SYLLABUS &

SYLLABUS & PROCEEDINGS SUMMARY

AMERICAN PSYCHIATRIC ASSOCIATION

1999 ANNUAL MEETING

The Clinician

Washington, DC ■ May 15 - 20, 1999

PROCEEDINGS SUMMARY

FOR YOUR RECORDS

The Certificate of Attendance below is for your personal records.

This is to certify that

_____

was a registered
participant at the
152nd Annual Meeting of the APA,
Washington, DC, May 15-20, 1999
President's Theme: The Clinician

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

Rodrigo A. Muñoz M.D.
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This certificate provides verification 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 15-20, 1999 Washington, DC

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 1 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 FIFTY-SECOND
ANNUAL MEETING OF THE
AMERICAN PSYCHIATRIC ASSOCIATION

Washington, DC

May 15-20, 1999

Published by

AMERICAN PSYCHIATRIC ASSOCIATION
1400 K Street, N.W.
Washington, D.C. 20005

$25.00

May 1999

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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 Gwynne Jackson in the Office to Coordinate Annual Meetings.

Pedro Ruiz, M.D., *Chairperson*
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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.

1999 ANNUAL MEETING
TOPIC AREAS FOR THE SCIENTIFIC PROGRAM

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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 individual presentations listed by number.

TOPIC INDEX

DISORDERS

PRACTICE AREAS

SUBSPECIALITY AREAS OR SPECIAL INTERESTS

Rodrigo A. Muñoz, M.D.

PAPER NO. 1: PRESIDENTIAL ADDRESS

The Clinician

Almost three years ago, at the beginning of my campaign for APA President, I promised to take every step to give APA back to its members. I wanted to make sure that every member knows, understands, and can use the benefits offered by APA. Now, at the end of my presidency, I want to report to you that we have made extraordinary progress.

The Board of Trustees took action in San Diego in July 1998 to create a strong, financially stable, and well-organized "new APA". The changes will require time, new organizational structures, and at least for some initiatives, a vote by the members on modifications to our bylaws. We are fully expecting that on January 2, 2001, the members of APA will belong to the best medical organization in the world.

The fall component meetings, in Washington, D.C., in September 1998, were an exceptional opportunity to initiate the implementation of the actions of Board of Trustees. A strong Council on Internal Organization has taken over the awesome task of integrating and coordinating the APA components, reviewing proposals for the Operations Manual, establishing clear mandates for the APA Councils, and creating rules that should enhance communications and decrease the duplication of efforts.

The Board of Trustees meeting in Los Angeles, in October 1998, permitted strong action on liaison with psychiatric groups that can work more closely with APA Councils, can profit from APA activities, and can better serve many psychiatries by working together with APA. Also in October, we gave new impetus to plans on career development and financial planning for psychiatrists. This was an opportunity to look at the new financial structure and to approve the American Psychiatric Publishing Group.

The Board of Trustees meeting in Denver, in December 1998, was largely devoted to psychiatric education, telemedicine, the structure of the new APA, and the report by the Council on Internal Organization about our new organization. The Task Force on Quality Performance Indicators presented its first report. It outlined the strategies for treatment guidelines and treatment proposals that enhance quality while protecting our patients' confidentiality and the clinician's independence.

The Board of Trustees meeting in Chicago, in March 1999, permitted us to evaluate in detail the characteristics of psychiatrist-sponsored networks. It saw the coming together of business representatives and clinicians interested in psychiatry in the workplace. At this meeting, we further insisted that the time has come for the employee to be seen as an asset and the main source of business profits. We are committed to moving employees from being considered "a cost center" to being regarded as a major center of strategy, planning, and business profitability.

The 1999 Annual Meeting will again give us an opportunity to show to the world the strength, science, power, and humane outlook of the American Psychiatric Association.

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SCIENTIFIC AND CLINICAL REPORT SESSION 1—CHALLENGES IN CONSULTATION-LIAISON PSYCHIATRY

No. 2
DESCRIPTION OF PSYCHIATRY CONSULTS IN PRIMARY CARE

William F. Pirl, M.D., *Department of Psychiatry, Memorial Hospital, 1275 York Avenue, New York NY 10021* B.J. Beck, M.D. Helen I. Kim, M.D., Steven A. Safren, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to describe different models of providing psychiatric care in a primary care setting; appreciate how one particular model, a consultation model, functions in detail; and identify areas for improvement and research in delivering psychiatric care in primary care.

SUMMARY:

Introduction: A consultation model of psychiatry in a large community primary care center is described. We examined prevalence of referred disorders; diagnostic agreement between primary care providers (PCPs), social workers, and psychiatrists; appropriateness of PCP initiated treatment; impact of treatment recommendations; and outcomes.

Methods: Charts of 78 consecutive psychiatry consults were reviewed retrospectively for one year after initial consultation. The MGH Guide to Psychiatry in Primary Care was used to rate appropriateness of interventions. PCP problem list at one year was used to indicate outcome.

Results: Major depression was the most common diagnosis (48.7%), followed by anxiety disorders (26.9%). PCP and social worker diagnoses matched psychiatrist diagnoses about half the time, 46.7% and 56.7%, respectively. PCPs initiated psychopharmacology in half the referrals. Medication choices were generally appropriate (76.9%). However, only 53.8% of medications were at therapeutic doses. PCPs tended to follow recommendations. If medications were discontinued, 81.5% of time the patients stopped them. Few patients were referred back after stabilization (19.2%), and at least 31.0% had documented improvement at one year.

Conclusion: Psychiatric care can be provided by a primary care consultation model with some suggestion of good outcomes. Barriers include interdisciplinary diagnostic agreement, PCP psychopharmacology knowledge, and medication adherence.

REFERENCES:

1. Nickels MW, McIntyre JS: A model for psychiatric services in primary care settings. Psych Services 1996; 47:522-526.
2. Stern TA, Herman JB, Slavin PL, eds: The MGH Guide to Psychiatry in Primary Care. New York, McGraw-Hill, 1998.

No. 3
PSYCHOSOCIAL ADJUSTMENT IN HEAD AND NECK CANCER

Mark R. Katz, M.D., *Department of Psychiatry, Toronto Hospital, 200 Elizabeth Street/EN8-228, Toronto ON M5G 2C4, Canada* Johnathan C. Irish, M.D., Gerald M. Devins, Ph.D., Gary M. Rodin, M.D., Patrick J. Gullane, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize factors that contribute to psychosocial adjustment following surgical treatment of head and neck cancer and be able to identify subpopulations of head and neck cancer patients who are at particular risk for poor psychosocial adjustment.

SUMMARY:

Objective: The purpose of this cross-sectional study was to examine the psychosocial impact of disfigurement, gender, and social support after surgical treatment of head and neck cancer.

Method: A convenience sample of 82 ambulatory head and neck cancer patients six months or more post treatment and free of active disease was assessed. Ratings of disfigurement were obtained using a valid and reliable nine-point Likert scale developed for the study. Social support was measured by the MOS Social Support Survey and psychosocial outcomes of interest included self-esteem (as measured by the Rosenberg Self-Esteem Scale and the Multidimensional Self-esteem Inventory), depressive symptoms (measured by the CES-D), and well-being (measured by the Bradburn Affect Balance Scale).

Results: The sample as a whole displayed high levels of self-esteem, low levels of depression, and positive feelings of well-being. Greater disfigurement and female gender were correlated with higher levels of depression and worsened body self-esteem. Well-being and global self-esteem were related to gender, degree of disfigurement, and social support in a complex three-way interaction; social support appeared to buffer the impact of greater levels of disfigurement on well-being and self-esteem for women but not for men.

Conclusion: These results suggest that women with head and neck cancer who experience low social support and face disfiguring treatment are at greatest risk for psychosocial dysfunction.

Source of funding: internal grants from the departments of psychiatry and otolaryngology, Toronto Hospital, Toronto, ON, Canada.

REFERENCES:

1. Moadel AB, Ostroff JS, Schantz SP: Head and neck cancer in: JC Holland (ed.) Psycho-oncology. New York, Oxford University Press, Inc. 1998; 314-323.
2. Katz MR, Rodin G, Devins GM: Self-esteem and cancer: theory and research, Can J Psychiatry 1995; 40:608-615.

No. 4
TREATMENT GUIDELINES FOR WOMEN AFTER MISCARRIAGE

Jennifer B. Athey, M.D., *Department of Psychiatry, Langley Porter, 401 Parnassus Ave/Box RTP-0984, San Francisco CA 94143*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: 1) describe the most common psychological sequelae after miscarriage, their rates, and their risk factors, 2) understand how women and their partners' reactions usually differ, 3) understand how to screen women for psychological morbidities after miscarriage, and 4) know how and when to intervene with psychiatric counseling and treatment.

SUMMARY:

Objective: 20% of pregnancies end in spontaneous abortion. Although 48%-52% of women experience psychological sequelae after miscarriage, no standard treatment guidelines currently exist. We propose clinical treatment guidelines for women after miscarriage based on a literature review and our clinical experience. We also review the rates of psychological morbidities after miscarriage, their risk factors, and differences in partners' reactions.

Method: We performed a literature search using the Melvyl database and key words: miscarriage and reaction, grief, depression, or intervention. Articles relevant to the topic from 1984-present were reviewed.

Results: Women experience grief, depression, and anxiety after miscarriage, with rates of approximately 40%, 12%-50%, and 22%-41%, respectively. Risk factors include having a psychiatric history,

poor social support, no living children, and no explanation for the event. Men grieve, but less intensely and more briefly; men also talk less about their feelings. Women consistently request follow-up after miscarriage. The General Health Questionnaire has good sensitivity and specificity in detecting psychological morbidity after miscarriage.

Conclusions: We suggest clinical guidelines for the assessment and treatment of psychological morbidities after miscarriage and discuss implications for obstetricians, c/l psychiatrists, and psychiatrists treating women.

REFERENCES:

1. Friedman T, Gath D: The psychiatric consequences of spontaneous abortion. British Journal of Psychiatry 1989; 155:810-813.
2. Janssen H, et al: Controlled prospective study on the mental health of women following pregnancy loss. Am J of Psychiatry 1996; 153:226-230.

SCIENTIFIC AND CLINICAL REPORT SESSION 2—KLEPTOMANIA AND DISSOCIATIVE IDENTITY DISORDER: REFINING THE PSYCHIATRIC DIAGNOSIS

No. 5
A TWIN STUDY OF DISSOCIATIVE EXPERIENCE

Joel F. Paris, M.D., *Department of Psychiatry, SMBD Jewish General Hospital, 4333 Cote Ste-Catherine Road, Montreal, PQ H3T 1E4, Canada* Kerry L. Jang, Ph. D., Hallie Zweig-Frank, Ph.D., John Livesley, M. D.

EDUCATIONAL OBJECTIVES

At the conclusion of this presentation, the participant should be able to communicate data from a twin study demonstrating that dissociation is a heritable trait.

SUMMARY:

Objective: This is a re-analysis of a larger sample of data first presented at the 1995 APA annual meeting. The purpose of the study was to measure the heritable component in the capacity to dissociate.

Methods: The sample consisted of 329 twins (MZ = 177, DZ = 152) recruited from the community. All subjects were administered the Dissociative Experiences Scale (DES), which was divided into pathological (DES-T) and nonpathological (DES-NP) subscales. The Diagnostic Assessment of Personality Pathology (DAPP-BQ) was also administered to all subjects.

Results: Using structural equation modeling with LISREL, the variance on both DES-T and DES-NP was accounted for by a heritable component (h^2 = .61 in females, h^2 = .35 in males) with the residual variance accounted for by unshared environment. Triangular factor analyses showed that three scales of the DAPP-BQ (cognitive distortion, affective lability, and suspiciousness) had genetic correlations greater than .35 with both DES-T and DES-NP scores. No environmental correlations were greater than .35.

Conclusions: These results suggest that the capacity to dissociate is a heritable trait related to other personality dimensions. They also suggest that dissociative symptoms are best understood using a stress-diathesis model.

REFERENCES:

1. Waller NG, Putnam FW, Carlson EB: Types of dissociation and dissociative types: a taxometic analysis of dissociative experiences. Psychol Methods 1995; 1:300-321.
2. Jang KL, Livesley WJ, Vernon PA, Jackson DN: Heritability of personality traits: a twin study. Acta Psychiatr Scand 1996; 94:438-44.

No. 6
DIAGNOSIS OF DID

Arthur Rifkin, M.D., *Hillside Hospital, 75-59 263rd Street, Glen Oaks NY 11004-1150*; Can Bulucu, M.D., Madhavi Mallipeddi, M.D., Eduardo Espiridion, M.D., Barbara Ponieman, M.D., Charles Jin, M.D., Christopher Dennis, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize that using self-report rating scales poorly predicts the diagnosis of dissociative identity disorder.

SUMMARY:

Objective: To assess the accuracy of using rating scales to diagnose dissociative identity disorder (DID).

Method: We asked all nonelderly women admitted to the psychiatric inpatient service of Hillside Hospital to complete two rating scales that previous investigators used to establish the diagnosis of DID: the Dissociative Experiences Scale (DES) and the Dissociative Disorders Interview Scale (DDIS). All subjects who scored positive for DID on either scale, using published criteria, and a subject who scored negative, had a diagnostic interview using the Structured Clinical Interview for DSM-IV-Dissociative Disorders (SCID-D) by a psychiatrist who did not know the diagnosis from the rating scales. Those diagnosed with DID received a further SCID-D interview by the senior author (AR).

Results: Of 127 subjects approached, 71 (60%) returned completed rating scales, of 18 whom (25%) met criteria for DID. Of these 18, four (22%) met criteria for DID based on the SCID-D interview. None of those without rating scale diagnoses of DID received a diagnosis of DID from the SCID-D interview. The senior author (AR) concurred with the diagnoses of DID. Overall, four of 71 (6%) subjects returning rating scales met SCID-D criteria for DID.

Conclusion: Self-report rating scales poorly predict diagnosis of DID.

REFERENCES:

1. Steinberg M: Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D). Washington DC., American Psychiatric Press, 1993.
2. Rifkin A, Ghisalbert D, Dimatou S, et al: Dissociative identity disorder in psychiatric inpatients. Am J Psychiatry 1998; 155:844-845.

No. 7
AXIS I COMORBIDITY IN KLEPTOMANIA

Donatella Marazziti, M.D., *Department of Psychiatry, University of Pisa, Via Roma 67, Pisa, Italy;* Silvio Presta, M.D., Chiara Pfanner, M.D., Alfredo Gemignani, M.D., Giovanni B. Cassano, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to identify the most frequent comorbid conditions in patients with kleptomania

SUMMARY:

Kleptomania is the recurrent failure to resist impulses to steal objects that are not needed for personal use or for their intrinsic value.

Psychiatric comorbidity seems to be frequent in kleptomania, although no systematic study has been carried out. The aim of the present research was, thus, to evaluate Axis I comorbidity in a group

of 25 outpatients with a DSM-IV diagnosis of Kleptomania. The patients were consecutively enrolled at the Dipartimento di Psichiatria, Neurobiologia, Farmacologia e Biotecnologie (section of psychiatry) at the University of Pisa in Italy and were evaluated with the Structured Clinical Interview for DSM-IV.

The most frequently encountered lifetime comorbidity was obsessive-compulsive disorder (60%), followed by panic disorder, bipolar disorder, bulimia, unipolar depression, generalized anxiety disorder, pathological gambling, trichotillomania, pyromania, sexual compulsions, self-injurious behavior and drug abuse.

Further studies are needed in order to better evaluate the clinical and therapeutic implications of the different comorbid patterns in kleptomania.

REFERENCES:

1. McElroy SL, Pope HG, Hudson JI, et al: Kleptomania: a report of 20 cases. Am J Psychiatry 1991; 148:652-657.
2. Goldman MJ: Kleptomania: making sense of nonsensical. Am J Psychiatry 1991; 148:986-996.

SCIENTIFIC AND CLINICAL REPORT SESSION 3—FOLLOW-UP ON HEALTH AND MENTAL HEALTH IN THREE SPECIAL POPULATIONS

No. 8
MENTALLY HEALTHY MEN AT MIDLIFE

Jerry F. Westermeyer, Ph.D., *Department of Psychology, Adler School, 65 East Wacker Place, Ste 2100, Chicago IL 60601*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to identify factors in young adulthood that predict adult life stage and alcohol abuse over the life course among men.

SUMMARY:

Objective: To better understand "positive" mental health, predictors of health and illness were studied among Grinker's "homoclites."

Method: 87 young college men selected for general health were prospectively assessed at age 21 and were reassessed at age 53. Predictors included self-rated assessments of social (peer), mentor, and parental relationships, parental discipline, and physical health and symptoms. Midlife outcomes included Erikson's Adult Life Stages (e.g., generativity, intimacy), and the Diagnostic Interview Schedule (DIS) assessments of depression and alcohol abuse.

Results: 1.) Most men achieving Erikson's generativity stage had successful careers and were happily married. 2.) Satisfactory peer and mentor relationships at age 21 predicted midlife generativity but did not predict depressive symptoms or alcohol abuse. 3.) An unfavorable father relationship and disruptive family environment in young adulthood or adolescence predicted subsequent alcohol abuse.

Conclusion: Although most middle-age "homoclites" maintained mental and physical health, some men developed mental disturbances or alcohol abuse. Several social adjustment and family factors in young adulthood were moderately predictive of outcomes at midlife among men initially selected for health.

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No. 9
STRESS LEVELS IN A DEPLOYED MARINE UNIT

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to identify risk factors for elevated levels of anticipatory stress in deployed service members and understand the role of anticipatory stress as a risk factor for psychiatric morbidity.

SUMMARY:

Both in military and civilian populations, increased attention has been focused on prevention of and early intervention in disorders caused by traumatic stress. Although there has been extensive retrospective research in the area of combat stress and other acute stress disorders, there is virtually no prospective research in this area. We prospectively studied the 22d Marine Expeditionary Unit (MEU) on its 1996 deployment in support of the Bosnian peacekeeping mission. Although this unit did not see action in Bosnia as anticipated, they were still at risk for developing anticipatory stress. In fact, they did see limited combat in Liberia. We administered the Impact of Events Scale, Brief Symptom Checklist, Beck Depression Inventory, Dissociative Events Scale, and Stanford Acute Stress Reactions Questionnaire just after deployment and just before disembarking at the completion of the seven-month mission. Faith in leadership and mission offered significant protection against anticipatory stress on various measures, supporting the hypothesis that a sense of meaning is protective in the face of traumatic stress. At the completion of the mission, there were no longer any significant differences across groups, indicating that the stress experienced was in fact situational.

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No. 10
GROUP TREATMENT OUTCOME FOR PSYCHOPATHIC INMATES

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the formal diagnosis of psychopathy as compared with antisocial personality; recognize the usual patterns of criminal recidivism; appreciate the contribution of intensive multimodal treatment programs for reducing recidivism.

SUMMARY:

The Regional Health Center (Pacific), a component of Correctional Service Canada, has developed intensive treatment programs that target criminogenic factors related to recidivism rates of violent and sexual offenders. This multidisciplinary treatment approach is unique in that it involves both structured cognitive-behavioral group psychotherapy and relatively unstructured insight-oriented group psychotherapy.

Previous literature suggests that psychopaths, as defined by the Revised Psychopathy Checklist (PCL-R; Hare, 1991), do not respond

to therapeutic interventions. However, the scientific question of the responsivity of the psychopath to intensive multimodal treatment has not been adequately answered in the empirical literature.

This study investigates the outcome for 300 violent/sexual offenders in relationship to their PCL-R scores following RHC's intensive eight-month treatment program. It is predicted that completers of the program will be placed at lower levels of institutional security posttreatment and that they will have fewer incident reports. It is also predicted that following release, treated offenders will have lower rates of recidivism. Recidivism rates are compared with standard CSC reoffending decay curves and with a matched sample of offenders who did not undergo treatment. Finally, it is predicted that psychopathic and nonpsychopathic offenders will not differ in terms of treatment outcome. Follow-up data are reported for a four to eight year follow-up term. This study is funded by the Group Psychotherapy Foundation, New York.

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SCIENTIFIC AND CLINICAL REPORT SESSION 4—CLINICAL RISK FACTORS FOR SUICIDE

No. 11
SUICIDAL BEHAVIOR IN BPD, MAJOR DEPRESSIVE EPISODE, AND COMORBID BPD PLUS MAJOR DEPRESSIVE EPISODE

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to identify important risk factors for suicidal behavior in patients with BPD, BPD+MDE, and MDE and to appreciate the effects of comorbidity (BPD + MDE) on suicidal behavior.

SUMMARY:

Objective: Suicidal behavior is highly prevalent in BPD and MDE, though attempt characteristics are believed to differ. Comorbidity may obscure attempt characteristics uniquely related to psychopathology of each disorder. We compared suicidal behavior in patients with BPD, MDE, and BPD + MDE, and asked if attempt characteristics differed between groups, and if aspects of core psychopathology predicted specific attempt characteristics.

Method: Eighty-one inpatients with BPD (32 BPD, 49 BPD + MDE) were compared with 77 inpatients with MDE on measures of depressed mood, hopelessness, impulsive-aggression, and suicidal behavior, including lifetime number of attempts, degree of lethal intent, objective planning, medical damage, and method of violence.

Results: There were no significant differences in attempt characteristics of BPD and MDE patients; however, patients with BPD + MDE had the greatest number of suicide attempts, the most objective planning, and a trend toward more medical damage. An increased number of attempts is predicted by a borderline diagnosis, and an increase in either impulsive-aggression or hopelessness. Hopelessness is associated with lethal intent in all three groups and with objective planning in the BPD + MDE group. Medical damage is related to lifetime number of attempts.

