.
3. Steketee G: Social Support as a Predictor of Follow-Up Outcome Following Treatment for OCD. *J of Behavioral Psychotherapy* 21:81-95, 1993.
4. Sichel DA, Cohen LS, Rosenbaum JF, Driscoll J: Postpartum Onset of OCD. *Psychosomatics* 34:277-279, 1993.

PART IV OF THE REVIEW OF PSYCHIATRY

PSYCHOPHARMACOLOGY ACROSS THE LIFE CYCLE: AN UPDATE

Chairperson: Susan L. McElroy, M.D.

16. Psychopharmacological Treatment of Psychotic Disorders Across the Life Span
Paul E. Keck, Jr., M.D., Stephen M. Strakowski, M.D.

17. Psychopharmacological Treatment of Bipolar Disorder Across the Life Span
Susan L. McElroy, M.D., Elizabeth Weller, M.D.

18. Pharmacotherapy of ADHD: A Life Span Perspective
Thomas Spencer, M.D., Joseph Biederman, M.D.

19. Child and Adolescent Psychopharmacology
Scott A. West, M.D., Charles Popper, M.D.

20. Overview of Geriatric Psychopharmacology
Andrew Satlin, M.D., Charles Wasserman, M.D.

EDUCATIONAL OBJECTIVES:

Participants in this session will gain knowledge about the presentation and psychopharmacologic treatment of various psychiatric disorders across the life cycle. They will learn that the number of mental disorders found to be amenable to psychopharmacologic treatment is increasing; the number of available psychopharmacological agents is increasing; psychopharmacological agents effective in one mental disorder are often effective in others; and many psychiatric disorders amenable to psychopharmacological treatment are life-long illnesses that begin early in life, and thus, require life-long psychopharmacological treatment.

SUMMARY:

The psychopharmacologic treatment of mental illness is a rapidly advancing area of medicine. An increasing number of psychiatric disorders in persons of all age groups have been found to be amenable to treatment with psychotropic medications, and the number of agents effective in disorders with established medical treatments is increasing. It has also been increasingly recognized that many psychiatric disorders amenable to psychopharmacologic treatment are life-long illnesses that persist and often progress over time, and that effective life-long psychopharmacologic treatment may reduce symptoms as well as illness progression. Although some of these disorders tend to begin later in life (i.e., dementis, delusional disorder), many others begin in childhood, adolescence, and/or early adulthood (e.g., ADHD, mood disorders, and schizophrenia). It is herefore imperative that these illnesses be recognized as early in the life cycle as possible, so that appropriate psychopharmacologic treatment may be instituted and maintained.

The psychopharmacologic treatment of mental illness across the life cycle, from childhood through old age, is addressed. The session will begin with two discussions that address overviews of childhood, adolescent, and geriatric psychopharmacology. The last three discussions will review the presentation and life-long psychopharmacologic treatment of three disorders that often span the entire life cycle: psychotic disorders, ADHD, and bipolar disorder.

REFERENCES:

1. Busse EQ, Blazer DG (eds): *Textbook of Geriatric Psychiatry, Second Edition.* American Psychiatric Press, Washington, DC, 1996.
2. Popper CW: Balancing Knowledge and judgement: A Clinician Looks at New Devopments in Child and Adolescent psychopharmacologicy. *Pediatric psychopharmacology II* 4:483-510, 1995.
3. Schatzberg AF, Nemeroff CB (eds): *The American Psychiatric Press Textbook of psychopharmacology.* American Psychiatric Press, Washington, DC, 1995.
4. Shulman KI, Tohen M, Kutcher SP (eds): *Mood Disorders Across the Lifespan.* Wiley, New York, 1996.

PART V OF THE REVIEW OF PSYCHIATRY

PSYCHOLOGICAL/BIOLOGICAL TESTING ISSUES FOR PSYCHIATRISTS

Chairperson: John F. Clarkin, Ph.D.
Co-Chairperson: John P. Docherty, M.D.

21. The Laboratory in Clinical Psychiatry
Philip G. Janicak, M.D., Elizabeth Winans, Pharm.D.

22. **Psychological Assessment in a Managed Care Climate: The Neuropsychological Evaluation**
Steven Mattis, Ph.D., Barbara C. Wilson, Ph.D.

23. **Guidelines for Selecting Psychological Instruments for Treatment Outcome Assessment**
Frederick L. Newman, Ph.D., Daniel Carpenter, Ph.D.