Conclusions: Comorbidity increases symptom severity, number, and seriousness of attempts. Hopelessness and impulsive-aggression independently increase risk of suicidal behavior in both borderline and depressed patients.

Supported by NIMH grants MH48463 (PHS) and MHCRC for the Study of Suicidal Behavior MH46745 (JJM)

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1. Soloff PH, Lis JA, Cornelius J, Ulrich R: Risk factors for suicidal behavior in borderline personality disorder. Am. J. Psychiatry 1994; 151:1316-1323.
2. Brodsky B, Malone KM, Ellis SP, et al: Characteristics of borderline personality disorder associated with suicidal behavior. Am. J. Psychiatry 1997; 154:1715-1719.

No. 12
RISK FACTORS FOR SUICIDE IN SCHIZOPHRENIA

Wayne S. Fenton, M.D., *Research, Chestnut Lodge Hospital, 500 West Montgomery Avenue, Rockville MD 20850*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to identify actuarially defined risk factors for suicide in schizophrenia and describe a clinical model for understanding and assessing risk.

SUMMARY:

Objective: Suicide is the largest cause of premature death among individuals with schizophrenia. This report examines illness natural history, symptom, and course-based variables to identify clinical markers of elevated long-term suicide risk followed up 20 years after index assessment.

Methods: Based on detailed index admission records, patients from the Chestnut Lodge Follow-up Study with schizophrenia (N = 174) and schizoaffective disorder (N = 78) were retrospectively assessed in relation to demographic, premorbid, illness natural history, and sign and symptom variables reflecting multiple domains of psychopathology. Suicide was ascertained based on interviews with surviving relatives an average of 20 years following hospital discharge. Because the relative rarity of suicide limits statistical power, multiple univariate analyses of potential predictors grouped into families were used to identify clinical risk factors.

Results: Suicide was the leading cause of death for patients in this sample: 17/252 (6.7%) died from suicide in the 20 years following discharge. Clinical predictors of suicide clustered into those reflecting good premorbid functioning (IQ, social functioning), later illness onset (first hospitalization), greater impulsivity (prior suicide attempts, promiscuity), retention of abstract thinking, more severe positive symptoms and depression and less severe negative symptoms.

Conclusions: Identification of suicide risk factors is one element of prediction and prevention. Along with data indicating high-risk periods for suicide in schizophrenia, risk factors identified in this study are consistent with a model of suicide-risk assessment that focuses on the dimensions of pressure (external stress), pain (particularly dysphoria, depression, and hopelessness), and perturbation (penchant for impulsive action).

REFERENCES:

1. Schneidman ES: Suicide: Understanding and Responding. Madison, Conn. International Universities Press, Inc. 1995.
2. Caldwell CB, Gottesman II: Schizophrenics kill themselves too: a review of risk factors for suicide. Schizophrenia Bulletin 1990; 16:571-588.

No. 13
HIGH SERUM CHOLESTEROL AND RISK OF SUICIDE

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the importance of high serum cholesterol as a marker for increased risk of violent suicide.

SUMMARY:

Objective: To estimate the association between serum cholesterol and mortality from different methods of suicide.

Method: We prospectively monitored mortality of 18,344 men and 19,291 women (aged 25-64) who participated in one of the five independent population surveys during 1972-1992 in Finland. The mean follow-up was 14.6 (range 1-24) years. The methods of violent suicides (N = 130) included hanging, firearms, cutting, jumping, and unspecified means. Drug overdose, gases, and drowning were classified as nonviolent suicides (N = 46). Using the Cox proportional hazards model we controlled for sex, age, marital status, education, smoking, alcohol consumption, coffee use, physical activity, body-mass index, psychiatric symptoms, psychotropic medication, heart disease, and general health.

Results: Serum cholesterol was positively related to risk of violent suicide. In the highest cholesterol category (≥8.00 mmol/l, 309.4 mg/dL), the relative risk of violent suicide was over two-fold (RR = 2.39, 95% CI's 1.07-5.31, p = 0.033) compared with the lowest category (<5.00 mmol/l, 193.3 mg/dL). No association between serum cholesterol and risk of nonviolent suicide was found. The violent/nonviolent suicide ratio increased linearly from the lowest to the highest cholesterol category (1.00 vs. 4.50, p = 0.044).

Conclusions: This is the first study to demonstrate the positive relationship of high serum cholesterol and increased risk of violent suicide.

REFERENCES:

1. Vartiainen E, Puska P, Pekkanen J, et al: Serum cholesterol concentration and mortality form accidents, suicide, and other violent causes. BMJ 1994; 309:445-447.
2. Iribarren C, Reed DM, Wergovske G, et al: Serum cholesterol level and mortality due to suicide and trauma in the Honolulu Heart Program. Arch Intern Med 1995; 155:695-700.

SCIENTIFIC AND CLINICAL REPORT SESSION 5—BRAIN CORRELATIONS OF PSYCHOPATHOLOGY

No. 14
COGNITIVE DEFICITS IN CHILDREN WITH LYME DISEASE

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the psychiatric and cognitive problems associated with pediatric Lyme disease. An important objective of this presentation is to increase awareness of the cognitive sequelae related to Lyme disease.

SUMMARY:

Objective: In adults, neurologic Lyme disease (LD) is known to cause cognitive dysfunction, but in children the one controlled study found no abnormalities. We examined this question further.

Methods: 20 children (aged 9-17) with chronic LD and persistent cognitive complaints and 20 age- and sex-matched controls were enrolled. Test included the WISC III, WRAML, WCST, CELF-R, Conner's CPT, CBCL, CDI, and a physical symptom analog scale.

Results: Patients and controls were comparable on demographic variables and premorbid ability. With Bonferonni correction, the patients scored significantly lower on Performance IQ (p = .005), General Memory (p = .004), Verbal Memory (p = .007), and WRAML Finger Windows (p = .003) scales. Significantly lower scores were also noted on Freedom from Distractibility (p = .010), Coding (p = .009), Visual Memory (p = .013), Number/Letter (p = .017), and others. After correction, the Lyme children also had significantly more psychopathology. After controlling separately for anxiety, depression, and/or fatigue, patients continued to have significantly worse cognitive scores across various tests.

Conclusion: Children with chronic LD have significant cognitive deficits, primarily affecting visual and auditory attention and short-term memory. Teachers, psychologists, and psychiatrists need to be aware that cognitive problems may be manifestations of ongoing LD.

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1. Kaplan RF, Meadows ME, Vincent LC, et al: Memory impairment and depression in patients with Lyme encephalopathy: comparison with fibromyalgia and nonpsychotically depressed patients. Neurology 1991; 42:1263-67.
2. Adams WV, Rose CD, Eppes SC, Klein JD: Cognitive effects of Lyme disease in children. Pediatrics 1994; 94:185-189.

No. 15
CBF IN LYME ENCEPHALOPATHY

Brian A. Fallon, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 13, New York NY 10023* John Keilp, Ph.D., Isak Prohounik, Ph.D., Ronald Van Heertum, M.D., Felice Tager, M.A., J. John Mann, M.D., Michael R. Liebowitz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to help in the differentiation of Lyme encephalopathy from major depression. The role of functional imaging and the implications of white matter involvement of this CNS disease will be addressed.

SUMMARY:

Objective: Because impaired memory from Lyme encephalopathy is often accompanied by mood and sleep disturbances, differentiation from major depression may be difficult. CSF and MRI may appear normal. This study examined whether patients with chronic Lyme disease have functional imaging deficits and whether these can be localized.

Methods: 11 patients with previously treated Lyme disease and current cognitive impairment were given neuropsychological tests and evaluated with $Xenon^{133}$ Regional Cerebral Blood Flow (rCBF). Tests included the WAIS, WMS, Buschke SRT, COWAT, and others. For the rCBF analysis, each patient was age- and sex-matched to two archival controls. Whole brain flows and detector-by-detector analyses were undertaken using MANOVA.

Results: While the Lyme patients did not differ on the two gray-matter rCBF indexes (the ISI and the f_g), they did differ significantly from controls in the slower clearing, white-matter index (the k_2). The reduced white matter rCBF, spanning primarily the posterior temporal and parietal lobes bilaterally, was significantly associated

with the magnitude of cognitive deficits (specifically memory impairment and visuospatial organization).

Conclusion: Patients with Lyme encephalopathy have functional imaging deficits affecting primarily the cerebral white matter. The implication of these findings for the pathophysiology and differential diagnosis of Lyme disease will be discussed.

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2. Logigian EL, Johnson KA, Kijewski MF, et al: Reversible cerebral hypoperfusion in Lyme encephalopathy. Neurology 1997; 49:1661-1670.

No. 16
CEREBRAL ACTIVATION PATTERN DURING AUDITORY HALLUCINATIONS: A FUNCTIONAL MAGNETIC RESONANCE STUDY

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that both in primary auditory cortex and areas of speech-processing metabolic activity was modulated by the occurance of hallucinations.

SUMMARY:

Objective: The pathogenesis of auditory hallucinations, particularly the involvement of the primary auditory cortex, is not yet clear. Previous neuroimaging studies have given only indirect evidence of the areas involved. It was our purpose to elucidate which cortical regions exhibit an increment of metabolic activity during periods of verbal auditory hallucinations.

Method: During an 18-month period, all patients admitted to the department of psychiatry with a history of hallucinations were screened for compatibility with a functional magnetic resonance (fMRI) protocol. Three patients suffering from paranoid schizophrenia (according to DSM-IV) could be included. Their verbal hallucinations alternated with hallucination-free periods. During one fMRI-measurement, the patients signaled the onset and offset of hallucinations by button-pressing. The defined periods of hallucinations were correlated with the signal time course of each voxel by BrainVoyager (Goebel 1997).

Results: We could demonstrate both temporal (including primary auditory area in Heschl's transversal gyrus) and frontal (including Broca's area) activation during the patients' hallucinations.

Conclusion: Herewith it is demonstrated for the first time that both primary auditory cortex and areas involved in the generation and understanding of speech are activated during auditory hallucinations. This provides a new contribution to the understanding of the pathogenesis of auditory hallucinations.

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1. David AS, et al: Auditory hallucinations inhibit exogenous activation of auditory association cortex. Neuroreport 1996; 7:932-936.
2. Silbersweig DA, et al: A functional neuroanatomy of hallucinations in schizophrenia. Nature 1995; 378:176-179.

SCIENTIFIC AND CLINICAL REPORT SESSION 6—TREATMENT ISSUES WITH SEROTONERGIC ANTIDEPRESSANTS

No. 17
COST AND EFFECTIVENESS OF SSRIS

H. George Nurnberg, M.D., *Department of Psychiatry, University of New Mexico, 2600 Marble Avenue, NE, Albuquerque NM 87131* Peter M. Thompson, M.D., Paula L. Hensley, M.D., Michael P. Dutro, P.D., Susan S. Paine, M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand how the switching rate of antidepressants influences cost considerations.

SUMMARY:

Objective: This study examines the effectiveness of the three most frequently used serotonin reuptake inhibitors (fluoxetine, paroxetine, sertraline) in a naturalistic clinical setting and then seeks to accurately and economically model the cost data of these agents. The drug therapy evaluation will compare average drug costs per day of the SRIs determined by stratifying the patients on each daily dose to the generally used tablet cost/mg. of average dose methodology.

Method: From 2,779 patients treated in a university outpatient psychiatric clinic, 2,140 (77%) were prescribed antidepressants, of whom 1,733 (62%) received one or more of the three SRIs and served for the data analysis. Patients were examined on the effectiveness variables of clinical improvement, time in treatment, clinical visits, dosages, and medication switching. Average drug cost per day was calculated by costing out the percentage of patients (stratification) on each daily dose (sum of distribution × cost/day) and costs based on average dose relative to cost of common tablet size (cost × avg.dose/tablet size). Drug costs used were obtained from the UNM pharmacy.

Results: There is no significant difference between the SRIs in rate of switching (122%) or clinical improvement. When medication change is the independent factor, significant differences are found only for total time in treatment and number of visits. The calculated average drug cost per day by nonstratified average dose method is $1.68 for fluoxetine, $1.58 for paroxetine, and $1.17/$2.32 for sertraline, 100mg/50mg tablet size, respectively. The accurate actual average cost per day determined by dose stratification is $1.79 for fluoxetine, $1.41 for paroxetine, and $1.21 for sertraline.

Conclusions: The SRIs appear to be equivalent in overall efficacy and effectiveness. The correct drug costing methodology to determine the actual average drug cost per day is by costing out the percentage of patients on each daily dose (stratification). Calculating drug costs based on the cost per milligram of average doses can be quite misleading. Because individual patients take individual tablets rather than mean doses, the limitation of an approach based on cost of tablet size relative to average dose is readily understandable.

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No. 18
TREATMENT OF SSRI-ASSOCIATED SEXUAL DYSFUNCTION

Steven D. Targum, M.D., *Department of Psychiatry, Clinical Studies LT, 400 Market Street, Suite 425, Philadelphia PA 19106* David Michelson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the components of human sexual response, to recognize distinct types of sexual dysfunction, and to identify and evaluate alternative intervention strategies to ameliorate dysfunction associated with the administration of selective serotonin reuptake inhibitors like fluoxetine.

SUMMARY:

Objective: We evaluated the efficacy of buspirone and amantadine in the treatment of sexual dysfunction associated with administration of an SSRI (fluoxetine).

Method: This 12-week trial consisted of a four-week baseline assessment period followed by an eight-week double-blind treatment period. Women who consented to participate and reported a deterioration in sexual function following initiation of fluoxetine therapy entered the assessment period. Patients who reported impairment of either vaginal lubrication or orgasm following the assessment period were randomized to treatment with either amantadine (50 or 100 mg), buspirone (20 or 30 mg), or placebo added to their ongoing fluoxetine therapy. Outcomes were assessed using a patient-rated daily diary and a clinician-rated structured interview.

Results: All treatment groups (buspirone n = 19, amantadine n = 18, and placebo n = 20) improved significantly on overall as well as most individual measures of sexual function as assessed by both the patient diary and the clinician-rated structured interview. There were no significant differences among treatment groups. Compared with placebo, the amantadine-fluoxetine group improved in mood and energy level on the patient-rated diaries.

Conclusion: Neither buspirone nor amantadine was more effective than placebo in ameliorating SSRI-associated sexual dysfunction. The methodologies used to evaluate sexual dysfunction and the implications of a significant placebo response will be discussed.

Funding is by Lilly Research Laboratories

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1. Harvey KV, Balon R: Clinical implications of antidepressant drug effects on sexual function (review). Annals of Clinical Psychiatry 1995; 7:189-201.
2. Bancroft J, Tyrer G, Warner P: The classification of sexual problems in women. British Journal of Sexual Medicine 1982; 9:30-37.

No. 19
EFFICACY OF TIANEPTINE IN THE TREATMENT OF DEPRESSIVE DISORDERS: A STUDY OF 316 OUTPATIENTS

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to test the efficacy of tianeptine, a novel antidepressant that enhances the uptake of serotonin, compared to other antidepressants, which inhibit serotonin reuptake.

SUMMARY:

Objective: Tianeptine is a novel antidepressant that has the unusual property of enhancing the uptake of serotonin. The purpose of this study was to evaluate its efficacy in the treatment of depressive disorders.

Methods: We enrolled 316 outpatients meeting the DSM-IV criteria for either major depressive disorder, dysthymic disorder, or bipolar depression in a six-week, open-label, fixed-dose, multicenter study. Evaluations were carried out at baseline and at weeks three and six of the study. Scales used included the Montgomery-Ashberg Depression Rating Scale (MADRS) and the Hamilton Anxiety Rating Scale (HARS). Patients were started on tianeptine 12.5 mg three times a day, and the dose was maintained throughout the study period.

Results: Mean age of study patients was 40.8 ± 11.9 years. Of the 316 patients, 53.2% were men and 46.8% were women; 89.6% of the patients had a unipolar depressive disorder (either major depressive disorder or dysthymic disorder) and 10.4% had bipolar depression. MADRS scores dropped significantly from 35.0 ± 8.9 at baseline to 22.1 ± 9.5 ($p < .05$) at week three, to 13.5 ± 10.0 ($p < .05$) at week six. Scores on the HARS dropped significantly from 28.2 ± 7.3 at baseline to 17.9 ± 8.7 ($p < .05$) at week three, to 11.5 ± 8.6 ($p < .05$) at week six. Common side effects reported by study patients were headache (2.8%), constipation (2.1%), drowsiness (1.7%), dry mouth (1.6%), nausea (1.4%), and dizziness (1.4%).

Conclusion: Tianeptine appears to be efficacious in the treatment of depressive disorders. Further double-blind placebo-controlled studies are needed to confirm our findings.

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SCIENTIFIC AND CLINICAL REPORT SESSION 7—ADOLESCENT EXPOSURE TO VIOLENCE

No. 20
SCHOOL-BASED MOURNING GROUPS: INNER-CITY VIOLENCE

Bruce H. Sklarew, M.D., *Department of Psychiatry, Howard University, 5480 Wisconsin Avenue, Ste 211, Chevy Chase MD 20815-3503* Janice L. Krupnick, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participants should be able to understand the psychodynamics of loss leading to depression, the effectiveness of mourning groups of inner-city children, and the cycle of violence in the inner city.

SUMMARY:

This paper describes the origin, evolution, and assessment of a preventive intervention project for bereaved and traumatized high-risk inner-city children conducted in 19 Washington, D.C. public elementary schools.

Effective mourning through grief groups helps children and adolescents acknowledge, bear, and work through losses and traumas and have the opportunity to invest in learning and adaptive relationships rather than act out sexually, aggressively or with drugs.

Seventy-three African-American children (43 subjects and 30 controls) between the ages of 6 and 14 participated in 20 weekly group

sessions. Innovative play techniques to deal with resistances and to promote mourning were developed. Comparing the treatment and control groups, we found an improvement in the treatment group in interpersonal problems on the Childhood Depression Inventory at the $p < .03$ level and on the Child Behavior Checklist completed by parents/guardians at the .05 to .01 levels on total problems, somatic complaints, anxiety, depression, attention, aggressivity, and internalizing behaviors.

The paper will conclude with clinical findings from the groups and a discussion of the cycle of violence in the inner city.

Funding has been received from the Kenworthy-Swift, AB, and American Psychiatric Foundations and the Project on Death in America.

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No. 21
CORRELATES OF COMMUNITY VIOLENCE EXPOSURE

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize important psychological and symptom correlates in psychiatrically hospitalized adolescents who have been exposed to high levels of community violence.

SUMMARY:

Objective: To examine the psychological and symptom correlates of community violence exposure in psychiatrically hospitalized adolescents.

Method: A nearly consecutive series of 107 adolescent inpatients aged 12-18 (mean 15.5 years) were administered a battery of psychometrically well-established psychological self-report instruments. Exposure to community violence was assessed using the Children's Exposure to Community Violence Scale (CECV; adapted from Richters & Martinez, 1990).

Results: Nearly two-thirds (65%) of the patients reported witnessing multiple incidents of community violence such as shootings, stabbings, and/or robberies. Two groups of patients (low violence exposure and high violence exposure) were identified based on median splits of their CECV scores. No significant differences were observed between the two groups with respect to age, gender, or ethnicity. Patients who reported high violence exposure also reported significantly higher ($p \leq .01$) levels of PTSD symptoms, drug and alcohol use, depression, hopelessness, and greater violence potential compared with patients with low violence exposure. Patients exposed to high degrees of community violence were also more likely to have been the victim of childhood abuse or neglect ($p \leq .001$) as well as a perpetrator of violence toward others ($p \leq .001$). Correlational analysis revealed that community violence exposure was significantly ($p \leq .001$) associated with depression, dissociative symptoms, suicidality, PTSD symptoms, drug and alcohol use, violence potential, and a history of other childhood trauma.

Conclusions: Traumatization via an exposure to community violence may serve as one important determinant in the development of mixed internalizing and externalizing psychopathology in adolescents. Adolescent inpatient programs should integrate methods of coping with community violence and trauma as part of an overall treatment plan.

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No. 22
EXPOSURE TO VIOLENCE AND POST-TRAUMATIC STRESS SYMPTOMS IN URBAN, INNER-CITY ADOLESCENTS

Deborah Lipschitz, M.D., *Department of Psychiatry, VA Connecticut 116A, 950 Campbell Avenue, West Haven CT 06516* Carlos M. Grilo, Ph.D., Ann M Rasmusson, M.D., Walter Anyan, MD, Steven M. Southwick, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the extent and effects of community- and family-based violence in inner-city youth; to diagnose PTSD and partial PTSD in nonpsychiatric treatment-seeking youth.

SUMMARY:

Aim: To assess exposure to community- and family-based violence, posttraumatic stress, and other psychopathology in urban, inner-city adolescents.

Method: 78 youngsters (90% female, mean age = 17+ 1.7 years, 80% African American), who attended an inner-city, hospital-based, adolescent primary care clinic were administered a battery of standardized self-report and interview measures assessing DSM-qualifying trauma's, posttraumatic stress symptoms, depression, anxiety, and substance use.

Results: 72 youngsters (92%) reported exposure to at least one type of trauma. Witnessing community violence was the most common trauma (85% of subjects); 16% of youngsters had been victims of a crime and 20% of youngsters had friends/family die secondary to violence. Forty percent of youngsters reported witnessing family violence, 14% reported sexual abuse, and 14% reported adolescent sexual assault. Forty-one youngsters (53%) met DSM-IV criteria for PTSD. There were significant differences in educational level ($p = .008$), but no significant gender, age, or ethnic differences between youngsters with and without PTSD. Youngsters with PTSD reported significantly more depression ($p < .001$), anxiety ($p = .001$) and problematic marijuana and alcohol use ($p = .02$) than traumatized controls.

Conclusion: Urban, inner-city youth are at extremely high risk for exposure to community- and family-based violence. Posttraumatic stress responses might be higher in this population than in other community-based samples. Risk factors for PTSD development should be explored.

REFERENCES:

1. Pfefferbaum B: Posttraumatic stress disorder in children: a review of the past 10 years. J Am Acad Child Adolesc Psychiatry, 1997; 36:1503-1511.

2. Singer MI, Anglin TM, Song LY, Lunghofer L: Adolescents' exposure to violence and associated symptoms of psychological trauma. JAMA, 1995; 273:477-482.

SCIENTIFIC AND CLINICAL REPORT SESSION 8—CULTURAL ISSUES IN BPD

No. 23
HOMOSEXUALITY/BISEXUALITY AMONG WOMEN WITH BPD

Mary C. Zanarini, Ed.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont MA 02478* Frances R. Frankenburg, M.D., Tilla F. Ruser, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize that a quarter of female borderline patients report a history of homosexuality/bisexuality. They should also be able to recognize that both temperamental and traumatic factors, including an openness to new and novel experiences, may be related to a preference for same-sex partners among borderline women.

SUMMARY:

Objective: The first purpose of this study was to assess the sexual orientation of a group of female borderline patients and to compare these rates to those reported by female Axis II controls. The second purpose of this study was to determine factors that might be significantly associated with homosexuality/bisexuality among borderline women.

Method: A series of semistructured interviews, including the Revised Diagnostic Interview for Borderlines (DIB-R) and self-report measures, were administered to 362 personality-disordered inpatients at baseline and the 95% of the surviving patients who were traced at two-year and four-year follow-up.

Results: Two hundred thirty-three female patients met DIB-R and DSM-III-R criteria for borderline personality disorder (BPD), and 46 women met DSM-III-R criteria for another type of Axis II disorder. Borderline patients were significantly more likely than Axis II controls to report having a homosexual/bisexual orientation and/or to have had a same-sex partner at some point over time (25% vs. 14%, $p = 0.008$). We then used a logistic regression to determine the relationship between homosexuality/bisexuality among borderline women and a number of temperamental and environmental factors. Three factors were found to be significantly related to borderline women reporting a homosexual/bisexual orientation: childhood sexual abuse by a caretaker, adult sexual assault, and a temperament high in openness to new and novel experiences.

Conclusions: The results of this study suggest that homosexuality/bisexuality are more common among borderline women than previously known. They also suggest that choice as well as trauma may play some role among borderline women who report an ideational and/or behavioral preference for same sex partners.

Supported in part by NIMH grant MH47588.

REFERENCES:

1. Dulit RA, Fyer MR, Miller FT, et al: Gender differences in sexual preference and substance abuse of inpatients with borderline personality disorder. J Personality Disorders 1993; 7:182-185.
2. Paris J, Zweig-Frank H, Guzder J: Psychological factors associated with homosexuality in males with borderline personality disorder. J Personality Disorders 1995; 9:56-61.

No. 24
SURVEY OF CLINICIAN ATTITUDES TOWARDS BPD

Bruce M. Pfohl, M.D., *Department of Psychiatry, University of Iowa Coll of Med, 200 Hawkins Drive, Iowa City IA 52242;* John G. Gunderson, M.D., Kenneth R. Silk, M.D., Mark Zimmerman, M.D., Janet B.W. Williams, D.S.W., Katharine A. Phillips, M.D., Clive Robins, Ph.D., A. John Rush, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to identify prevalent attitudes towards patients with borderline personality disorder among psychiatrists, psychiatry residents, psychologists, social workers, and nurses; to recognize how such attitudes may inhibit or facilitate the provision of effective care to patients with BPD.

SUMMARY:

Objective: To examine attitudes towards borderline personality disorder (BPD) among mental health professionals at eight different academic departments of psychiatry in the U.S.

Method: Surveys forms using a series of statements followed by seven-point Likert response scales were sent to clinicians at eight sites.

Results: Currently, preliminary results are available from 295 clinicians representing four sites. As a group, clinicians strongly disagreed with the statement that BPD is not a valid diagnosis, and a majority (67%) disagreed with the statement that the prognosis for BPD is hopeless. A relatively large minority (44%) gave some level of endorsement to the statement, "I prefer to avoid caring for patients with BPD." Psychologists were significantly more likely to view themselves as highly competent to treat BPD patients than were other clinicians. Social workers and psychologists viewed psychotherapy as potentially very effective. Social workers, psychiatrists, and psychiatric residents gave stronger support than did psychologists to the statement that medications may be of some benefit for BPD. Nurses (who most often work on acute inpatient units) were the most pessimistic group regarding the prognosis of BPD. They gave little support to the statements that medications or psychotherapy are helpful for BPD.

Conclusions: These findings hold important implications for clinician education and coordination of care for patients with borderline personality disorder.

REFERENCES:

1. Miller SA, Davenport NC: Increasing staff knowledge of and improving attitudes toward patients with borderline personality disorder. Psychiatric Services 1996; 47:533-5.
2. Gallop R, Lancee WJ, Garfinkel P: How nursing staff respond to the label "borderline personality disorder." Hospital & Community Psychiatry 1989; 40:815-9.

No. 25
DSM-III-R BORDERLINE AND SCHIZOTYPAL PERSONALITY DISORDERS: DISCRIMINATING SYMPTOM AND CATEGORY

Charles A. Sanislow, Ph.D., *Department of Psychiatry, Yale Psychiatric Institute, PO Box 208038/184 Liberty St., New Haven CT 06519* Carlos M. Grilo, Ph.D., William S. Edell, Ph.D., Thomas H. McGlashan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will be aware of diagnostic and symptom overlap for borderline and schizotypal personality disorders and have a better grasp of the notion of comorbidity, especially as it pertains to these two disorders.

SUMMARY:

Objective: To compare DSM-III-R borderline personality disorder (BPD) and schizotypal personality disorder (SPD) at the category and symptom level.

Method: A consecutive series of 118 inpatients (mean age = 23.6 yrs, SD = 5.6) were assessed with structured diagnostic interviews for Axis I (SCID-P) and Axis II personality disorders (PDE). Diagnoses were reliable; kappas for inter-rater reliability ranged from .65 to 1.0 (average kappas were .77 for Axis I and .84 for Axis II).

Results: Seven of 10 individuals diagnosed with SPD also met criteria for BPD (70%), whereas only seven of 44 individuals diagnosed with BPD also met criteria for SPD (15.9%). Correlations between respective BPD and SPD symptoms computed for the entire sample yielded the following significant findings: SPD "ideas of reference" with BPD "emptiness or boredom" ($r = .20$, $p = .046$); SPD "excessive social anxiety" with BPD "unstable interpersonal relationships" ($r = .24$, $p = .016$) and "identity disturbance" ($r = .21$, $p = .057$) and "emptiness or boredom" ($r = .21$, $p = .039$); SPD "unusual perceptual experiences" with BPD "inappropriate anger" ($r = .28$, $p = .005$); SPD "odd speech" with BPD "inappropriate anger" ($r = .21$, $p = .039$) and "identity disturbance" ($r = .21$, $p = .043$).

Conclusions: Despite distinct theoretical differences, SPD and BPD share similar features at the symptom level in the areas of interpersonal deficits and subpsychotic symptoms. As with prior, pre-DSM-III-R studies, results are consistent in demonstrating a high degree of overlap at the symptom and diagnostic level. SPD individuals are more likely to have a BPD diagnosis than the reverse.

REFERENCES:

1. McGlashan TH: Testing DSM-III symptom criteria for schizotypal and borderline personality disorders. Archives of General Psychiatry, 1987; 44:143-148.
2. Widiger TA, Frances A, Warner L, Bluhm C: Diagnostic criteria for the borderline and schizotypal personality disorders. J Abnormal Psychology, 1986; 95:43-51.

SCIENTIFIC AND CLINICAL REPORT SESSION 9—CULTURAL AND RACE ISSUES IN MENTAL ILLNESS

No. 26
MANAGEMENT OF MAJOR DEPRESSION IN HISPANIC PATIENTS IN THE PRIMARY CARE SETTING

David Mischoulon, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street/WAC 812, Boston MA 02114* Rachel McColl, B.A., Shauna Howarth, B.A., Isabel T. Lagomasino, M.D., Jonathan E. Alpert, M.D., Andrew A. Nierenberg, M.D., Maurizio Fava, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognized major depression in the primary care setting, particularly in Hispanic patients, and provide appropriate management, as well as improved communication with the primary care physician.

SUMMARY:

Objective: To determine how primary care physicians (PCPs) manage Hispanic patients who are newly diagnosed with major depression.

Method: Forty outpatients (35 Hispanic) were screened for major depression by SCID and HAM-D-17 at the Chelsea MGH Health Center. A letter explaining positive findings was sent to the patients' primary care physician. Medical record charts were reviewed three months later to determine the PCPs' management following the diagnosis.

Results: Of the 31 Hispanic patients who have completed three months of the study, 12 (39%) received no intervention after the PCP was informed of their diagnosis. Five (16%) were prescribed an antidepressant by the PCP, but were given no mental health referral. Seven (23%) were given mental health referrals by their PCP. Four (13%) were prescribed antidepressants by their PCP and also referred. Three (10%) did not follow up with their PCP. Forty-two percent of all patients received no intervention after a diagnosis.

Conclusion: PCPs do not address major depression aggressively enough in their practice setting. Possible explanations may include time constraints during primary care visits, cultural factors, and insufficient education of PCPs about depression. Improved education of PCPs regarding major depression in Hispanics is necessary.

Supported in part by the Program for Minority Research Training in Psychiatry of the American Psychiatric Association.

REFERENCES:

1. van der Feltz-Cornelis CM, Lyons JS, Huyse FJ, et al: Health services research on mental health in primary care. Intl J Psychiatry in Medicine 1997; 27:1-21.
2. Simon GE: Can depression be managed appropriately in primary care? J Clinical Psychiatry 1998; 59 (Suppl 2):3-8.

No. 27
EFFECT OF RACE ON RESIDENTIAL TREATMENT OUTCOMES

Kathleen M. Stack, M.D., *Hampton VAMC, 100 Emancipation Drive, Hampton VA 23667* Jorge A. Cortina, M.D., Carl Samples, C.R.D., Mario G. Zapata, M.D., Lisa Fore Arcand, Ed.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize factors associated with unsuccessful completion of residential substance abuse treatment; to discuss the association of lower completion rates with racial minority status for white males.

SUMMARY:

Objective: The purpose of this study is to identify demographic variables associated with successful completion of residential substance abuse treatment.

Method: The records of 340 veterans admitted to a 120-day drug and alcohol program were retrospectively analyzed using TTEST, CHI Square, and ANOVA. The likelihood of successful completion of residential treatment was calculated as a function of race, age, gender, diagnosis, homelessness, legal history, family history, and duration of addiction.

Results: Eighty-two percent of the veterans admitted to the program were black and 16% were white. Black veterans completed the program at a higher rate (72%) than their white counterparts (50%). Overall, 67% of veterans completed the program. Otherwise, completion rates did not vary by psychiatric diagnosis, homelessness, medical problems, legal histories, number of previous treatments, or parental history of addiction. Veterans in race-matched patient-therapist pairs were no more likely to complete the program than those in unmatched pairs.

Conclusion: The demographic data associated with completion of residential treatment suggest that racial minority status may affect outcomes of white veterans. Being in the racial minority appeared to have a greater influence on a patient's likelihood of successful completion than that of being assigned to a therapist of the same race.

REFERENCES:
1. Williams D, Lavizzo-Maurey R, Warren R: The concept of race and health status in America. Public Health Rep 1994; 109:26-41.
2. Rosenheck R, Leda Seibyl C: Participation and outcome in a residential treatment and work therapy program for addictive disorders: the effects of race. Am J Psychiatry 1988; 155:1029-1034.
3. Sue S: Psychotherapeutic services for ethnic minorities. Am Psychol 1988; 43:301-308.

No. 28
EATING DISORDERS: A TRUE WESTERN-CULTURE-BOUND SYNDROME?

Katarzyna Bisaga, M.D., *Child Psychiatry, NY State Psychiatric Institute, 3750 Hudson Manor Terr, #5CW, Bronx NY 10463* Albert C. Gaw, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to 1) understand the basic concepts of culture, culture-bound syndrome (CBS), and the pathoplastic effect of the culture on the development of eating disorders (ED); 2) recognize the role of the cultural factors in the development of ED in both Western and non-Western cultures applying a new cross-cultural psychiatry approach; 3) be familiar with the cross-cultural studies of ED and their significance for the conceptualization of ED as CBS.

SUMMARY:

Objective: The eating disorders (ED) of anorexia nervosa and bulimia nervosa have been described as Western culture-bound syndromes (CBS). Given new data from cross-cultural studies of ED, the notion of ED as a CBS is open to challenge.

Method: Peer reviewed journals published between 1979-1998 and focusing on the topic of ED and culture were reviewed. Pertinent books published in this period were also included.

Results: Epidemiological data from cross-cultural studies demonstrate that ED presenting outside the Western countries can no longer be considered "orphan cases." Available data regarding cultural factors implicated in the development of ED don't offer convincing evidence for the causal relationship. Historical data regarding the anorectic syndrome pose further questions for cultural causation hypothesis. Different ideals of femininity present in non-Western societies are identified to clarify the true content of cultural values in developing countries and their postulated relationship to the development of ED. Current conceptualization of CBS and the rationale for setting ED as CBS apart from other disorders is critically reviewed.

Conclusions: There is growing evidence to challenge the conceptualization of ED as a case of a Western CBS. The pathoplastic effect of the culture on the manifestation and the course of the mental illness is not unique for ED and should not be equated with the pathogenic effect.

REFERENCES:

1. Prince R: The concept of culture-bound syndrome: anorexia nervosa and brain-fog. Soc Sci Med 1985; 21:197-203.
2. Pumariega AJ: Acculturation and eating attitudes in adolescent girls. J Am Acad Child Adolesc Psychiatry 1986; 28:111-114.

SCIENTIFIC AND CLINICAL REPORT SESSION 10—CURRENT ISSUES IN FORENSIC PSYCHIATRY

No. 29
INCOMPETENT, UNRESTORABLE PATIENTS: A NEW APPROACH

Howard H. Sokolov, M.D., *2355 Bryden Road, Bexley OH 43209-2129*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to review the options to increase public safety and enhance treatment continuity for incompetent to stand trial, unrestorable patients in the community; understand and describe a new solution to the safety and treatment issues regarding unrestorable, incompetent to stand trial patients.

SUMMARY:

Objective: To increase public safety and community treatment continuity regarding incompetent to stand trial patients who are unrestorable (IST-U).

Method: Report of the findings of a special government committee that expressed significant concerns about public safety based on continuing voluntary treatment of the IST-U patient in the community after hospital discharge. Review of the options to increase public safety and increase treatment continuity for these patients.

Results: A new legislative option in Ohio. This option creates a separate class of IST-U defendants charged with violent offenses who are maintained in the community on a conditional release under the jurisdiction of the criminal court. Criteria for retention in criminal court and psychiatric and legal consequences of the decision will be explained. Data will be presented regarding the clinical and legal characteristics of the first patient group under this novel procedure, including charges, diagnoses, and demographics. Potential constitutional challenges to the legislation will be addressed.

Conclusion: This report will present a unique solution balancing public safety, treatment continuity, and patient rights regarding defendants who have not been restored to competency to stand trial.

REFERENCES:

1. Melton GB, Petrila J, Poythress HG, Slobogin C: Psychological Evaluations for the Courts. New York, The Guilford Press, 1987.
2. Ohio Revised Code, Sections 2945.37-2945.402, 1997.

No. 30
EFFECT OF OUTPATIENT COMMITMENT ON TREATMENT COMPLIANCE IN SCHIZOPHRENIA

Barbara M. Rohland, M.D., *Department of Psychiatry, University of Iowa, Psychiatry Research-MEB, Iowa City IA 52242* Christopher Richards, M.A., James E. Rohrer, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to identify the characteristics of patients and service organizations that influence the effect of outpatient commitment on treatment compliance and service utilization; understand the effect of outpatient commitment duration on service utilization; set realistic goals for outpatient commitment based on patient and service organization characteristics.

SUMMARY:

Objective: To determine the effect of outpatient commitment on treatment compliance in persons with schizophrenia, service utilization during outpatient commitment duration of one year or more was compared with service utilization in the 12-month period prior to commitment.

Method: 81 persons with serious mental illness who were on outpatient commitment to a single treatment agency during a five-year study period were identified. Service utilization, defined as the number of outpatient visits, emergency room visits, hospital admissions, average length of stay per admission, and total number of hospital days per year, was measured at periods of commitment up to 15 1/2 years and compared with utilization in the 12 months prior to commitment.

Results: A statistically significant increased number of outpatient visits with a concurrent decrease in hospital admissions, total number of hospital days, and lengths of stay per admission were observed at commitment duration of greater than one and five years.

Conclusion: Outpatient commitment improves compliance with outpatient treatment and reduces hospital use in patients with serious and persistent mental illness who are on outpatient commitment to a single treatment agency at periods up to five years.

Funding source: Nellie Ball Foundation.

REFERENCES:

1. Geller JL: Clinical guidelines for the use of involuntary outpatient treatment. Hospital and Community Psychiatry 1990; 41:749-755.
2. Munetz MR, Grande T, Kleist J, Peterson GA: The effectiveness of outpatient civil commitment. Psychiatric Services 1996; 47:1251-1253.

No. 31
SCHIZOPHRENIC VIOLENCE: RELATIONSHIP TO SYMPTOMS

Menahem Krakowski, M.D., *Nathan Kline Institute, 140 Old Orangeburg Road, Orangeburg NY 10962* Pal Czobor, PhD,

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand better the heterogeneity of violent behaviors in schizophrenic inpatients by considering persistence and resolution of violence over time; to relate the course of violence to underlying psychotic symptoms and neurological deficits.

SUMMARY:

Objective: To examine persistence/resolution of physical assaults in relation to psychiatric/neurological symptoms.

Method: Psychiatric symptoms were assessed with the Brief Psychiatric Rating Scale (BPRS) in violent (N = 96) and nonviolent (NVs; N = 81) schizophrenic inpatients. Patients were followed for four weeks; those who showed resolution of assaults were classified as transiently violent (TVs; N = 52), those who remained assaultive as persistently violent (PVs; N = 44). After four weeks, the BPRS and a Quantified Neurological Scale (QNS) were administered.

Results: Overall, violent patients presented with more severe psychiatric symptoms than NVs (repeated measures ANOVA; $F = 9.79$, $df = 2,159$, $p < .001$ for BPRS), but TVs showed greater improvement than PVs or NVs (ANOVA, Group X Time: $F = 3.44$, $df = 2,159$, $p = .03$). After four weeks, PVs presented with more severe hostility/suspiciousness, negative symptoms, and neurological impairment than NVs and TVs (ANOVA; $F = 3.74$, $df = 2,144$, $p = .03$; QNS score). Discriminant analyses revealed two dimensions that differentiated the groups: the first, characterized by positive psychotic symptoms, was high in violence as opposed to NVs; the second, characterized by neurological impairment, high endpoint negative symptoms and hostility/suspiciousness, was high in PVs as opposed to TVs.

Conclusions: The identification of specific symptoms associated with persistent violence has important implications for prediction and treatment of violence in patients with schizophrenia.

REFERENCES:

1. Krakowski M, Convit A, Jaeger J, et al: Neurological impairment in violent schizophrenic inpatients. Am J Psychiatry 1989; 146:849-853.
2. Heinrichs DW, Buchanan RW: Significance and meaning of neurological signs in schizophrenia. Am J Psychiatry 1988; 145:11-18.

SCIENTIFIC AND CLINICAL REPORT SESSION 11—PROGNOSTIC FACTORS IN THE TREATMENT OF SCHIZOPHRENIA

No. 32
PREMORBID ASSOCIALITY AND NEUROPSYCHOLOGICAL STATUS

Marshall L. Silverstein, Ph.D., *Department of Psychology, Long Island University, CW Post Campus, Brookville NY 11548* George Mavrolefteros, M.D., David Close, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: 1) provide an updated understanding of measures from the Wisconsin Card Sorting Test, a widely used neuropsychological instrument for examining cognitive deficits in schizophrenics; 2) present research findings showing that Wisconsin Card Sorting abnormalities are more prominent in schizophrenics with histories of early premorbid asociality.

SUMMARY:

Objective: Neuropsychological deficit in schizophrenia can be demonstrated reliably; however, there remain questions about its relationship to course and outcome. Since premorbid asociality compromises functioning prior to the onset of clinical schizophrenia, its effect on neurocognitive performance is largely unknown. This report examines the relationship between premorbid asociality and cognitive dysfunction in schizophrenia.

Method: Subjects were 50 outpatients with chronic schizophrenia (28 of good premorbid and 22 with poor premorbid psychosocial adjustment) who received a battery of neuropsychological tests. A reliable informant from the patient's family was interviewed using a structured inventory to elicit information about social adjustment and school performance during childhood and adolescence. The interview, supplemented by school transcripts, formed the basis for ratings on the Premorbid Adjustment Scale (PAS) developed by a NIMH workgroup for rating sociability/withdrawal and academic performance/behavioral adjustment to school.