24. **Performance Measurement in Healthcare Delivery Systems**
Naakesh A. Dewan, M.D., Daniel Carpenter, Ph.D.

EDUCATIONAL OBJECTIVES:

Participants in this session will gain knowledge about assessment of psychiatric patients in the era of health care reform. Participants will learn of the guidelines for necessary laboratory tests and special referral of psychiatric patients for neuropsychological assessment. They will also be informed about the selection and use of instruments for assessing treatment outcome and evaluating health care delivery systems.

SUMMARY:

The transformation of the delivery of psychiatric services by managed-care has created a need for rapid patient assessment and evaluation, treatments targeted to the most central problem areas, and assessment of patient satisfaction with service and symptom change. Psychiatrists in leadership roles in large systems of care need the tools to examine the: delivery of care according to treatment guidelines; the timely delivery of care, patients outcome and satisfaction with services, and the distribution of scarce treatment resources in a capitated system. The technologies to provide such assessment are also developing rapidly, and a timely review is needed.

With these developments in mind, we have organized this section around key areas of assessment in the rapidly changing treatment environment. Philip Janicak and Elizabeth Winans describe guidelines for referral of psychiatric patients for laboratory tests. Steven Mattis and Barbara Wilson review the commonly used neuropsychological tests and indicate the reasons for referral of psychiatric patients for specialized neuropsychological assessment. The additional authors approach assessment from a systems perspective. Fred Newman and Daniel Carpenter present guidelines for selecting instruments that are useful in treatment outcome assessment. And, finally, Naakesh Dewan and Daniel Carpenter describe the existing performance measurement systems to evaluate a health care delivery system.

REFERENCES:

1. Clarkin JF, Hurt SW, Mattis S: Psychological and Neuropsychological Assessment. *In: Hales RE, Yudofsky SC, Talbott JA (eds), American Psychiatric Press Textbook of Psychiatry,* 2nd edition, 247-276. American Psychiatric Press, Washington, DC, 1994.
2. Butler LE, Berrin MR (eds): *Integrative Assessment of Adult Personality.* Guilford Press, New York, NY, 1995.
3. Docherty JP, Dewan NA: *Outcomes Assessment Monograph.* NAPHS, Washington, DC, 1995.
4. Docherty JP, Streeter MJ: Measuring Outcomes. *In: Sederer L, Dickey B (eds), Outcomes Assessment in Clinical Practice.* Williams and Wilkins, New York, NY, 1996.
5. Newman FL, Hunter RH, Irving D: Simple Measures of Progress and Outcome in the Evaluation of Mental Health Services. *Eval and Program Planning* 10:209-218, 1987.

PART VI OF THE REVIEW OF PSYCHIATRY

COMPUTERS, THE PATIENT AND THE PSYCHIATRIST

Chairperson: Zebulon Taintor, M.D.

25. **Computers and Patient Care**
Zebulon Taintor, M.D., Marc Schwartz, M.D.

26. **Using the Internet**
Bertram Warren, M.D.

EDUCATIONAL OBJECTIVES:

Participants will know: a) how the use of computers in psychiatry has evolved to date; b) what software is available from what sources; c) how health care information systems are evolving with the changing systems of care; and d) what managed care organizations do with computers and how psychiatrist can deal with them.

SUMMARY:

The use of computers in psychiatry has alternated promise, fear and disappointment with real progress. New impetus is provided by decreasing costs and increased use of hardware, and increased flexibility of software. In relation to "medicine is a science, healing an art and health care a business," computers have served well in the scientific and, unfortunately, the business dimensions of what we do. Computers are a convenient target for those concerned with maintaining the art of healing, but this session will show that art can be enhanced.

Use of computers has evolved from large scale reporting systems that gradually have become information systems down to stand-alone office applications. Information systems have continued to evolve and are the sources of normative data against which practice and outcome data are reviewed. Managed care organizations use computers in a variety of ways and psychiatrists can learn how to use computers to cope with managed care and electronic reporting mandates.

Software for psychiatry comes from general medical systems, psychiatric specialty systems and many individuals who may be more or less interested in an/or able to make a profit. Software will be mentioned for use as a patient moves from intake to assessment, history, mental status, problems and treatment goals, diagnostic templates, psychological testing, laboratory and EEG treatment planning, drug ordering and prescriptions, aides to psychotherapy, cognitive and other rehabilitation, billing and quality assurance. Patients can use computers to find psychiatrists, learn about mental illness, support one another and for self-help.