Results and Conclusions: Findings indicate that premorbid functioning, particularly psychosocial adaptation to the school environment, adversely influences neuropsychological performance in chronic schizophrenia. The early effect of deficient social functioning by itself does not lead to cognitive deficit. The clinical implications of these findings suggest that interpersonal withdrawal during childhood or adolescence does not predict neurocognitive dysfunction in adulthood, unless the pattern of premorbid asociality is associated with pronounced psychosocial disturbance affecting school performance as well.

REFERENCES:

1. Cannon-Spoor HE, Potkin SG, Wyatt RJ: Measurement of premorbid adjustment in chronic schizophrenia. Schizophrenia Bulletin, 1982; 8:470-484.
2. Braff DL, Henton R, Kuck J, et al: The generalized pattern of neuropsychological deficits in outpatients with chronic schizophrenia. Arch Gen Psychiatry 1991; 48:891-898.

No. 33
NEGATIVE SYMPTOMS AND FUNCTIONING IN SCHIZOPHRENIA

Ellen S. Herbener, Ph.D., *Department of Psychiatry, University of Illinois, 1601 West Taylor Street, Chicago IL 60612* Martin Harrow, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the importance of looking for persistent positive and negative symptom combinations in schizophrenic patients and understand the effects of positive and negative symptoms on social, work, and cognitive functioning.

SUMMARY:

Objective: To investigate the roles of positive and negative symptoms in instrumental and cognitive functioning.

Method: Sixty-four individuals with schizophrenia spectrum disorders received structured follow-up interviews at five, seven to eight, and 10 years post-index admission. Using standardized interviews and test instruments at each follow-up, data were collected on major symptoms and social, work, and cognitive functioning.

Results: 1) Schizophrenics who showed a combination of positive and negative symptoms at one follow-up tended to show the same symptom pattern at later follow-ups. 2) Positive symptoms appeared to be particularly strongly related to deficits in social and work functioning, with individuals who exhibited a combination of positive and negative symptoms performing most poorly. 3) Negative symptoms appeared to be particularly influential in cognitive performance, with individuals with both positive and negative symptoms typically performing most poorly.

Conclusions: Our data suggest that 1) there is a subgroup of schizophrenics characterized by simultaneous presence of positive and negative symptoms; 2) this symptom combination persists over time; 3) the presence of simultaneous positive and negative symptoms is typically associated with the most severe impairments in work, social, and cognitive functioning. 4) Positive symptoms were more strongly associated with deficits in instrumental functioning, while negative symptoms were more strongly associated with deficits in cognitive functioning.

REFERENCES:

1. Davidson L, McGlashan TH: The varied outcomes of schizophrenia. Can Journal of Psychiatry 1997; 42:34-43.
2. Andreasen NC, Arndt S, Alliger A, et al: Symptoms of schizophrenia: methods, meanings and mechanisms. Arch Gen Psychiatry 1995; 52:341-351.

No. 34
DO SCHIZOAFFECTIVE PATIENTS HAVE A CHRONIC COURSE?

Martin Harrow, Ph.D., *Department of Psychiatry, University of Illinois, 912 South Wood Street, Chicago IL 60612* Ellen S. Herbener, Ph.D., Joseph F. Goldberg, M.D., Kalman J. Kaplan, Ph.D., Marshall L. Silverstein, Ph.D., Rajiv P. Sharma, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should have a better understanding of ways in which long-term clinical course and outcome for schizoaffective patients are similar to and differ from bipolar manic and schizophrenia patients.

SUMMARY:

Objective: The current research, using longitudinal data to analyze clinical course over time in schizoaffective disorders, sought to determine whether schizoaffective patients differ from schizophrenia patients in terms of 1.) schizoaffective disorders having a less chronic course, 2.) schizoaffective patients having less severe symptoms over time, and 3.) schizoaffective patients having a course involving more periods of complete remission or recovery than schizophrenia patients.

Method: 193 patients from the Chicago Follow-up Study (including 36 schizoaffective and 71 schizophrenia patients) were evaluated at the acute phase and then followed up four times over the next 10 years. Employing standardized assessments, patients were evaluated for psychosis, affective syndromes, thought disorder, psychosocial functioning, and medications. Newly developed measures were used to assess clinical course over time, or "chronicity."

Results: 1.) The data from four successive follow-ups over 10 years indicated that almost 70% of the schizoaffective patients showed a relatively "chronic course." 2.) Less than 12% of the schizoaffective patients showed sustained remission throughout the 10-year period. 3.) Unlike the schizoaffective patients, the bipolar manic patients showed a less chronic picture, with more periods of sustained remission.

Conclusions: Overall, the schizoaffective patients manifested a relatively chronic course over time. Unlike the bipolar patients, with their more intermittent episodes, the schizoaffectives showed some similarity to schizophrenics. In terms of their relatively chronic course, schizoaffective patients might be viewed as part of the schizophrenia spectrum disorder. However, the symptom severity of schizoaffective patients over time was less severe than that of schizophrenia patients.

REFERENCES:

1. Winokur G, Monahan P., Coryell W, Zimmerman M.: Schizophrenia and affective disorder—distinct entities or continuum?: an analysis based on a prospective 6-year follow-up. Comprehensive Psychiatry 1996; 37:77-87.
2. Grossman L., Harrow M., Goldberg J., et al: Outcome of schizoaffective disorder at two long-term follow-ups: comparisons with outcome of schizophrenia and affective disorders. Am J Psychiatry 1991; 148:1359-1365.

SCIENTIFIC AND CLINICAL REPORT SESSION 12—DEPRESSION AND THE LIFE CYCLE IN WOMEN

No. 35
PAST DEPRESSION AND MIDDLE-AGED WOMEN'S HEALTH

Joyce T. Bromberger, Ph.D., *Dept of Epidemiology, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh PA 15213* Howard M. Kravitz, M.P.H., Adriana Cordal, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to: understand the interrelatedness of prior mental health and the physical and psychological experiences of women at midlife and the potential ethnic differences in symptoms experienced by middle-aged women, particularly in vasomotor and dysphoric symptoms.

SUMMARY:

Objective: Midlife is a time of psychosocial and biological changes for women. Still debated is whether rates of depression and other psychological/somatic symptoms increase during this stage of life. Using data from the Pittsburgh site of the Study of Women's Health Across the Nation (SWAN), we tested the hypothesis that women with past major depression are a subset at risk for physical and psychological problems during midlife.

Method: Our community sample of women aged 42-52 provided data on symptoms and stress at a screening interview and three to nine months later were administered the Structured Clinical Interview for DSM-IV. We examined associations of past depression and ethnicity with psychological/somatic symptoms and stress in 118 black and 241 white women without current depression. We included psychosocial and menopausal status covariates in multiple linear and logistic regression analyses comparing women with and without past depression.

Results: Women with past depression reported higher perceived stress ($t = 2.82$, $p = .005$) and more total psychological/somatic ($t = 3.91$, $p < .001$), dysphoric (e.g., irritable, blue) ($t = 2.65$, $p = .008$), and physical symptoms (e.g., headaches, stiffness in joints, vaginal dryness) ($t = 3.99$, $p < .001$). Blacks reported higher odds for vasomotor (OR = 1.67, 95% CI = 1.00 – 2.86) and a trend for fewer dysphoric symptoms than whites.

Conclusions: These preliminary data suggest that women with prior depression have more symptoms during midlife. Prospective SWAN data will assess the influence of past depression on women's health during the menopause transition.

Funded by NIA.

REFERENCES:

1. Matthews KA, Wing RR, Kuller LH, et al: Influences of natural menopause on psychological characteristics and symptoms of middle-aged healthy women. J Consult Clin Psychol 1990; 58:345-351.
2. Moldin SO, Scheftner WA, Rice JP, et al: Association between major depressive disorder and physical illness. Psychological Medicine 1993; 23:755-761.

No. 36
SYMPTOM EXPRESSION IN POSTPARTUM MOOD DISTURBANCE

Ruta M. Nonacs, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street/WACC 812, Boston MA 02114* Lee S. Cohen, M.D., Sarah A. Howlett, B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize patterns of symptom expression that are characteristic of postpartum depression.

SUMMARY:

Introduction: While postpartum depression (PPD) is similar to major depression occurring in women at other times, there has been controversy as to whether postpartum psychiatric disorders constitute a distinct diagnostic entity. Clinically, PPD appears to be more commonly associated with anxiety and somatization; however, few studies have systematically assessed differential symptom expression in women suffering from PPD.

Methods: We examined patterns of symptom expression using the Kellner Symptom Questionnaire in a group of 150 postpartum women with severe depressive symptomatology (as identified with the Center for Epidemiologic Studies Depression Scale, CES-D) in an outpatient obstetrical clinic. This cohort was compared with a group of age-matched, nonpuerperal women with depression. A similar analysis was performed on a subset of women with confirmed DSM-IV major depression with onset within the first three postpartum months. This smaller group was also assessed using the following clinical instruments: SCID, Hamilton Depression Rating Scale, Beck Depression Inventory.

Results: Comorbid anxiety disorders were common, occurring in 25% of postpartum women with DSM-IV major depression. Women with PPD were noted to have a particular pattern of symptom expression characterized by prominent anxiety and somatic concerns.

Conclusions: Regardless of whether PPD is a discrete diagnostic entity, women who suffer from this disorder appear to exhibit prominent anxiety symptoms or frank anxiety disorder. The implications of these findings on diagnosis and treatment of PPD will also be discussed.

REFERENCES:

1. Whiffen VE: Is postpartum depression a distinct diagnosis? Clin Psychol Rev 1992; 12:485-508.
2. Nonacs R, Cohen LS: Postpartum mood disorders: diagnosis and treatment guidelines. J Clin Psychiatry 1998; 59(suppl 2):34-40.

No. 37
THE USE OF NORTRIPTYLINE FOR PREVENTION OF POSTPARTUM DEPRESSION IN A HIGH-RISK GROUP OF WOMEN

Kathleen S. Peindl, Ph.D., *Department of Psychiatry, Case Western Reserve Univ., 11400 Euclid Avenue, Suite 280, Cleveland OH 44106* Katherine L. Wisner, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the importance of a treatment plan for the prevention of postpartum depression.

SUMMARY:

Objective: We compared the efficacy of nortriptyline (NTP) and placebo (PL) for the prevention of postpartum depression (PPMD) in an interim analysis of our data.

Method: The study compared the efficacy of NTP versus PL during the first 20 weeks postpartum in a group of women who had experienced a previous episode of PPMD (high risk). Fifty-six women were randomized to either PL or NTP in a double-blind clinical trial. All women were well when randomization occurred.

Results: We found that there was no difference in the NTP versus the PL group for recurrence rate or time to recurrence. The observed recurrence rates were .25 and .21 for the PL and NTP groups, respectively. We also found that there was no difference between the two groups on continuous measures of depression, either self-related or clinical-related.

Discussion: The data suggest that NTP may not be the first-choice drug for treatment of PPMD. One-fourth of the women at risk for PPMD suffered a recurrence. NTP does not confer an advantage over PL. Since SSRIs have become first-line drugs for depression, the compelling question is whether these drugs will be more effective than PL in the prevention model.

REFERENCES:

1. Prien RF, Kupfer KJ, Mansky PA, et al: Drug therapy in the prevention of recurrences in unipolar and bipolar affective disorders. Arch Gen Psychiatry 1984; 41:1096-1104.
2. Feigenbaum SL: Quality assurance in clinical trials. Seminars in Reprod Endocrinology 1996; 14:93-100.

SCIENTIFIC AND CLINICAL REPORT SESSION 13—BURNING ISSUES IN PSYCHIATRIC EDUCATION

No. 38
EFFECTS OF MANAGED CARE ON PSYCHIATRIC EDUCATION

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to summarize the perceptions of medical student educators in psychiatry regarding the impact of changes in health care financing on the education of medical students in psychiatry and on their careers; to discuss the implications of the above findings.

SUMMARY:

Objective: Little is known about the consequences of the reorganization of health care financing for undergraduate psychiatric education. This is the first study of psychiatric educators' perceptions of these potential changes. It is part of a national study of all major clerkship organizations under the auspices of the Alliance for Clinical Education.

Method: A survey soliciting opinions about changes in faculty participation, directors' administrative and clinical duties, teaching sites, content and formats, quality of student learning, and general effects of managed care was mailed to directors of medical student education in psychiatry at all 137 U.S. and Canadian medical schools.

Results: 108 surveys were returned (79%). Chi square analysis of the number of endorsements that a particular aspect of the student teaching program had worsened rather than improved showed that managed care negatively impacted every feature examined. Particularly affected are teacher recruitment, quality of directors' professional lives, and students' clerkship experiences.

Conclusions: These findings raise questions about the quality of psychiatric education, directors' morale, and recruitment and support the need for independent funding of medical education.

REFERENCES:

1. Pardes H: The future of medical schools and teaching hospitals in the era of managed care. Acad Med 1997; 72:97-102.
2. Campbell EG, Weissman JS, Blumenthal D: Relationship between market competition and the activities and attitudes of medical school faculties. JAMA 1997; 278:222-226.

No. 39
IMPACT OF PATIENT SUICIDE ON PSYCHIATRIC TRAINEES

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be increasingly aware of the impact and frequency of patient suicide on the psychiatric trainee.

SUMMARY:

Objective: This study set out to determine the impact and frequency of patient suicide on psychiatric trainees at the University of Toronto postgraduate psychiatry program.

Method: A survey questionnaire mailed to 495 University of Toronto psychiatric trainees completing training between 1980-1995 included questions to elicit demographic and educational information, personal exposure to suicide, professional exposure to suicide, impact of suicide(s), use of support systems, presence of ASD and PTSD symptoms, and scores on the Impact of Event Scale (IES).

Results: Of the 495 questionnaires sent, 239 were returned completed, giving a response rate of 48%. Of all trainees, an unexpectedly high number of respondents, 50%, had exposure to patient suicide; of these, 57% experienced patient suicide by the end of PGY-1. IES disclosed that 24% of trainees had intrusion scores at a clinical level > 12, s.d. = 5.6, while 22% showed clinical avoidance scores > 10, s.d. = 5.3.

Conclusion: This study showed a high risk for PGY-1 trainees to experience patient suicide. Special considerations for training, teaching, and supervision are discussed.

Funding Source: research grant—department of psychiatry—Mount Sinai Hospital research grant—psychotherapy program—University of Toronto, department of psychiatry

REFERENCES:

1. Brown HN: The impact of suicide on therapists in training. Comprehensive Psychiatry 1987; 28:101-105.
2. Chemtob CM, Hamada RS, Bauer G, et al: Patients' suicides: frequencies, and impact on psychiatrists. Am J Psychiatry 1988; 145:224-228.

No. 40
A MODEL PSYCHOPHARMACOLOGY CURRICULUM

Ira D. Glick, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Suite 2122, Stanford CA 94305-5490* Nicholas G. Ward, M.D., Donald F. Klein, M.D., P. Murali Doraiswamy, M.D., Jessica R. Osterheld, M.D., David S. Janowsky, M.D., David W. Preven, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will be aware of the elements of a new model psychopharmacology curriculum and how it worked in its first year of use in residency training programs.

SUMMARY:

Three central issues bear on the teaching of clinical psychopharmacology in the 1990's. First, there is ever more information to assimilate as a result of advancing knowledge in the neurosciences and the availability of new pharmaceuticals. Second, there are ever more ways to acquire this new information: print, audiovisual, online Internet, etc. Finally, the increasingly specialized roles of neuroscience and mental health professionals require that educational materials be designed for and targeted to meet the diverse needs of such groups as medical students, residents in psychiatry, clinical practitioners, industry, and federal scientists, and CRO's.

Accordingly, as a starting point, we present a model psychopharmacology curriculum for psychopharmacology residency programs. The curriculum consists of an overview, learning and educational objectives, what and how to teach, how to evaluate, how to organize a psychopharmacology program, and an investigative psychiatry curriculum. It also includes 31 lecture outlines with hard copies of 1500 slides, which comprise basic and advanced courses, as well as a compendium of patient rating scales, rating forms for trainees, and course evaluation and annotations on recommended texts and journals.

A follow-up evaluation of the experience of users of the curriculum will be presented.

Funding source: American Society of Clinical Psychopharmacology (in part)

REFERENCES:

1. Glick ID, Janowsky DS, Salzman C, Shader RI: A proposal for a model psychopharmacology curriculum for psychiatric residents. Neuropsychopharmacology 1993; 8:1-5.

2. Schatzberg AF, Nemeroff CB (eds): Textbook of Psychopharmacology, Second Edition. Washington, DC, American Psychiatric Press, 1998.

SCIENTIFIC AND CLINICAL REPORT SESSION 14—DIAGNOSIS AND TREATMENT OF MENSTRUAL CYCLE DISORDERS

No. 41
VARIABILITY OF DEPRESSIVE SYMPTOMS DURING THE MENSTRUAL CYCLE

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the relationship between depressive symptoms and menstrual cycle phase and to understand the importance of controlling for menstrual cycle phase in premenopausal women enrolled in depression studies.

SUMMARY:

Objectives: To evaluate the variability of depressive symptoms during the menstrual cycle in women seen in a primary care clinic.

Methods: All consecutive patients seen in a women's primary care clinic (ages 18-77 years) in a six-month period were asked to complete a questionnaire about their mood, menstrual status, and antidepressant (AD) use, if any. Mood was assessed with the Community Epidemiology Scale for Depression (CES-D). A CES-D score above 16 suggests a depression diagnosis. Of the 1219 women who completed the questionnaire, 655 had regular menstrual cycles (ages 18-54 years). For these women with regular cycles, we compared the percent of premenstrual women with elevated CES-D scores with that of postmenstrual women.

Results: Fifty percent of women with regular cycles were in the premenstrual phase. Of these, 28% had a CES-D score above 16, as compared to 20% of postmenstrual women ($p = 0.016$). Because there was an excess of premenstrual women on AD therapy, we stratified the analysis on the presence or absence of AD therapy. Premenstrual women were still more likely to have CES-D scores over 16 (adjusted RR = 1.34, $p = 0.046$, Mantel-Haenszel).

Conclusions: On a standardized depression scale, women in the premenstrual phase were more likely to be depressed. Given the observed relationship between menstrual cycle phase and depression scores, studies of depression may need to control for menstrual phase.

Research supported by the Kaplan Depression Research Fellowship, Harvard Medical School.

REFERENCES:

1. Leibenluft E, Fiero PL, Rubinow DR: Effects of the menstrual cycle on dependent variables in mood disorder research. Arch Gen Psychiatry 1994; 51:761-781.
2. Hamilton JA, Parry BL, Blumenthal SJ: The menstrual cycle in context, I: affective syndromes associated with reproductive hormonal changes. J Clin Psychiatry 1988; 49:474-480.

No. 42
PMS AND MENTAL HEALTH DURING MENOPAUSE

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EDUCATIONAL OBJECTIVES

At the conclusion of this presentation, the participant should be able to recognize that women with previous moderate to severe premenstrual complaints are particularly vulnerable to mental health problems at the time of the menopause and, therefore, to understand that some women may be more vulnerable to the effects of the hormonal and environmental changes associated with the menstruation and menopause.

SUMMARY:

Background: Psychiatric symptoms are frequent in the perimenopause. They are similar to symptoms observed at different stages of a woman's life cycle, suggesting an association between mental disturbances of the perimenopause and those observed during premenstrual and postnatal periods.

Objective: This study determined the reliability of using a modified version of Steiner PMT self-report questionnaire for assessing retrospectively the presence of premenstrual complaints and evaluating the association between previous premenstrual complaints and psychiatric symptoms at the time of the menopause.

Method: Perimenopausal women ($n = 41$) were selected to establish the reliability to assess premenstrual symptoms retrospectively (4-8 weeks interval between measures)—agreement between measurements was assessed with the kappa statistic. Ninety-six women were later recruited from a menopause clinic to study the association between premenstrual complaints and the presence of psychiatric symptoms at the time of the menopause (as measured by the SRQ-20). SRQ total scores greater than 7 were considered indicators of psychiatric morbidity.

Results: All 36 PMT scale items showed good test-retest reliability ($0.44<\text{kappa}<1.0$). There was a significant correlation between total PMT and SRQ-20 scores (spearman=0.75, $p < 0.001$). SRQ total score greater than 7 was observed in 47.9% of patients.

Conclusions: Premenstrual symptoms can be reliably measured in perimenopausal women. Women who report having experienced premenstrual dysphoria are more likely to present with psychiatric symptoms at the time of the menopause.

REFERENCES:

1. Arpels JC: The female brain hypoestrogenic continuum from the premenstrual syndrome to menopause. J Reproductive Medicine 1996; 41:633-639.
2. Novaes Soares C, Almeida OP: Premenstrual syndrome and psychiatric morbidity at the menopause. J Psychosom Obstet Gynaecol. (in press).

No. 43
FLUOXETINE'S EFFICACY IN IMPROVING PHYSICAL SYMPTOMS ASSOCIATED WITH PDD: RESULTS FROM A MULTISITE, RANDOMIZED, PLACEBO-CONTROLLED TRIAL

Meir Steiner, M.D., *Department of Psychiatry, McMaster University, 50 Charlton Ave E/St. Joseph's, Hamilton, ONT L8N 4A6, Canada* Steven J. Romano, M.D., Susan Babcock, M.S., Susanne I. Steinberg, M.D., Donna E. Stewart, M.D., Diana Carter, M.B., Charlene Berger, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the affective and somatic symptoms contributing to PMDD and understand the accumulated data regarding fluoxetine's efficacy in the treatment of both symptom categories; participants will also discuss the possible mechanisms of this efficacy.

SUMMARY:

Introduction: A previously reported, placebo-controlled, multisite trial found fluoxetine effective in mediating PMDD mood symptoms; these data are now used to determine fluoxetine's effectiveness on PMDD physical symptoms. Though cyclical mood disturbance is the pathognomonic feature of PMDD, physical symptoms (e.g., breast tenderness and bloating) frequently contribute to the severity of presentation.

Methods: Physical symptoms were assessed in 320 PMDD patients who were randomized to fluoxetine 20 mg/day, fluoxetine 60 mg/day, or placebo. Physical symptoms were assessed by both Visual Analogue Scale (VAS; breast tenderness, bloating, headache, and 3-item average; range 0-100), and physical subtotal (pain, general; painful, tender breasts, swelling/bloating) of the patient-rated Premenstrual Tension Syndrome Scale (PMTS-P). Outcome measures were change from mean baseline luteal phase scores to mean treated luteal phase scores.

Results: Fluoxetine treatment (20 and 60 mg/day) was statistically significantly superior to placebo treatment via VAS (breast tenderness, bloating, and 3-item average) and PMTS-P physical subtotal (all analyses significant; $p < .05$). For all comparisons, 20 mg/day and 60 mg/day doses were not significantly different.

Conclusions: Fluoxetine treatment was statistically significantly superior to placebo in improving frequently reported PMDD-associated physical complaints (breast tenderness and bloating) as measured by VAS and a derived physical subtotal of the PMTS-P. Possible mechanisms will be discussed.

REFERENCES:

1. Steiner M, Steinberg S, Stewart D, et al: Fluoxetine in the treatment of premenstrual dysphoria. New England Journal of Medicine. 1995; 332:1529-1534.
2. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 4th ed. Washington, DC: American Psychiatric Association, 1994. pp. 717-718.

SCIENTIFIC AND CLINICAL REPORT SESSION 15—COMORBIDITY OF ANXIETY AND DEPRESSION

No. 44
COMPARISON OF SOCIAL FUNCTIONING IN PATIENTS WITH ANXIOUS DEPRESSION OR MDD

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the differences in social impairment in patients with anxious depression versus nonanxious depression.

SUMMARY:

Objective: Major depressive disorder is accompanied by impairment in social functioning. Anxious depression, when defined as major depressive disorder (MDD) accompanied by one or more comorbid anxiety disorders, is a common subtype of major depression. The purpose of this study was to compare social functioning in patients with anxious depression versus nonanxious depression.

Methods: We enrolled 220 outpatients (115 patients with anxious depression, and 105 patients with major depression that was not accompanied by one or more current comorbid anxiety disorders) in our study. Assessments included the Structured Clinical Interview for DSM-III-R (SCID-I/P), 17-item Hamilton Rating Scale for Depression (HAM-D-17), and the self-rated Social Adjustment Scale (SAS-SR). The Mann-Whitney U test was used to assess the differences in social adjustment between patients with anxious depression and those with nonanxious depression.

Results: Mean age of patients with anxious depression was 39.1 ± 11.0 years, and that of patients with nonanxious depression was 40.4 ± 10.3 years. There were 66 women and 49 men in the anxious depressed group, and 53 women and 52 men in the nonanxious depressed group. Anxious depressives had statistically significantly greater overall impairment compared with nonanxious depressives on SAS-SR overall adjustment scores. The SAS-SR subscales of social leisure, work outside, relationship with extended family, role as a parent, and membership in a family unit also showed significant differences between the two groups, with the anxious depressed group showing a significantly greater impairment in these areas than the nonanxious depressed group. We also found a statistically significant relationship between number of comorbid anxiety disorders and degree of overall social adjustment.

Conclusion: Our findings suggest that anxious depression is accompanied by a significantly greater degree of social impairment than is nonanxious depression.

REFERENCES:

1. Weissman MM, Prusoff BA, Harding PS, et al: Social adjustment by self-report in a community sample and in psychiatric outpatients. J Nervous and Mental Disease, 1978; 166:317-326.
2. Hiller W, Zaudig M, von Bose M: The overlap between depression and anxiety in different levels of psychopathology. J Affective Disorders, 1989; 16:223-231.

No. 45
ANXIETY DISORDERS IN MAJOR DEPRESSION

Maurizio Fava, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC 812, Boston MA 02114* Meredith A. Rankin, B.A., Emma Wright, B.S., Jonathan E. Alpert, M.D., Andrew A. Nierenberg, M.D., Joel Pava, Ph.D., Jerrold F. Rosenbaum, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should be able to be familiar with the types of comorbid anxiety disorders that occur among patients with major depression. They should also be able to recognize some of the clinical features that may distinguish this group of patients.

SUMMARY:

Prevalence and clinical impact of anxiety disorder comorbidity in major depression were studied in 255 depressed adult outpatients consecutively enrolled in our depression research program. Comorbid anxiety disorders diagnoses were present in 50.6% of these patients and included social phobia (27.0%), simple phobia (16.9%), panic disorder (14.5%), generalized anxiety disorder (10.6%), obsessive-compulsive disorder (6.3%), and agoraphobia (5.5%). While both social phobia and generalized anxiety preceded the first episode of major depression in 65% and 63% of cases, respectively, it was much less likely for panic disorder (21.6%) and agoraphobia (14.3%) to have preceded the first episode of major depression than to have emerged subsequently. Although comorbid groups were not distinguished by depression, anxiety, hostility, or somatic symptom scores at time of study presentation, patients with comorbid anxiety disorders tended to be younger during the index episode and to have had an earlier onset of their major depressive disorder than patients with major depression alone.

Our results support the distinction between anxiety symptoms secondary to depression and anxiety disorders comorbid with major

depression and provide further evidence for different temporal relationships with major depression among the several comorbid anxiety disorders.

REFERENCES:

1. Fava M, Uebelacker LA, Alpert JE et al: Major depressive subtypes and treatment response. Biological Psychiatry 1997; 42:568-576.
2. Otto MW, Pollack MH, Fava M, et al: Elevated anxiety sensitivity index scores in patients with major depression: correlates and changes with antidepressant treatment. Anxiety Disorders 1995; 9:117-123.

No. 46
DEPRESSION AND ANXIETY COMORBIDITY USING THE PRIME-MD

Mary Kay Smith, M.D., *Department of Psychiatry, Medical College of Ohio, 3120 Glendale Avenue, RHC 0079, Toledo OH 43614* Denis J. Lynch, Ph.D., Rollin Nagel, M.A., Marijo B. Tamburrino, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss the utility of using the Prime-MD to identify primary care patients with depressive and anxiety disorders and to recognize the significance of identifying those individuals with both depression and anxiety in primary care settings and the role that comorbidity plays in the eventual diagnosis of depression.

SUMMARY:

Objective: Major depressive disorder occurs in over 50% of primary care patients. This study used the Prime-MD to identify depression and comorbidity with anxiety in primary care settings.

Method: Of the 1,704 people screened with the Prime-MD PQ, 27.9% (N = 475) screened positive for depression, with 24.2% (N = 413) positive for anxiety as well. The Prime-MD CEG was administered by telephone to 301 of the 475 subjects screening positive for depression.

Results: Of those screening positive only for depression, 22% received a depression diagnosis on the Prime-MD CEG. Of those screening positive for both depression and anxiety, 54.2% received a depression diagnosis and 26.9% received both depression and anxiety diagnoses. On the Prime-MD CEG, 49.8% (N = 150) of individuals who had screened positive for depression received a DSM-IV depression diagnosis and 23.3% (N = 70) received a comorbid anxiety diagnosis.

Conclusions: Major depressive disorder accounted for five times the rate of anxiety comorbidity found with either dysthymic disorder or minor depressive disorder alone. These findings suggest that the Prime-MD is useful for identifying comorbid depression and anxiety, and that a finding of comorbidity on screening is more suggestive of an ultimate depression diagnosis, most commonly major depressive disorder.

REFERENCES:

1. Roy-Byrne P, Katon W, Broadhead W: Subsyndromal ("mixed") anxiety-depression in primary care. J Gen Intern Med 1994; 9:507-512.
2. Brown C, Schulberg H, Madonia M: Treatment outcomes for primary care patients with major depression and lifetime anxiety disorders. Am J Psychiatry 1996; 153:1293-1300.

SCIENTIFIC AND CLINICAL REPORT SESSION 16—HIV AND PSYCHOIMMUNOLOGY

No. 47
THE OPTION OF EUTHANASIA FOR HIV DISEASE IN EUROPE

Panayiotis I. Vyras, M.D., *Department of Psychology, University of Crete, Gen Kolokotroni 59 Koukaki, Athens 11741, Greece* Roberta Andraghetti, M.D., Bob Colebunders, M.D., Nikos A. Papadopoulos, B.Sc., Ioannis N. Nestoros, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the extend to which HIV+ persons in Europe favor the possibility of legally available euthanasia options and acknowledge that being able to make a choice of "dying well" may ease patients' fears concerning eventual disease progression and unbearable suffering.

SUMMARY:

Objective: To present findings from an EU study (1996-97) concerning an eventual legalization of euthanasia for people with HIV disease. The aim is to provide health and legal professionals with a perspective from patients regarding the right one has to discontinue life and die with dignity when terminally ill.

Method: In a cross-sectional descriptive survey of ambulatory outpatients attending major HIV/AIDS centers of 11 EU countries, 2751 standardized, anonymous, self-administered questionnaires were distributed, of which 1341 were returned completed (49%). Questions addressed patients' experience with treatment and quality of care. Data in EXCEL formats were validated and analyzed with EPEMFO 6 (descriptive statistics, stratified logistic regression models, results with $p < 0.05$).

Results: Respondents in this sample favor euthanasia in cases of severe physical suffering (78%), severe psychological suffering (47%), and mere patient request (24%). Prospective euthanasia practices are pain alleviation with double effect (81%), passive euthanasia (69%), medical euthanasia (62%), physician assisted suicide (45%). Euthanasia (nonspecified) is envisaged for terminal illness after other treatment options are exhausted (50%). Social indicators (educational level, occupation) seem more significant than disease status in predicting patients acceptance of euthanasia. Motivation to discuss death and dying with care givers relates to patients' health status (CD4 counts).

Conclusion: The possibility of legally performed euthanasia practices seems to be a viable prospect among HIV+ persons in Europe. Eventual availability of such options may reduce patients anxiousness regarding end-of-life decisions.

This study was partly funded by the EU Commission (Eurosupport Project).

REFERENCES:

1. Seale C, Addingron Hall J: Euthanasia: why people want to die earlier. Soc Sci Med 1994; 39:647-654.
2. Starace F, Shea L: Suicidal behaviors, euthanasia and AIDS. AIDS 1998; 12:339-347.

No. 48
IMMUNOLOGICAL STATUS VERSUS DEPRESSION AS PREDICTORS OF QUALITY OF LIFE IN HIV-INFECTED INDIVIDUALS

Jose R. Maldonado, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Room 2317, Stanford CA 94305* Dennis Israelski, M.D., Cheryl Koopman, Ph.D., Cheryl Gore-Felton, Ph.D., Susan Diamond, C.S.W., Aaron M. Chapman, M.D., David Spiegel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the relationship between CD4 cell count and quality of life among HIV positive patients, and understand the relationships between depression and CD4 cell count with quality of life (QOL) among HIV-positive patients.

SUMMARY:

Objective: This study examined the relationships between depression and CD4 cell count with quality of life (QOL) among HIV-positive patients.

Method: 103 HIV-positive subjects, 73 males and 30 females, were recruited into a randomized clinical trial on the effects of groups psychotherapy on health risk behavior and QOL. The subjects' mean age was 40 years, 47% were low income, 63% white, 25% African American, and 12% other ethnicity. Half of the subjects had been diagnosed with AIDS.

Results: In the multiple regression analysis, depression was found to be significantly related to perceived poor health, pain experienced, pain interference with duties, difficulty in reasoning and problem solving, forgetfulness, difficulty in sustaining attention, difficulty in concentrating and poor health, and health-limiting social activities. In contrast, CD4 cell count was significantly related only to health limiting social activities.

Conclusions: Depression more than CD4 cell count is related to most indices of quality of life among HIV-positive adults. Thus, in HIV-infected persons, a subject's experience of depressive symptoms is a better predictor of poor quality of life than a low CD4 cell count. These results suggest that depression adversely affects QOL, and that effective treatment of depression may dramatically improve the QOL of HIV-infected persons.

REFERENCES:

1. Crocchiolo PR, Lizioli A, Cantaluppi P, et al: CD4+: neopterin ratio correlates with p24 antigenaemia in HIV infected patients. J Clin Lab Imm, 1990; 31:55-7.
2. Burack JH, Barrett DC, Stall RD, et al: Depressive symptoms and CD4 lymphocyte decline among HIV-infected men. JAMA 1993; 270:2568-73.

No. 49
DIURNAL CORTISOL AND EARLY CANCER MORTALITY

David Spiegel, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Room 2325, Stanford CA 94305-5544* Sandra E. Sephton, M.S., Robert M. Sapolsky, Ph.D., Helena C. Kraemer, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize dysregulation of endocrine and other aspects of circadian physiology that predict poorer health outcome.

SUMMARY:

Evidence has accumulated demonstrating a connection between psychosocial stress and support and the rate of disease progression among women with breast cancer. Laboratory studies have shown that abnormalities in stress-induced cortisol response are associated with more rapid tumor progression. Abnormalities of endocrine circadian rhythms have been observed in patients with cancer, but the prognostic value of such alterations has not previously been confirmed. These findings point to a possible role of cortisol in mediating the effects of psychosocial variables on disease progression. The association between diurnal variation of salivary cortisol and subsequent survival of the metastatic breast cancer patient was examined, and the relationship between cortisol rhythms and immunological function was investigated.

Daytime salivary cortisol levels of 109 metastatic breast cancer patients were assessed at study entry on each of three consecutive days, and the slope of diurnal cortisol variation was calculated using log transformed regression analysis. The slope of diurnal cortisol was associated with subsequent survival time up to four years later. Shorter survival was noted among patients with relatively "flat" diurnal cortisol rhythms indicating lack of normal diurnal variation (Cox Proportional Hazards $p = .02$). These patients also had diminished natural killer (NK) cell numbers. Patients lacking diurnal variability of daytime salivary cortisol levels suffered earlier mortality. Data regarding related immune suppression will also be discussed. Dysregulation of diurnal cortisol patterns may be a mediator of more rapid breast cancer progression.

REFERENCES:

1. McEwen BS: Protective and damaging effects of stress mediators. New England Journal of Medicine 1998; 338:171-179.

SCIENTIFIC AND CLINICAL REPORT SESSION 17—DEPRESSION AND SUICIDE IN SCHIZOPHRENIA

No. 50
LIFE EVENTS TRIGGER DEPRESSION IN EARLY SCHIZOPHRENIA

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be familiar with the literature on the relationship between stress and depressive exacerbation in chronic and early-phase schizophrenia.

SUMMARY:

Objective: Previous studies that linked stressful life events with depression in chronic schizophrenia used retrospective data-gathering methods and included life events that could have been influenced by the patients' illnesses.

Method: Using prospective methods, we sought to determine if occurrences of stressful life events independent of the illness could trigger depressive symptoms in the early course of schizophrenia. Ninety-nine schizophrenia outpatients receiving fluphenazine and psychosocial treatment were followed for one year after outpatient stabilization. Life-event interviews were conducted every four weeks, and psychiatric symptom assessments every two weeks. Survival analyses were used to examine the risk of depressive exacerbation for one to six months after a major stressful event.

Results: Stressful events were significantly associated with subsequent depressive symptoms. Interestingly, an analysis of competing risk showed that the risk of psychotic exacerbation following a major independent life event was not significantly greater than the risk for depressive symptoms.

Conclusions: Stressful events pose a similar risk for triggering depressive exacerbations and psychotic exacerbations in the early course of schizophrenia. A period of heightened risk for depressive or psychotic symptoms is present for the first month after a stressful event, but can extend to six months.

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2. Roy A, Thompson R, Kennedy S: Depression in chronic schizophrenia. Brit J Psychiatry, 1983; 142:465-470.

No. 51
NATIONAL COLLABORATIVE STUDY OF EARLY PSYCHOSIS AND SUICIDE: AN INTRODUCTION

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the scope of the NCSEPS project as well as the potential implications for learning more about the etiology, prevalence, and course of the illnesses studied.

SUMMARY:

Objective: We have begun a collaborative project with the United States Department of Defense (DOD) and the Department of Veterans Affairs (VA)—the National Collaborative Study of Early Psychosis and Suicide (NCSEPS). Its goal is to study individuals who develop psychotic illnesses, especially bipolar disorder (BD), major depressive disorder (MDD), or schizophrenia (S), while on active duty through their treatment in the DOD and subsequently the VA.

Method: There are now well over 10,000 patients who were hospitalized for either BD, MDD, or S while on active duty and 20,000 controls in the NCSEPS database. Sociodemographic and hospitalization characteristics are being compiled.

Results: Preliminary data indicate that a disproportionately large number of individuals who develop these disorders are hospitalized within the first 15 days of active duty. In addition, all patients hospitalized with either BD, MDD, or S scored at or above national norms on a vocational aptitude test (portions of which correlate highly with other measures of IQ) given prior to active duty. Women have three times the rate of MDD and twice the rate of BD as men. Blacks and Hispanics have about twice the rate of S as whites. As patients leave the DOD and are followed into the VA, their diagnoses appear remarkably stable.

Conclusion: Analyzing these data will provide important clues about the etiology and course of severe psychiatric illnesses.

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1. Helmkamp JC, Kennedy RD: National mortality profile of active duty personnel in the U.S. armed forces: 1980-1993. DHHS (NIOSH) Report No. 96-103. Washington, DC, 1996.
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No. 52
CLINICAL CORRELATES OF INSIGHT IN PSYCHOTIC DISORDERS

Giovanni B. Cassano, M.D., *Department of Psychiatry, University of Pisa, VIA Roma 67, Pisa 56100, Italy* Stefano Pini, MD, Liliana Dell'Osso, MD, Marco Saettoni, MD, Giovanni Marcacci, MD, Alessandra Papasogli, MD, Serena Vignoli, MD,

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the clinical relevance of insight within the spectrum of psychotic disorders.

SUMMARY:

This study investigated whether psychotic patients with poor insight differed from those with good insight in severity of psychopathology and rates of Axis I comorbidity, after controlling for the principal psychotic diagnosis.

Method: A cohort of 198 consecutively hospitalized patients with psychotic symptoms with a primary SCID diagnosis of schizophrenia spectrum, bipolar disorder, or major depression completed a battery of psychometric measures. The entire cohort was dichotomized in two groups on the basis of the Scale for Unawareness of Mental Disorder (SUMD) scores: poor insight group (n = 139) and good insight group (n = 59).

Results: Overall, the good insight group showed a better functioning than the poor insight group (40.7 ± 13.1 vs 30.8 ± 12.0, $p < 0.001$). Patients with good insight showed a higher frequency of suicide attempts and suicidal ideation than patients with poor insight (35.6% vs 21.6%, $p < .0.05$). The BPRS and the SANS total scores were higher in the poor insight group that in the good insight group (respectively, 43.8 ± 11.1 vs. 39.8 ± 10.7, $p < 0.01$; 36.9 ± 26.2 vs. 28.8 ± 21.9, $p < 0.05$). Patients with good insight showed a higher total score at the SCL-90 and higher rates of Axis I comorbidity than those with poor insight (respectively, 119.5 ± 66.9 vs. 96.5 ± 58.4, $p < 0.05$; 55.9% vs. 36%, $p < 0.01$).

Conclusions: Overall, it appeared that either lack of insight and good insight have important clinical correlates in psychoses. The implications of these findings will be discussed.

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1. Amador XF, Strauss DH, Yale SA, et al: Assessment of insight in psychosis. Am J Psychiatry 1993; 150:873-879.
2. Cassano GB, Pini S, Saettoni M, et al: Occurrence and clinical correlates of psychiatric comorbidity in patients with psychotic disorders. J Clin Psychiatry 1998; 59:60-68.

SCIENTIFIC AND CLINICAL REPORT SESSION 18—PSYCHIATRIC ISSUES IN THE PUBLIC HEALTH ARENA

No. 53
WHAT THE STATES ARE DOING TO PROVIDE SERVICES TO FAMILIES OF ADULTS WITH SEVERE MENTAL ILLNESS

Lisa B. Dixon, M.D., *Department of Psychiatry, University of Maryland, 701 West Pratt Street, Rm 476, Baltimore MD 21201* Howard H. Goldman, M.D., Abdighani Hirad, M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to describe services recommended by best practices guidelines for families of persons with severe mental illness, the efforts that states are making to provide services to families, and the obstacles to providing such services.

SUMMARY:

Objective: APA practice guidelines and the PORT treatment recommendations suggest that families of persons with schizophrenia

should receive education and support. We determined the extent to which states are facilitating the delivery of services to families of adults with severe and persistent mental illness (SPMI).

Methods: We conducted a survey of state mental health authorities to determine the presence of state policies and funding of services to families of adults with SPMI.

Results: Of the 44 responding states, 73% do *not* have a policy with regard to the types of services delivered to families, but 80% reported that they fund a family-support intervention. The large majority (77%) of state-supported interventions were not clinical psychoeducation programs, but family-to-family programs such as those sponsored by the National Alliance for the Mentally Ill. Funding level ranged from $11,500 to $150,000 per year. Only 23% of states reported that they monitor services, and monitoring efforts were meager.

Conclusion: This study underscores the importance of the advocacy movement in obtaining funding and support for services to families as well as the existing gap in services to families delivered by mental health professionals.