REFERENCES:

1. Colby KM: Clinical Computing: A Computer Program Using Cognitive Therapy to Treat Depressed Patients. *Psychiatric Services* 46(12):1223-1226, 1995.
2. Ferguson T: Health Online: *How to Go Online to Find Health Information, Support Forums and Self-Help Communities in Cyberspace.* Addison-Wesley Publishing Company, Reading, MA, 1996.
3. Powsner S: Medical Informations and the Quality of Professional Life. *Psychiatric Services* 48(1):27-28, 1997.

SOCIAL SECURITY WORKSHOP

JOINTLY SPONSORED BY THE SOCIAL SECURITY ADMINISTRATION, APA OFFICE OF PSYCHIATRIC SERVICES, AND THE APA COMMITTEE ON PSYCHIATRIC DISABILITY AND REHABILITATION

Disability Evaluation Under Social Security: A Presentation for Treating Psychiatrists

Chairperson: Jerome E. Shapiro, M.D.
Participant: Dale Cox

EDUCATIONAL OBJECTIVES

At the conclusion of the presentation, the participant should be able to (1) define the kinds and extent of medical evidence SSA needs to make a disability determination, (2) understand how SSA processes claims and determines that applicants meet the definition of disability, using medical information provided by treating psychiatrists, and (3) recognize how their medical records assist their patients who apply for disability benefits.

SUMMARY:

This workshop was developed by the SSA, in cooperation with the APA and AMA, to educate the treating psychiatrist in the clinical and administrative process required by the SSA to make an appropriate, prompt evaluation of the extent of an applicant's psychiatric impairment and eligibility for SSA disability benefits. This includes the process of collecting sufficient clinical evidence based on symptoms, signs and functional assessments to permit a State's Disability Determination Service to make a disability decision based on SSA's Child and Adult Listing of Impairments. The workshop is presented in four basic segments: (1) the history and background of SSA Disability Programs, including new legislation affecting claimants disabled by drug abuse and/or alcoholism and welfare refor legislation affecting disabled children, (2) a discussion and examination of the ways in which the treating psychiatrist can best serve patients who apply for SSA disability benefits, (3) a review of the content of the clinical information required to expedite the disability determination process and an outline of the various administrative steps taken the adjudication of a claim, (4) an interactive discussion using clinical experiences of participants in the application of the listing of mental impairments, how impairments are evaluated (symptoms and signs, diagnoses, and level of severity), and what constitutes adequate evidence to support disability decisions.

REFERENCES:

1. Social Security Administration: Disability Evaluation Under Social Security, U.S. Department of Health and Human Services, Washington, DC 1992.
2. Meyerson, A.T., Fine T. (eds): Psychiatric Disability: Clinical, Legal and Administrative Dimensions. American Psychiatric Press, Inc., Washington, DC, 1987.

WORKSHOP ON PRIVATE PRACTICE ISSUES

APA COMMITTEE ON PRIVATE PRACTICE

Building Alliances for Success in Private Practice

Chairperson: Richard A. Bernstein, M.D.
Participants: Michael C. Hughes, M.D., Peter Jay Stein, M.D., K. Lynne Moritz, M.D., David Z. Starr, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop participants will be sufficiently informed about the logistics and methods of forming alliances with other psychiatrists, non-psychiatrist physicians and non-physician therapists, and the need for forming these alliances to survive in private practice so that they will be better prepared and more ready to do so in their own practices.

SUMMARY:

Four members of the Committee on Private Practice with the Chair as moderator will present from experiences in their own practices examples of bridge building to and affiliations with other professionals. These twelve minute discourses on: 1) the formation of a statewide PPO, 2) the development and maintenance of a behavioral multi-specialty group practice, 3) the implementation of a network with extra-mural medical sub-specialists and family physicians, and 4) the nurturing and sustaining of referral sources, will be interspersed with forty-five minutes of dialogue between the panel and participants.

Each of the presenters will emphasize the clinical, ethical, administrative, political and social consequences of the affiliation(s) he/she describes.

REFERENCES:

1. Sederer, LI, Dickey, B: *Outcomes Assessment in Clinical Practice*, Baltimore, Williams and Wilkins; 1995.
2. Wyatt RJ: Practical Psychiatric Practice: *Forms and Protocols for Clinical Use*, Washington, D.C. APPI; 1994.

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