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1. Lehman AF, Steinwachs DM, PORT Co-Investigators: At issue: translating research into practice: The Schizophrenia Patient Outcomes Research Team (PORT) treatment recommendations. Schizophrenia Bulletin 1998; 4:1-9.
2. Dixon L, Lyles A, Scott J, Lehman A, et al: Services to families of adults with schizophrenia: from treatment recommendations to dissemination, submitted for publication.

No. 54
THE EFFECTS OF EDUCATION ABOUT DEPRESSION IN PRIMARY CARE

Christopher Thompson, M.D., *Univ Dept of Mtl Health, Royal South Hants Hospital, Brinton's Terrace, Southampton SO14 0YG, England*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the importance of an evidence-based approach to evaluating the effects of continuing professional education and appreciate the lack of high-quality guidelines for treating subsyndromal major depressive disorder in primary care.

SUMMARY:

Objective: Many studies have suggested that primary care physicians are poor at recognizing and treating depression, yet most such patients are treated in that setting. Several small-scale uncontrolled studies have appeared to show improvements from educational programs. We set out to determine the effectiveness in improving the recognition and outcome of depression in primary care of an educational program based on a clinical practice guideline (CPG).

Method: A randomized controlled trial in a representative sample of 155 primary care physicians (26% of the total) in Hampshire, England. Education was quality tested by feedback from participants and experts. The primary endpoints were 1) differences between educated and control groups in GP's sensitivity to depression as identified on screening by the Hospital Anxiety and Depression Scale (HAD), and 2) differences between groups in the proportion of patients in each practice who had improved on the HAD depression scale at six weeks and six months.

Results: The education was very well received by participants and was rated above average by experts. No significant improvements occurred in sensitivity and specificity to depression. In the whole group of depressed patients, education did not influence outcome, but the subgroup of recognized patients did better at six weeks with a recently educated physician (odds ratio. 1.8; $p < .05$).

Conclusions: Primary care education based on clinical guidelines is unlikely to have an impact on the public health burden of depression. Education may enhance six week recovery in patients who are diagnosed.

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2. Rutz W, Walinder J, Eberhard G, et al: An education programme for depressive disorders on Gotland: background and evaluation. Acta Psych Scand 1989; 79:19-26.

No. 55
THE ASSOCIATION BETWEEN PSYCHIATRIC COMORBIDITY AND RETENTION IN A SAMPLE OF WOMEN ATTENDING COMPREHENSIVE ADDICTION TREATMENT

Catherine A. Nageotte, M.D., *Department of Psychiatry, University of Illinois, 912 South Wood Street, Chicago IL 60612-7327* Thomas M. Brady, M.D.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to: 1) understand the association between comorbid depression and the utilization of addiction treatment services; 2) articulate the importance of mental health services in comprehensive addiction treatment programs for childbearing women; 3) identify one method of enhancing retention of women in prenatal care and addiction treatment.

SUMMARY:

Objective: The purpose of this study is to test the hypothesis that pregnant or post-delivery mothers who suffer from clinical depression attend more treatment sessions or stay in treatment over a longer period of time in comprehensive outpatient drug treatment compared with their nondepressed counterparts.

Background: Depression is a socially important condition that is often left untreated (Wells, 1997), and research suggests that depression increases the use of both inpatient and outpatient general medical services (Manning et al., 1992).

Methods: This study examines a cohort of 132 pregnant and post-delivery women in treatment for substance use disorder. Pregnant women attended an outpatient comprehensive substance abuse treatment program for childbearing women at one of the NIDA-sponsored Perinatal-20 program sites. Time in treatment and the number of days attending the program are respectively examined as outcome variables. Subjects completed the Beck Depression Inventory (BDI) and the Addiction Severity Index, 5th ed. (ASI). Using Cox Regression modeling, we defined the exposure variable as moderate to severe depression (BDI > 18). We controlled for patient variables: age, race, education, social support, involvement with child protective custody, and number of children. We also controlled for treatment variables associated with treatment retention: number of outreach contacts and number of home visits.

Results: Women with moderate to severe depression remained in treatment for 6.7 months compared with 5.2 months for women with low ratings of depression. Depressed women attended more days of treatment (Kaplan-Meier log rank statistic 3.87, 1 df, $p = 0.05$). In the Cox procedures, depression had a protective effect in the hazards model (beta 0.5455, 95% C.I. {0.34, 0.87}, Wald 6.4210, $p = 0.01$).

Conclusions: Pregnant and post-delivery women who are moderately to severely depressed tend to stay in outpatient addiction treatment longer and attend more outpatient addiction visits. We also found that home visits by a nurse were also significantly associated with longer duration of treatment and higher number of treatment contacts. These findings strongly suggest that detection and interven-

tion for maternal depression in the context of comprehensive addiction treatment could improve addiction treatment outcomes, given that duration of treatment attendance and adherence are the strongest predictors of abstinence, particularly in the short term.

REFERENCES:

1. Wells KB: Caring for depression in primary care: defining and illustrating the policy context. Journal Clinical Psychiatry 1997; 58 supp 1:24-27.
2. Manning WG, Wells KB: The effects of psychological stress and psychological well-being on the use of medical services. Medical Care 1992; 30:541-553.

SCIENTIFIC AND CLINICAL REPORT SESSION 19—SCREENING AND TREATMENT OF SUBSTANCE ABUSE

No. 56
ENHANCING TREATMENT OF COCAINE-DEPENDENT MOTHERS

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to improve clinical outcomes of cocaine-dependent mothers with young children. By addressing the psychosocial needs of this population with onsite services such as individual therapy and parenting skills classes, treatment retention and use reduction can be enhanced.

SUMMARY:

Objective: In this study, we examine whether the treatment of cocaine-dependent mothers can be enhanced by providing services targeted at addressing their acute psychosocial needs.

Method: Eighty-four cocaine-dependent mothers were randomly assigned either to a case-management-oriented outpatient treatment program (CM) or to a psychosocially enhanced treatment program (PET). While both programs offered in-house child care and daily group therapy sessions, the PET program offered a variety of additional in-house services including parenting skills class, GED class, and access to onsite individual therapy.

Results: At the one-year mark, PET had significantly better program retention as measured by total weeks of attendance ($t = 2.11$, $P < .04$). Days of cocaine use decreased from baseline to follow-up in both conditions. For the 21 CM patients who provided 12-month follow-up, mean reported days use of past 30 dropped from 12.9 to 7.4 ($t = 1.94$, $p = .06$). For the 21 PET patients who provided 12-month follow-up, days use dropped from 10.9 to 2.4 ($t = 3.45$, $p < .001$). In addition, the PET group had significantly fewer days of cocaine use at follow-up than the CM group ($t = 2.16$, $p < .04$).

Conclusion: These results suggest that providing supplementary psychosocial services on site can enhance program participation and treatment outcome for cocaine-dependent mothers.

This research was supported by NIDA grant # P50 DA09252.

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1. Kileen TK, Brady KT, Thevos A: Addiction severity, psychopathology and treatment compliance in cocaine-dependent mothers. J Addictive Diseases, 1995; 14:75-84.
2. Fiorentine R, Anglin MD: Does increasing the opportunity for counseling increase the effectiveness of outpatient drug treatment. Am J Drug Alcohol Abuse 1997; 23:369-382.

No. 57
NALTREXONE PLUS COGNITIVE-BEHAVIOR THERAPY FOR ALCOHOLISM

Raymond F. Anton, M.D., *Institute of Psychiatry, Medical University of SC, 850 MUSC Complex, Suite 553, Charleston SC 29425* Darlene H. Moak, M.D., L. Randolph Waid, Ph.D., Patricia K. Latham, Ph.D., James K. Dias, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to show how outpatient management/treatment of alcoholism can be improved by combining a pharmacotherapy and a psychosocial therapeutic approach. New ways of assessing outcome and craving will be highlighted, and the need for post-treatment follow-up will be discussed.

SUMMARY:

Objective: To evaluate in a double-blind, randomly controlled trial whether the effectiveness of cognitive behavioral therapy (CBT) in recently abstinent alcohol-dependent outpatients would be improved by naltrexone.

Method: 131 alcoholics were treated with 12 weekly sessions of CBT and either 50 mg. of naltrexone ($n = 68$) or placebo ($n = 63$). Alcohol consumption, craving, adverse events, and blood markers of alcohol abuse were assessed during the trial and at three months after treatment ended.

Results: Treatment completion (83%) and medication compliance (>70%) were high with no group differences. Naltrexone-treated subjects drank significantly less, took longer to relapse, and exhibited more resistance and control over alcohol-related thoughts and urges (OCDS scale). While by the end of treatment, 62% of the naltrexone/CBT group did not relapse to heavy drinking, compared with 40% of the placebo/CBT group, ($p < 0.02$), during post-treatment follow-up these rates decreased to 44% and 32%, respectively ($p < 0.05$).

Conclusions: Individuals with moderate alcohol dependence can be treated with increased effectiveness when naltrexone is used in conjunction with outpatient weekly CBT. While this effect persists once medication is stopped, some individuals need continued treatment to remain in remission.

Supported by grant # RO1AA09568 from NIAAA.

REFERENCES:

1. O'Malley SS, Jaffe AJ, Chang G et al: Naltrexone and coping skills therapy for alcohol dependence. Arch Gen Psychiatry 1992; 49:881-887.
2. Volpicelli JR, Alterman AI, Hayashida M, O'Brien CP: Naltrexone in the treatment of alcohol dependence. Arch Gen Psychiatry 1992; 49:876-880.

No. 58
THE DRUG ABUSE SCREENING TEST FOR ADOLESCENTS

Steve Martino, Ph.D., *Department of Psychiatry, Yale University, PO Box 208038, New Haven CT 06520;* Carlos M. Grilo, Ph.D., Dwain C. Fehon, Psy.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to identify the psychometric properties of the Drug Abuse Screening Test for Adolescents and understand its utility for identifying adolescents who have drug-related problems.

SUMMARY:

Background: Despite progress made in the brief assessment of adolescent alcohol use, surprisingly little progress has been made in

the development of psychometrically sound instruments to screen youth for drug abuse.

Objective: To develop and test the psychometric properties of a screening measure for adolescent drug abuse.

Method: The Drug Abuse Screening Test (DAST), a psychometrically well-established measure for adults was revised for use with adolescents (DAST-A). The DAST-A (27 items using a yes-no format) was administered to a series of 194 adolescent psychiatric inpatients aged 13 to 19 (M = 15.8, SD = 1.6) soon after admission.

Results: The item-total correlation ranged from .26 to .70 (M = .49); coefficient alpha was .91. One-week test-retest reliability with a random subset was .89. Concurrent validity was tested using clinical consensus discharge diagnoses; subjects who had received discharge diagnoses of drug-related disorders had significantly higher DAST-A scores (M = 10.6 vs. 3.1, $t(1,192) = -10.9$, $p < .00$). Likewise, higher DAST-A scores were significantly positively correlated with higher levels of alcohol-related problems as measured by the AAIS and with greater substance abuse proneness as measured by the MACl. In addition, the discriminating power of the DAST-A using an optimal cutoff score of >6 to indicate the presence of a drug-related disorder resulted in a positive predictive power of 82%, sensitivity of 79%, and specificity of 85%.

Conclusions: Our findings based on an adolescent psychiatric inpatient study group suggest that the DAST-A is a psychometrically sound, brief screening device for adolescent drug abuse and may serve as a useful clinical and research tool to help identify youth struggling with drug-related problems.

REFERENCES:

1. Skinner HA: The drug abuse screening test. Addictive Behaviors 1982; 7:363-371.
2. Winters KC: The need for improved assessment of adolescent substance involvement. Journal of Drug Issues 1990; 20:485-500.

SCIENTIFIC AND CLINICAL REPORT SESSION 20—NEW ISSUES IN DIAGNOSIS AND TREATMENT OF ANXIETY DISORDERS

No. 59
INTEGRATED THERAPY OF PANIC DISORDER: A CONTROLLED STUDY

Gabriella Ba, M.D., *Department of Psychiatry, University of Milan, Via F. Sforza 35, Milano 20122, Italy;* Caterina Vigano, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to diagnose and treat panic disorders, learn an integrated approach of therapy, evaluate and compare the clinical results of a long-term follow-up.

SUMMARY:

Background: Several studies recognize the complex nature of panic disorders. Neurobiological vulnerability, psychological sensitivity for panic, conflicts, and problems when undergoing panic attacks suggest the need for an integrated therapeutic approach.

Objective: The present study examined the efficacy of an integrated therapy for panic disorders, including pharmacotherapy, group cognitive-behavior intervention, and psychodynamic psychotherapy to reduce the panic symptoms, avoidances, and psychological vulnerability to panic.

Method: In this study we recruited 30 patients with panic disorders with or without agoraphobia (DSM-IV criteria). After a clinical and instrumental diagnostic assessment, these patients were randomly assigned to three different groups: 1) integrated therapy: drug therapy, group cognitive-behavioral therapy, psychodynamic psychotherapy, 2) drug therapy and group cognitive behavior therapy, and 3) drug therapy. The protocol planned an outcome follow up, with clinical interviews and questionnaires, at months 1, 3, 6, 12, and 24.

Results: In this study we report preliminary results at 12-month follow up. The integrated treatment seems to be more effective than the others in reducing panic symptoms, avoidances, advanced anxiety, phobias, and depression and improving the quality of life.

REFERENCES:

1. Clark DM, Salkovskis PM, et al: A comparison of cognitive therapy, applied relaxation and imipramine in the treatment of panic disorders. British J Psychiatry 1994; 164:759-69.
2. Rosenbaum JF, Pollock RA, Pollack MH: Integrated treatment of panic disorders. Bull Menninger Clinic 1995; 59:suppl A, A4-A26.
3. Andrews G, Crino R, Hunt C, et al: The Treatment of Anxiety Disorders, New York, Cambridge University Press, 1994.

No. 60
LONG-TERM ANTIDEPRESSANT TREATMENT OF PANIC/AGORAPHOBIA

Matig R. Mavissakalian, M.D., *Department of Psychiatry, Case Western University, 11100 Euclid Avenue, Cleveland OH 44106;* James Perel, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the extent of relapse/reversals in the first 12 months following remission of panic disorder with agoraphobia and also the effectiveness of maintenance treatment with antidepressants.

SUMMARY:

Objective: The question of relapse and the intimately related issue of the need for and effectiveness of maintenance treatment are relevant to patients who show marked and stable response, i.e., achieve remission with acute treatment. The aim of the present research was to conduct a controlled maintenance/discontinuation study of imipramine in panic disorder with the following methodological advantages: a) homogeneous sample of patients with moderate to severe panic disorder with agoraphobia (where the effects of treatment specifically due to pharmacotherapy are most marked and reliable); b) uniform acute-phase treatment in terms of dosage and duration; c) inclusion of only those patients who achieve remission characterized by a virtually asymptomatic state with no functional disability due to symptoms; d) at-risk period of observation for 12 months, and e) use of empirically validated and clinically meaningful response/relapse criteria.

Method: The first 56 patients to meet remission criteria and randomly assigned to double-blind continuation or discontinuation after six months of imipramine 2.25 mg/kg treatment were followed with planned assessments every two months for 12 months. There were no behaviorally oriented interventions or instructions during the 18 months of the study.

Results: Survival analysis was done to compare the estimated probability of not relapsing, of not experiencing a worsening, or of completing the experimental 12 months on study medication. A Mantel-Cox test showed a significant ($p \leq .01$) difference between maintenance treatment (N = 29) and discontinuation (N = 27) conditions for each outcome category.

Discussion: Results will be discussed in the context of the available long-term follow-up and outcome literature and in terms of their generalizability to other antidepressants. This study is being funded by NIMH.

REFERENCES:

1. Mavissakalian M, Perel JM: Imipramine in panic disorder with agoraphobia: dose ranging and plasma level-response relationships. Am J Psychiatry 1995; 152:673-682.
2. Mavissakalian M: Long-term treatment of panic disorder with antidepresant medications. In Long-term Treatment of Anxiety Disorders, edited by Mavissakalian M, Prien R. American Psychiatric Press, Inc., Washington, D.C., 1996.

No. 61
RECOGNITION AND MANAGEMENT OF A SUBGROUP OF OCD AND TIC DISORDERS

Susan E. Swedo, M.D., *Pediatrics, NIMH, 9000 Rockville Pike, Bethesda MD 20892*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to identify the unique clinical course of strep-triggered OCD and tic disorders, learn the inclusionary criteria for the PANDAS subgroup, and become aware of the utility of immunomodulatory treatments for PANDAS.

SUMMARY:

Objective: This presentation will focus on the clinical management of children with PANDAS, a newly described subgroup of childhood-onset OCD and tic disorders (TD).

Method: Over the past decade, the NIMH research group has conducted studies of Sydenham chorea (a variant of rheumatic fever) and pediatric neuropsychiatric disorders that demonstrated that GABHS infections can trigger onset or exacerbation of OCD, tics, emotional lability, and separation anxiety. The phenomenology of this subgroup of patients will be discussed. In addition, results will be presented for controlled trials of penicillin prophylaxis and immunomodulatory treatments.

Results: A double-blind crossover study (n = 39) comparing penicillin and placebo (four months each) showed that penicillin was not superior to placebo in reducing severity of tics or OCD symptoms, perhaps because a number of strep infections occurred during the penicillin phase. A randomized-entry, controlled trial of plasmapheresis (n = 10), intravenous immunoglobulin (n = 9), and placebo (n = 10) for acute symptom exacerbations among children with PANDAS. Both active treatments produced dramatic reductions in symptoms severity (45%-70% mean reduction at one month and sustained improvements at one-year follow-up.)

Conclusion: Unique treatment opportunities make it important to recognize PANDAS cases.

REFERENCES:

1. Swedo SE, Leonard HL, Garvey M, et al: Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections: clinical description of the first 50 cases. Am J Psychiatry 1998; 155:264-271.
2. Allen AJ, Leonard JL, Swedo SE: Case study-a new infection-triggered autoimmune subtype of pediatric OCD and Tourette's syndrome. J Am Acad Child Adolesc Psychiatry 1995; 34:307-311.

SCIENTIFIC AND CLINICAL REPORT SESSION 21—RACE AND GENDER SENSITIVITY IN THE TREATMENT OF PSYCHIATRIC DISORDERS

No. 62
THE RATIONALE FOR WOMEN-CENTERED PROGRAMMING: GENDER DIFFERENCES IN THE UTILIZATION OF INTENSIVE OUTPATIENT TREATMENT

Joseph A. Flaherty, M.D., *Department of Psychiatry, University of Illinois, 912 South Wood Street, MC 913, Chicago IL 60612* Thomas M. Brady, M.P.H., Susan J. Adams, M.D., Bernard H. Baum, Ph.D., Dorothy Thomas, C.A.D.C.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to articulate why women of childbearing age may have difficulty completing addiction treatment, identify common barriers to treatment unique to women of childbearing age, and provide two examples of services treatment programs can offer women that may enhance female patient retention.

SUMMARY:

Objectives: 1) Based on a brief review of the literature, this study will illustrate barriers to substance abuse treatment unique to women and from an existing institutional database, explore differences in retention based on a convenience sample of outpatients attending a university-based treatment program.

Methods: Design was a cross-sectional sample of all Medicaid or Medicaid/Medicare outpatients from June 1995 to April 1998; 634 records were sampled to discern if there were gender differences in the retention or length of stay in treatment. The outcome variables were completing intensive outpatient treatment and the summation of group therapy visits. Procedures included logistic regression as well as survival analysis.

Results: Data were available on 611 patients, including 315 males and 296 females. There were no gender differences in program completion; 28.9% of men and 26.7% of women completed intensive outpatient treatment. Using Cox regression and controlling for race, age, primary diagnosis, and payer type (Medicaid/Medicare or Medicaid), there were no differences between males and females in retention. However, age was a significant correlate, and women under 30 years old were more likely to drop out of treatment prior to completion than women over 30 (odds ratio 3.189, 95% C.I. {1.28, 7.92}, $\chi^2 = 6.776$, 1 df, $p = .009$).

Conclusion: In analyzing retention, youth more than gender may have been the risk factor for attrition from this treatment program, and there appears to be a significant interaction between age and sex, with important clinical implications. The unique service needs of young addicted women present the substance abuse treatment system with a variety of challenges. Numerous barriers contribute to the high drop-out rate of women from addiction programs, and adequate child care, transportation, parenting training, and housing are often unmet needs.

Funding Source: NIMH 54212 Research Infrastructure Support Grant

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2. Zankowski GL: Responsive programming: meeting the needs of chemically dependent women. Alcoholism Treatment Quarterly 1987; 4:53-66.

No. 63
THERAPIST/PATIENT RACE AND SEX MATCHING

Edward Gottheil, M.D., *Department of Psychiatry, Jefferson Medical College, 1201 Chestnut Street, #1505, Philadelphia PA 19107-4123* Robert Sterling, Ph.D., Stephen Weinstein, Ph.D. Ronald D. Serota, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that despite the intuitive appeal of the notion, the matching of substance-dependent patients and therapists on factors such as sex and race does not necessarily improve treatment outcome(s).

SUMMARY:

Objective: Most studies of addiction treatment conclude with the recommendation that outcomes could be potentiated by more effective matching of patients and treatments. While matching variables abound, therapist/patient similarity on sex and race factors remains an area of interest. Having previously found that such matching did not improve outcomes for persons in intensive group therapy, we decided to examine this question in individual therapy, where similarity/dissimilarity should be more salient.

Method: Subjects were 122 cocaine-dependent admissions to a university-based, outpatient, substance abuse treatment program. Patients beginning individual therapy were assigned by senior staff to counselors who may or may not have shared the same race and gender profile as that of the patient.

Results: A series of two-way ANOVAs using patient and therapist race and sex as factors indicated that neither sex nor race matching facilitated retention. Nine-month follow-up functioning as assessed by the Addiction Severity Index also was not reliably improved by race or sex matching.

Conclusions: From an administrative point, it appears that patients can be assigned on the basis of caseloads and facility needs. In this sample, being unable to assign a female to a female or an African American (AA) to an AA did not appear to be doing patients a disservice.

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1. Sterling RC, Gottheil E, Weinstien SP, Serota RD: Therapist/patient race and sex matching: retention and 9-month follow-up outcome. Addiction 1998; 93:1043-1050.
2. Atkinson DR, Schein S: Similarity in counseling. Counseling Psychologist 1986; 14:319-354.

No. 64
RECOGNITION OF PSYCHIATRIC DISTRESS IN LOW-INCOME ASIAN AND LATINO PRIMARY CARE PATIENTS

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize that primary care physicians have an important role in identifying patients with psychiatric distress. In addition, factors other than shared common language and ethnicity impact on the accurate identification of patients in psychiatric distress.

SUMMARY:

Objective: Few studies of recognition of depressive symptoms have been conducted on ethnic minorities, particularly non-English speaking. In this pilot study, we examined primary care physician recognition of psychiatric distress in an ethnically diverse primary care sample composed primarily of Asians and Hispanics. In addition, the relationship of patient and physician sociodemographic factors and diagnostic congruence was investigated.

Method: The study sample is comprised of 252 consecutive patients in the general medicine clinics in a large ambulatory medical facility who agreed to participate and completed the following measures prior to their medical visit: Center for Epidemiologic Studies-Depression (CES-D) scale, a demographic questionnaire, and an acculturation scale. Immediately after the visit, physicians completed a mental health treatment summary. Sixteen primary care providers agreed to participate in the study; 90% were attending physicians, and 30% have moderate to complete fluency in either Spanish or Chinese (Cantonese or Mandarin). To make meaningful differential comparisons between ethnic groups, only Asian and Latino patients were included in the statistical analyses (n = 224). Hierarchical logistic regression analyses were performed examining provider recognition of psychiatric distress and CES-D/provider congruence in relation to demographic characteristics and acculturation.

Results: 45% of the sample were psychiatrically distressed as measured by the CES-D, whereas 35.6% were judged by physicians to be distressed ($X = 28.4$, $df = 1$, $p < .01$). Physicians were more likely to diagnose distress in Hispanics (Wald statistic = 6.5, $p < .01$) and for those with higher acculturation status (Wald statistic = 4.5, $p < .05$). Higher patient acculturation status was the only factor that improved diagnostic congruence (Wald statistic = 4.5, $p < .05$).

Conclusions: Primary care physicians (PCP) in this study "diagnosed" psychiatric distress more frequently in Latino patients and in those who have higher acculturation status. Higher acculturation status improved diagnostic congruence (agreement between a positive CES-D and provider stating the patient had distress and a negative CES-D and the provider stating that the patient had no distress), but language match did not. We speculate that PCP are more likely to respond to the communication style of patients in recognizing psychiatric distress; particularly among patients who are more likely to express their distress in a psychological or emotional context.

This work was supported by NIMH Research Transition Grant Program (RTGP) grant #R24MH53816 awarded to Cornell University Medical College.

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SCIENTIFIC AND CLINICAL REPORT SESSION 22—SOCIOECONOMIC FACTORS IN THE MANAGEMENT OF DEPRESSION

No. 65
USE OF ANTIDEPRESSANTS IN A NATIONAL SAMPLE

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the high rates of, and possible factors leading to, underuse of antidepressant medications in individuals with major depressive disorder.

SUMMARY:

Objective: We studied the prevalence and predictors of antidepressant treatment in the community for a national sample of young adults with major depression.

Method: Between 1988 and 1994, 7,589 individuals aged 18-39 drawn from a national probability sample were administered the Diagnostic Interview Schedule as part of the National Health and Nutrition Examination Survey. Interviewers asked about prescription drug use and checked medication bottles to record the name and type of medications.

Results: A total of 312 individuals, or 4.1% of the sample, met criteria for current major depression. Only 7.4% of those with current major depression were being treated with an antidepressant, and only 11.8% of those with current major depression who also reported suicidal ideations were taking an antidepressant. For depressed individuals, lack of insurance, lack of a regular provider, or failure to inform the provider about depressive symptoms each conferred four to five times the risk of not taking an antidepressant.

Conclusions: The study's findings suggest a serious underuse of antidepressant medications for the treatment of major depression in the community. Underreporting of depressive symptoms to providers and problems with access to health care appear to be two major contributors to this problem.

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No. 66
PRIME-MD SCREENING: RELEVANCE FOR MINOR DEPRESSION

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to assess the usefulness of the Prime-MD as a screening tool for depression and to recognize the impact of minor depressive disorder on patient functioning and well-being.

SUMMARY:

Objectives and method: The Prime-MD has increasingly been promoted as a screening instrument to help family physicians identify common psychiatric disorders such as depression.

In this study, persons screening positive for depression on the Prime-MD at three family practice settings were also given the HRSD over the phone to compare the two instruments.

Results: 1,752 patients completed the Prime-MD Patient Questionnaire (PQ); 478 (27.3%) of the subjects scored positive for depression on the PQ. Of these 478 patients, 296 received telephone follow-up with the Prime-MD Mood Module and the HRSD. Prime-MD Mood Module diagnoses were: major depression, 72 (24.3%); dysthymic disorder, 28 (9.5%); minor depression, 47 (15.9%); and no depression, 149 (50.3%). The mean HRSD scores by diagnosis were: major depression, 19.60; dysthymic disorder, 12.93; minor depression, 11.53; no depression, 5.74. Post-hoc analyses using Dunnett's C test indicated each of the four groups was significantly different at $p = .05$, except for dysthymic disorder and minor depression.

Conclusions: As previous studies have validated the Prime-MD, our findings of similar HRSD scores for dysthymic disorder and minor depression support the growing belief that persons with minor depression have significant symptomatology and impairment. The other finding of nearly twice as many patients with minor depression as dysthymic disorder suggests that more research is needed in the area of minor depression.

This study was supported by an unrestricted educational grant of $5,000 from Roerig Division U.S. Pharmaceuticals Group, Pfizer, Inc., and a research grant of $5,227 from the Ohio Academy of Physicians.

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No. 67
SOCIOECONOMIC DEPRIVATION AND DEPRESSION PREVALENCE

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the importance of social and economic factors in the prevalence and outcome of depression. This has implications for health care systems that attempt to provide resources according to need.

SUMMARY:

Objective: To examine the influence of the socioeconomic deprivation in primary care practices on the prevalence of depressive symptoms in the United Kingdom. To examine the influence of deprivation on six-month outcome.

Method: We screened 18,414 consecutive adult patients of 152 primary care physicians in 60 practices using the Hospital Anxiety and Depression (HAD) Scale and a questionnaire for employment status. Depression was defined as an HAD-Depression score of at least 11 and outcome was assessed at six weeks and six months using the same scale. A widely used index of deprivation (the Jarman score) was derived from the 1991 U.K. population census for each practice's electoral area.

Results: Practices and practitioners were representative of U.K. primary care. Socioeconomic deprivation accounted for 48.3% of the variance between practices in the prevalence of depression, after adjustment for age and sex. In individual patients, middle age, employment status, and the practice's Jarman score were associated with high depression scores. A high Jarman score predicted chronicity of depressive symptoms up to six months after adjusting for age, gender, employment status, and severity.

Conclusion: The Jarman score of the locality accounts for almost half the variance between primary care practices in the prevalence of depression. Patients consulting primary care physicians in deprived areas are less likely to improve over six months. This relationship is so strong that it seems likely to be in part causal.

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2. Jarman B: Identification of underprivileged areas. BMJ 1983; 286:1705-1709.

SCIENTIFIC AND CLINICAL REPORT SESSION 23—NEONATAL AND CHILDHOOD EXPOSURE TO PSYCHOTROPICS

No. 68
PSYCHOTROPIC MEDICATION TRENDS IN PRESCHOOLERS

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to appreciate the increased utilization of psychotropic medications among preschool-aged youngsters according to U.S. HMO and Medicaid enrollment populations and recognize the need for effectiveness research on the preschoolers' most frequently prescribed psychotropic medications.

SUMMARY:

Objective: Three large population-based computerized data sources were analyzed to determine the prevalence of psychotropic medication use in preschool-aged youths and the rate of increase across a five-year span.

Method: Data from Medicaid enrollees younger than age 5 from a midwestern state (N = 240,969 in 1991) and a mid-Atlantic state (N = 97,612 in 1991) as well as from HMO enrollees (N = 31,695 in 1991) from a northwest region of the U.S. were organized according to age and gender. Four classes of prominently prescribed psychotropic medications were examined. Age-specific, gender-specific, and total prevalence data for these medications and their rates of increase from 1991 to 1995 were compared across the three locations/systems.

Results: In 1993, preschoolers had 10-19 times lower prevalence of methylphenidate use compared with their elementary school counterparts among midwestern Medicaid (0.43% vs 4.78%), mid-Atlantic Medicaid (0.198% vs 3.71%), and HMO enrollees (0.17% vs 2.06%), respectively. Midwestern Medicaid prevalence for clonidine increased an order of magnitude every two years (0.006%; 0.023%; and 0.14% for '91, '93, and '95, respectively). Selective serotonin reuptake inhibitors (SSRIs) had a similar rise (.008%; .024%, and 0.054%, for the same periods); use of tricyclic antidepressants (TCAs), by contrast, was stable throughout (0.10%; 0.11%; 0.15%). Preschool Medicaid youths with SSRI or TCA use were more frequent than among HMO enrollees. Although the trends are consistent in the three systems, there is considerable variation in the rates, which may be explained by racial variation, practice differences, patient preference, or access/quality issues. More detailed comparisons will be presented.

Conclusions: Regardless of the data source, psychotropic medications prescribed for preschoolers have increased dramatically in the 1990s; the predominance of medications with unlabeled indications suggests the need for prospective studies to describe diagnostic and treatment patterns, multidimensional outcomes, and studies of the effectiveness of these medications in the usual practice settings.

Funded by the National Institute of Mental Health, Services Branch.

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No. 69
NEONATAL OUTCOME ASSOCIATED WITH LITHIUM USE DURING PREGNANCY

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to demonstrate that the frequency of perinatal toxicity as well as risk for obstetrical complications is low with in utero exposure to lithium.

SUMMARY:

Women with bipolar disorder frequently make difficult decisions regarding continuing or discontinuing lithium during pregnancy. The high risk of relapse when off lithium during pregnancy must be balanced against the small teratogenic risk of lithium use during the first trimester. Perinatal toxicity due to lithium exposure has been described in anecdotal reports with symptoms including "floppy baby" syndrome, hypothyroidism, and nephrogenic diabetes. However, the incidence of lithium-associated perinatal toxicity has not been established.

Objective: To assess neonatal outcome following fetal exposure to lithium.

Method: Data on 30 infants exposed to lithium during labor and delivery were reviewed retrospectively. Information regarding length of labor, type of delivery, frequency of medical/obstetrical complications, Apgar scores, birth weight, acute neonatal outcome, and disposition was examined and compared with that for a cohort of age-matched, non-exposed controls.

Results: Based on preliminary analysis of these data, the frequency of perinatal toxicity with lithium is low. Lithium use during pregnancy does not appear to be associated with higher risk for obstetrical complications compared with age-matched normal controls.

Conclusion: These findings will help to refine treatment guidelines for pregnant bipolar women as they approach labor and delivery. This can limit risk for postpartum relapse as this is a vulnerable subgroup who frequently discontinue mood stabilizers during the peripartum period.

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2. Ananth J: Side effects of fetus and infant of psychotropic drug use during pregnancy. Pharmacopsychiatry 1976; 11:246-260.

No. 70
MATERNAL USE OF PSYCHOTROPICS DURING LACTATION: QUANTIFYING INFANT EXPOSURE

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to quantify the extent of infant exposure to psychotropics following maternal use of these agents during lactation.

SUMMARY:

Introduction: Postpartum psychiatric illnesses are highly prevalent. However, many women who suffer from these disorders defer treatment with psychiatric medications while breastfeeding because of concerns regarding potential adverse impact of these agents on the newborn. Systematically derived guidelines do not exist to help clinicians and their patients decide on the relative risk of psychotropic drug use during lactation.

Methods: A consecutive series of 60 mother-infant pairs was studied as part of an investigation in which infant exposure to psychotropics (SSRIs, benzodiazepines, TCAs) was quantified. A research quality assay with sensitivity of <2ng/ml was used across SSRIs (fluoxetine, sertraline, paroxetine, and venlafaxine), benzodiazepines (lorazepam and clonazepam), and TCAs (desipramine, nortriptyline, doxepin). Sera were obtained from mother and infant in all cases as was breast milk (when available). Other information regarding maternal dose of medication, timing of last dose, gestational age of infant at delivery, weight of the infant, and number of feedings per day was also obtained.

Results: Across the SSRIs, detectable concentrations of drug were not noted in plasma of newborns (sensitivity <2ng/ml). In a very finite number of cases, metabolites of the parent compound were observed. No evidence of "neonatal accumulation" of drug was observed across shorter- or longer-acting SSRIs or benzodiazepines.

Conclusions: Maternal use of psychotropic medications during lactation, including SSRIs, appears to be associated with extremely modest infant exposure. The extent to which even trace amounts of these medications have long-term and significant impact on the developing CNS of the newborn remains to be clarified. The possibility of any potential adverse long-term effect of psychotropic drug use during lactation needs to be weighed against the morbidity of untreated maternal psychiatric illness.

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SCIENTIFIC AND CLINICAL REPORT SESSION 24—AXIS II COMORBIDITY

No. 71
AXIS II COMORBIDITY WITH BPD IN ADOLESCENTS

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the differences between adolescent and adult comorbidity patterns of borderline personality disorder with other personality disorders and the ways in which this comparison may inform us about the nature of borderline psychopathology in adolescents.

SUMMARY:

Objective: The authors examined the comorbidity of borderline personality disorder (BPD) with other personality disorders in a sample of adolescents admitted consecutively to the Yale Psychiatric Institute. For comparison, Axis II comorbidity with BPD was also examined in a consecutive sample of adults admitted to the same hospital, during the same period of time.

Method: One hundred thirty-eight adolescents and 117 adults were assessed with the Personality Disorder Examination, a semistructured diagnostic interview for DSM-III-R personality disorders. Assessments were reliable (average kappa = .84). Sixty-eight adolescents and 50 adults met diagnostic criteria for BPD. Personality disorder co-occurrence in the group of subjects with BPD was statistically compared to that in the group without BPD, for adolescents and adults separately.

Results: For the adults, Yates-corrected chi-square analysis revealed significant diagnostic co-occurrence with BPD for antisocial ($p = .002$) and narcissistic personality disorders ($p = .05$). For the adolescents, BPD showed significant co-occurrence with schizotypal ($p = .009$), narcissistic ($p = .03$), and passive aggressive ($p = .008$) personality disorders.

Conclusions: In the adults, BPD was significantly comorbid only with other cluster B disorders. The adolescents, by comparison, displayed a broader pattern of BPD comorbidity, encompassing aspects of all three personality disorder clusters. These results suggest that the BPD diagnosis may represent a more diffuse range of psychopathology in adolescents than in adults.

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No. 72
AXIS I COMORBIDITY WITH DSM-IV AXIS II DISORDERS

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to explain how mood D/Os and BPD emerged as broad domains of psychopathology that merged with each other and several other entities across the Axis I and II boundary.

SUMMARY:

Background: High rates of DSM-IV Axis I syndromal comorbidity with Axis II personality disorder (PD) are common. Common *patterns* of such co-occurrence, however, are not. Some associations have been made between schizotypal PD (SPD) with psychotic disorders, borderline PD (BPD) with mood disorders, and avoidant PD (AVPD) and obsessive-compulsive PD (OCPD) with anxiety disorders, but replications are sporadic.

Objective: To test these patterns of association between DSM-IV SPD, BPD, AVPD, and OCPD and Axis I disorders in a large clinical epidemiologic sample (N = 456) drawn from four sites (Boston, Providence, New Haven, New York) in the Collaborative Longitudinal Personality Study.

Method: Axis I and II were ascertained reliably with face-to-face semistructured interviews using SCID and DIPD, respectively. Axis

I categories included mood disorders (D/O) (N = 278), anxiety D/Os (N = 293), substance use D/Os (N = 94), and eating D/Os (N = 77). Psychotic D/Os (N = 7) were exclusionary and dropped from analysis. Axis II disorders included SPD (N = 69), BPD (N = 227), AVPD (N = 273), and OCPD (N = 204). Patterns of comorbidity between Axis I categories and Axis II PDs were calculated using odds ratios.

Results: Significant positive odds ratios emerged between: 1) SPD and mood D/Os; 2) BPD and mood D/Os, substance use D/Os and eating D/Os; and 3) AVPD and mood D/Os. A significant negative odds ratio emerged between OCPD and substance abuse.

Significance: Axis I and II comorbidity was common but not ubiquitous. The expected associations of AVPD and OCPD with anxiety D/Os did not emerge. An association between BPD and mood D/Os did emerge, but mood D/O comorbidity was not specific to BPD. An association between SPD and psychotic D/Os could not be tested since the latter were excluded. Mood D/Os were significantly comorbid with three of the study PD's (SPD, BPD, AVPD) and BPD was significantly comorbid with three of the Axis I syndromal groups (mood, substance use, eating disorder). Overall, in this large treatment-seeking sample, mood D/Os and BPD emerged as broad domains of psychopathology that merged with each other and several other entities across the Axis I and II boundary. This suggests that mood D/Os and BPD are either defined too broadly or are generic to the pathophysiology of many Axis I and II entities.

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No. 73
COMORBIDITY AMONG PATIENTS WITH DSM-IV PERSONALITY DISORDERS

Carlos M. Grilo, Ph.D., *Department of Psychiatry, Yale Psychiatric Institute, PO Box 208038/184 Liberty St., New Haven CT 06520* Thomas H. McGlashan, M.D., Andrew E. Skodol II, M.D., Leslie C. Morey, Ph.D., M. Tracie Shea, Ph.D., Mary C. Zanarini, Ed.D., John G. Gunderson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the diagnosis of DSM-IV Axis II personality disorders, their patterns of co-occurrence, and possible comorbidities.

SUMMARY:

Objective: We examine the "comorbidity" among the DSM-IV personality disorders (PDs). The nature and degree of diagnostic co-occurrence represent descriptive measures of the homogeneity and boundaries of diagnoses.

Method: Subjects were 464 adult patients (aged 18 to 45) participating in the Collaborative Longitudinal Personality Study (CLPS), a multisite (Brown, Columbia, Harvard, Yale) effort. The presence of all DSM-IV-defined PDs was assessed reliably by trained and monitored evaluators using the semistructured Diagnostic Interview for Personality Disorders-Version IV (DIPD-IV). This report focuses on four PDs of central interest in the CLPS: schizotypal (STPD; N = 61), borderline (BPD; N = 168), obsessive-compulsive (OCPD; N = 128), and avoidant (AVPD; N = 107).

Results: Substantial overlap was observed among the PD diagnoses. Duncan Multiple Range Test ($F(3,460) = 26.99$, $p < .000$) revealed that STPD had significantly more additional PD diagnoses assigned than BPD (means = 2.6, 1.9) and both STPD and BPD had significantly more additional PD diagnoses than AVPD (M = 1.1) and OCPD (M = 0.8), which did not differ from each other. To test for meaningful levels of co-occurrence, odds ratios were calculated for each PD pair diagnosed together compared with the odds for the occurrence of each PD diagnosis alone. Pairs with significant odd ratios elevated above 3 were: STPD with paranoid (odds ratio (OR) = 4.2), STPD with schizoid (OR = 5.7), BPD with dependent (OR = 6.0), and BPD with antisocial (OR = 3.6). OCPD had significant negative odd ratios with BPD and with AVPD.

Conclusions: In our sample of treatment-seeking patients with PDs, high rates of PD diagnosis co-occurrence were observed. However, our analyses, which take into account base rates, suggest that most PDs have relatively clear boundaries within the universe of Axis II phenomenology. Schizotypal PD had significantly elevated odds of having paranoid and schizoid PDs, and borderline PD had significantly elevated odds of having dependent and antisocial PDs. OCPD and AVPD were characterized by clear boundaries.

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1. Oldham JM, Skodol AE, Kellman HD, et al: Diagnosis of DSM-III-R personality disorders by two structured interviews: patterns of comorbidity. Am J Psychiatry 1992; 149:213-220.
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SCIENTIFIC AND CLINICAL REPORT SESSION 25—NEW HORIZONS IN DEPRESSION

No. 74
DIAGNOSTIC STABILITY OF MDD

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to list the demographic and clinical features associated with a change in clinical diagnosis and to discuss the implications of these findings for the validity of DSM criteria.

SUMMARY:

Objective: To examine the stability of clinical diagnosis of major depressive disorder (MDD).

Method: The sample was all patients (n = 466) who had more than one hospitalization between 1/1/96 and 12/31/97 and a diagnosis of MDD for the first and/or last hospitalization (median time between admissions = 4 months). Chi square analysis and t-tests were used to examine associations between a change in diagnosis and demographic and treatment variables.

Results: Diagnosis changed for 35.4% of subjects. Patients with MDD at last but not first hospitalization (n = 70) were most likely to change from bipolar disorder (22.9%) or substance use disorder (15.7%). These patients were more likely to be older ($p = .001$), have more admissions during study time ($p = .004$), and have a substance use diagnosis at first admission ($p = .001$). Patients with MDD at first but not last hospitalization (n = 95) were most likely to change to schizoaffective (16.8%) or bipolar (13.7%) disorder, but there was not a statistically significant association with any of the independent variables.

Conclusion: Change in diagnosis is common; these data raise important questions about the use of diagnostic criteria in clinical settings.

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No. 75
METHYLFOLATE AS AN ADJUNCT IN SSRI REFRACTORY DEPRESSION

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the potential prognostic significance of low folate for antidepressant response to selective serotonin reuptake inhibitors (SSRIs) and to understand the rationale for and the limitations of folate supplementation among depressed patients who have an inadequate response to SSRIs.

SUMMARY:

Background: Low folate is associated with poorer response to selective serotonin reuptake inhibitors (SSRIs) in major depressive disorder (MDD). To our knowledge, this is the first study of folate supplementation in SSRI-refractory MDD.

Objective: To assess the efficacy of methylfolate, the major physiological form of folate, as adjunctive treatment among adults with MDD and inadequate response to an SSRI.

Method: 20 adults (65% female; mean age 44.0+/– 10.0 years) who met DSM-IV criteria for MDD, had shown partial or non-response to an SSRI after at least four weeks of treatment, and had a 17-item Hamilton Depression Rating Scale (HAM-D-17) ≥ 12 were enrolled in this eight-week open trial. Exclusions included current use of anticonvulsants or psychotropics other than an SSRI or B12 deficiency. Leucovorin, which is metabolized to methylfolate, was added to SSRIs at 15 mg-30 mg per day. As expected, folate levels rose from 26.7 +/– 21.3 to 408.3 +/– 203.1. HAM-D-17 scores post-treatment among completers (14.0 +/– 7.0) were lower than baseline scores (20.0 +/– 5.0) ($p < 0.001$ two-tailed, paired t-test). However only three patients achieved at least a 50% reduction in HAM-D-17 scores (response), and only one patient achieved a HAM-D-17 ≤ 7 (remission).

Conclusions: Leucovorin appears to be minimally effective as an adjunct among SSRI-refractory depressed individuals with normal folate levels. The more limited application of leucovorin as an SSRI adjunct in the setting of significant folate deficiency deserves further study.

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No. 76
BRAIN FUNCTION AND THE PLACEBO RESPONSE

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to review the clinical findings regarding placebo response; present data on brain physiologic changes in placebo responders.

SUMMARY:

Placebo has been defined as a treatment with no known medicinal value. Nevertheless, 20%-60% of depressed patients who receive placebo have a partial or complete remission of symptoms. It is unclear whether the placebo response represents a true remission of depression or a transient reduction in symptoms. Studies of brain function in placebo responders could help to elucidate the mechanism of the placebo response. We performed a double-blind, placebo-controlled study of fluoxetine in patients with major depression, and examined changes in brain function during treatment using quantitative electroencephalogram (QEEG) cordance. Fifty percent of patients receiving either fluoxetine or placebo met criteria for response (final Ham-D score ≤ 10), and the two groups did not differ either in their mean initial or final Ham-D scores. The patients responding to medication had substantial reductions in frontal brain activity subjects within 48 hours of starting medication. Conversely, the placebo responders showed significant increases in frontal brain activity within 48 hours. Changes in both groups persisted over several weeks of therapy. These results indicate that placebo responders have significant alterations in the same brain regions affected by fluoxetine treatment, but that these changes are distinct from those associated with medication response.

REFERENCES:

1. Montgomery SA, Roberts A, Patel AG: Placebo-controlled efficacy of antidepressants in continuation treatment. International Clinical Psychopharmacology, 1994; Suppl 1:49-53.
2. Shapiro AK, Shapiro E: The Powerful Placebo: From Ancient Priest to Modern Physician. Baltimore, John Hopkins University Press, 1998 (in press).

SCIENTIFIC AND CLINICAL REPORT SESSION 26—NEW ISSUES IN PSYCHIATRIC GENETICS

No. 77
POLYMORPHISMS IN THE SEROTONIN TRANSPORTER GENE AND COCAINE DEPENDENCE

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the importance of genetic factors in cocaine dependence, in particular the possible association between genetic variations in the serotonin transporter and susceptibility to cocaine dependence.

SUMMARY:

Objective: Considerable evidence indicates that serotonergic (5-HT) mechanisms, including transporter-facilitated 5HT uptake, are involved in cocaine use. We investigated whether allelic variants of

the serotonin transporter (5-HTT) gene confer susceptibility to cocaine dependence (CD).

Method: 125 CD subjects and 68 age-matched, drug-free controls were studied. Polymerase chain reaction based genotyping of a biallelic repeat polymorphism in the 5′ promotor region (5-HTTLPR) that modulates gene expression was performed. Chi-square analysis was used to compare genotype and allele frequencies and detect any departure from Hardy-Weinburg equilibrium.

Results: Two alleles of the 5′ region containing 484 (S) and 528 bp (L) repeats were detected. Interestingly, the L polymorphic variant was significantly overrepresented among CD patients (90.4%) compared with controls (76.5%) ($\chi^2 = 6.89$, df = 2, $p = 0.008$). Similarly, CD patients (48%) showed a significant excess of the LL genotype ($\chi^2 = 7.54$, df = 2, $p = 0.02$) compared with controls (35.3%). There were no significant associations between sex and race and 5-HTTLPR polymorphisms among the sample.

Conclusion: The results indicate a possible association between the long allelic variant of 5-HTTLTR and CD. Moreover, race or sex do not seem to influence 5-HTTLTR genotype distribution or allele frequencies. Further studies with larger sample sizes are required to confirm these findings. (funded in part by NIDA grant # DA340-02).

REFERENCES:

1. Aronson SC, Black JE, McDougle CJ, et al: Serotonergic mechanism of cocaine effects in humans. Psychopharmacology 1995; 199:179-185.
2. Lesch KP, Mossner R: Genetically driven variation in serotonin uptake: is there a link to affective spectrum disorders, neurodevelopmental and neurodegenerative disorders? Biological Psychiatry 1998; 44:179-192.

No. 78
SEROTONIN GENETIC POLYMORPHISM IN SAD AND BULIMIA NERVOSA

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the role of serotonin in disorders of mood and increased eating behavior and to understand the use of genetic association strategies for complex traits and disorders.

SUMMARY:

Serotonin is known to play a key role in feeding behavior and mood, and evidence points to serotonergic dysfunction in seasonal affective disorder (SAD) and bulimia nervosa (BN), two disorders of young adult women characterized by increased eating behavior and depressed mood. The goal of the current study is to assess the possible role of three serotonin genes, i.e., tryptophan hydroxylase (TPH), the serotonin 2C receptor (HTR2C), and the serotonin transporter (5-HTT), in women with either SAD (and carbohydrate craving/increased eating) or BN. For both SAD and BN, parental control triads and cases with matched controls were collected and genotyped for the TPH, the cys23ser HTR2C, and 5-HTT polymorphisms, and chi-square analysis was employed.

Initial data suggest an association between SAD and the TPH L-allele in both the parental control sample ($p = 0.029$, $n = 22$ triads) and the extended sample ($p = 0.001$, $n = 47$). For BN, the extended sample shows a significant finding in the same direction for TPH ($p = 0.016$, $n = 39$), while the parental control sample does not show statistical significance ($p = 0.33$, $n = 17$ triads). No significant findings for HTR2C or 5-HTT have been found. Although replication in larger samples is required, our preliminary results indicate that polymorphism of the tryptophan hydroxylase gene may play a role in susceptibility to both SAD and BN.

REFERENCES:

1. Levitan RD, Kaplan AS, Brown GM, et al: Hormonal and subjective responses to intravenous metachlorophenylpiperazine in women with seasonal affective disorder. Arch Gen Psychiatry 1998; 55:244-249.
2. Masellis M, Paterson AD, Badri F, et al: Genetic variation of the 5HT2A receptor and response to clozapine. Lancet 1995; 346:1108.

No. 79
GENETIC ANTECEDENTS OF DOPAMINE DYSFUNCTION IN SCHIZOPHRENIA

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EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize that many nonpsychotic relatives of schizophrenic patients may also manifest dopamine abnormalities, and that the dopamine dysfunction of schizophrenia may have genetic antecedents.

SUMMARY:

Background: Relatives of schizophrenic probands frequently manifest attenuated features of this illness including the negative symptoms and the milder positive psychotic symptoms. These two symptom dimensions are hypothesized to be associated with decreased and increased brain dopamine (DA) functions, respectively, raising the possibility that DA abnormalities may be present in the relatives of schizophrenic probands.

Methods: Plasma homovanillic acid (HVA), the major DA metabolite and an indicator of brain DA activity, was measured in nonpsychotic, physically healthy, first-degree relatives ($n = 55$) of schizophrenic probands and in normal subjects ($n = 20$) without a family history of schizophrenia.

Results: Plasma HVA inversely correlated with negative symptoms and positively correlated with attenuated positive symptoms. Also, relatives had decreased plasma HVA compared with normal subjects, consistent with the fact that these relatives are characterized by negative symptoms. These findings were not related to major peripheral factors that could affect plasma HVA, suggesting that the findings reflect changes in brain DA activity.

Conclusions: Negative symptoms indicating a genetic diathesis to schizophrenia in relatives may have a biological basis in reduced DA activity, and the DA dysfunction of schizophrenia may have genetic antecedents. This opens an important new avenue for further study of DA in this illness. (Biological Psychiatry, in press)

REFERENCES:

1. Amin F, Siever LJ, Silverman JM, et al: Plasma HVA in schizotypal personality disorder. In Friedhoff AJ, Amin F, editors, Plasma Homovanillic Acid in Schizophrenia: Implications for Presynaptic Dopamine Dysfunction. Washington DC: American Psychiatric Press, Inc., 1997, pp. 133-149.

2. Davis KL, Kahn RS, Ko G, Davidson M: Dopamine in schizophrenia: a review and reconceptualization. Am J Psychiatry 1991; 148:1474-1486.

SCIENTIFIC AND CLINICAL REPORT SESSION 27—COMPULSION: EATING AND GAMBLING

No. 80
ASSESSING ADOLESCENT PERCEPTIONS OF GAMBLING RISK

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EDUCATIONAL OBJECTIVE:

At the conclusion of this symposium, the participant should be able to understand the factors influencing adolescent gambling behavior, both environmental and temperamental, and understand how these factors can be addressed by prevention programs.

SUMMARY:

Objectives: To develop and pilot test a self-report questionnaire that samples adolescent perception of risks of, and accessibility to, gambling behavior.

Method: Subjects were approximately 100 adolescents in the general community and in juvenile detention in Louisiana. The study took place in three phases. Phase I involved focus groups that used small-group discussion to identify elements of risk accessibility and motivation to initiate, maintain, or cease gambling behavior. Audiotaped discussions were transcribed and coded into categories. In Phase 2, categorical responses from Phase 1 were rewritten in question format that also allowed for open-ended responses. This intermediate form of the questionnaire was administered to a second set of subjects. In Phase 3, adolescents completed the second revision of the questionnaire, which incorporated additions and corrections from the intermediate form. Adolescents also completed the juvenile temperament and character inventory, a personality survey.

Results: The survey will be presented in its current form. Accessibility of legalized gambling to adolescents, adult attitudes about the risk of gambling, especially parental attitudes and sensation seeking, were important factors in adolescent gambling behavior.

Conclusion: Modifiable environmental factors such as accessibility to legalized gambling and community and parental gambling attitudes are important factors when assessing adolescent gambling.

REFERENCES:

1. Vitaro F, Arseneault L, Tremblay RE. Dispositional predictor of problem gambling in male adolescents. Am J Psych 1997; 154:237-241.
2. Radecki TE: The sales of lottery tickets to minors in Illinois. J Gam Studies 1994; 10(3):213-218.

No. 81
LONG-TERM TREATMENT OF BULIMIA NERVOSA FOLLOWING ACUTE RESPONSE: A COMPARISON OF FLUOXETINE AND PLACEBO

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be familiar with the benefits of long-term pharmacotherapy in the treatment of bulimia nervosa.

SUMMARY:

Objective: To evaluate the efficacy of fluoxetine treatment versus placebo treatment in preventing relapse of bulimia nervosa (BN) during a 52-week period following successful acute fluoxetine therapy.

Methods: Patients (N = 232) who met DSM-IV BN criteria (purging type) were treated in single-blind fashion with fluoxetine 60 mg/day for eight weeks. Responders (patients with at least a 50% decrease from baseline in frequency of vomiting episodes) were randomized to fluoxetine 60 mg/day or placebo and were monitored for relapse for up to 52 weeks. Patients met relapse criteria if they experienced a return to baseline vomiting frequency for two consecutive weeks.

Results: 150 patients (65%) who met acute phase response criteria were randomized to continuation treatment. Among patients who responded to fluoxetine 60 mg/day, continued fluoxetine treatment was associated with a significantly lower rate of relapse than placebo treatment (Kaplan-Meier estimated one-year relapse rates: fluoxetine 33%; placebo 52%; one-tailed p-value = .006). In addition, continued fluoxetine treatment was statistically superior to placebo in mean change from randomization to endpoint for all primary and secondary efficacy measures except HAMD-17.

Conclusion: Following acute response at 60 mg/day, bulimia patients who continued fluoxetine treatment had a statistically significantly lower relapse rate than patients switched to placebo.

REFERENCES:

1. Goldstein D, Wilson M, Thompson V, et al: Long-term fluoxetine treatment of bulimia nervosa. Brit J Psychiatry. 1995; 166:660-666.
2. Keel P, Mitchell J: Outcome in bulimia nervosa. Am J Psychiatry. 1997; 154:313-321.

No. 82
PREDICTORS OF EARLY TREATMENT OUTCOME IN ANOREXIA

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to use the described prognostic indicators to aid in the decision of when to transfer inpatients with anorexia nervosa to a less intensive level of care.

SUMMARY:

Objective: Clinicians are under increasing pressure to transition inpatients with anorexia nervosa to less intensive treatment earlier in their hospital course. The purpose of this study is to identify prognostic factors clinicians can use in determining the earliest time to transfer an anorexic inpatient to a day hospital program (DHP).

Method: This retrospective study utilizing chart reviews is based on 71 patients with anorexia nervosa consecutively transitioned from inpatient care to an eating disorder DHP. We evaluate the prognostic significance of a variety of anthropometric, demographic, illness history, and psychometric parameters on short-term treatment outcome.

Results: Increased risk of DHP treatment failure and inpatient readmission is associated with comorbid diabetes, longer duration

of illness (>6 years) and amenorrhea (>3 years), lower rate of weight gain on the inpatient unit (<2 lbs/wk), and lower body mass index (BMI), both at the time of inpatient admission (BMI < 16.5 or <75% normal) and at transition to the DHP (BMI < 19.5 or < 90% normal).

Conclusion: Our results suggest that anorexic inpatients who have the identified poor prognostic indicators are in need of longer inpatient treatment to avoid immediate relapse and greater treatment cost and duration.

REFERENCES:

1. Lieberman PB, Wiitala SA, Elliott B, et al: Decreasing length of stay: are there effects on outcomes of psychiatric hospitalization? Am J Psychiatry 1998; 155:905-909.
2. Hebebrand J, Himmelmann GW, Wewetzer C, et al: Body weight in acute anorexia and at follow-up assessed with percentiles for the body mass index: implications of a low body weight at referral. Int J Eating Disorders 1996; 19:347-357.

SCIENTIFIC AND CLINICAL REPORT SESSION 28—CLINICAL RISK FACTORS FOR MENTAL DISORDERS

No. 83
VICTIMIZATION AS A RISK FACTOR FOR MAJOR DEPRESSION

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to: better understand the relationship between childhood and adulthood victimization as a modifiable risk factor and the likelihood of subsequent major depressive disorder among adults; to facilitate in the development of prevention programs.

SUMMARY:

Victimization resulting from violence in childhood or adulthood may be risk factor for subsequent mental conditions including depression. This study presents an epidemiological examination of the effects of victimization on depression.

Hypotheses: 1) Males and females who have suffered victimization as children will be at higher risk of major depressive episodes (MDE). 2) Women who have experienced victimization will be at a higher risk of MDE.

Methods: The analyses were based on the Canadian 1994 National Population Health Survey (N = 16,291), which provided information on MDE and victimization. Analyses were conducted using logistic regression.

Results: The presence of any childhood victimization resulted in an increased likelihood of an MDE. The odds of an MDE for exposure from any event was 2.6. The cumulative odds of multiple victimizations increased from 2.2 to 4.0 for two events and 4.7 for three events. Women who experienced any adult victimization were 3.5 times more likely to report an MDE.

Conclusion: To develop population-based health interventions for depressive disorders requires the identification of modifiable risk factors to guide the development of prevention programs. These findings suggest that victimization during childhood or adulthood, which is amenable to interventions, is a significant risk factor for MDE.

REFERENCES:

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2. Robins LN: Sturdy childhood predictors of adult antisocial behavior: replications from longitudinal studies. Psychological Medicine 1978; 8:611-622.

No. 84
MORTALITY AND MORBIDITY AMONG PSYCHIATRIC PATIENTS

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the increased suicidality in psychiatric patients and the association of physical and psychiatric illness.

SUMMARY:

Objective: To examine the mortality and the comorbidity of psychiatric and physical disorders in the 1966 North Finland birth cohort, an unselected population sample (n = 12.058) ascertained during midgestation and followed to age 28.

Method: We studied 11,017 subjects who were alive in Finland at age 16. Subjects with DSM-III-R schizophrenia and other diagnostic categories were identified using a two-stage diagnostic validation for DSM-III-R criteria screening individual case records.

Results: Up to the end of 1993, the total number of deaths was 117, and 79.5% of these deaths were from unnatural causes. There was a significantly higher mortality risk in men with schizophrenia (OR = 9.3, 95% CI = 3.1-25.5), other psychoses (OR = 10.3, 95% CI = 2.4-37.0), and personality disorders (OR = 4.3, 95% CI = 1.0-14.7). In the group of major mental disorders, 75% of deaths were suicides. Up to the end of 1994, 77.0% (298/387) of the psychiatric patients had been treated for physical illness compared with 62.9% (6687/10,630) of persons without a psychiatric disorder. Injuries and poisonings were more common in persons with psychiatric disorder. Men with psychiatric disorder had more than 50-fold odds for poisoning by psychotropic drugs, and women with psychiatric disorder 20-fold odds. Epilepsy was strongly associated with schizophrenia (OR = 11.1, 95% CI = 4.0-31.6).

Conclusions: Medical professionals should be aware of the increased risk of comorbid physical illness in psychiatric patients. Early evaluation of the suicidality may be the most important step in preventing the death of persons with major mental disorders.

REFERENCES:

1. Isohanni M,, Mäkikyrö T, Moring J: A comparison of clinical and research DSM-III-R diagnosis of schizophrenia in a Finnish national birth cohort. Soc Psych Psych Epid 1997; 32:303-308.
2. Mäkikyrö T, Karvonen JT, Hakko H: Comorbidity of hospital-treated psychiatric and physical disorders with special reference to schizophrenia: a 28-year follow-up of the 1966 northern Finland general population birth cohort. Public Health 1998; 112:1-8.

No. 85
SCHOOL PREDICTORS OF HOSPITAL-TREATED PSYCHIATRIC DISORDERS IN THE 1996 NORTHERN FINLAND BIRTH COHORT

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Peter B. Jones, Ph.D., Marjo-Riitta Jarvelin, M.D., Jari Jokelainen, B.Sc., Pentti Nieminen, Ph.D., Paula Rantakallio, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the association of school performance and later psychiatric morbidity.

SUMMARY:

Objective: We studied the association between school performance and later onset hospital-treated psychiatric morbidity experienced by the Northern Finland 1966 birth cohort (n = 11,017).

Method: School performance was operationalized: (1) school class level (in normal, ie. age-appropriate class vs. not in normal class) at the age of 1; (2) marks for individual school subjects at the age of 16. These were linked to data on psychiatric morbidity from the National Finnish Hospital Discharge Register. By the end of 1994, a total of 387 subjects had psychiatric illness. DSM-III-R diagnoses were grouped: schizophrenia, other psychoses, nonpsychotic disorders no psychiatric hospitalization (comparison group).

Results: In the comparison group, 6.8% of boys and 3.4% of girls were not in their normal class. In all the diagnosis groups, the proportion of those not in normal class were from two to eight times higher than in the comparison group. Among adolescents who later developed nonpsychotic disorders, means of school marks were lower ($p < 0.05$, adjusted for social class and place of residence) than in the comparison group. Lower marks were not found in categories of schizophrenia or other psychoses. Surprisingly, six (11%) of preschizophrenic boys had excellent mean school marks compared with only 3% (166/5245) of the comparison group (OR 3.8; 95% CI 1.6-9.3).

Conclusion: These findings may be an early manifestation of the disorders themselves or a marker of vulnerability or other risk factors. The mechanisms may differ between diagnoses.

REFERENCES:

1. Isohanni I, Järvelin M-R, Nieminen P: School performance as a predictor of psychiatric hospitalization in adult life: a 28-year follow-up in the northern Finland 1966 birth cohort. Psychol Med 1998; 28:967-974.
2. Jones P, Rantakallio P, Hartikainen A-L: Schizophrenia as long-term outcome of pregnancy, delivery and perinatal complications: a 28-year follow-up of the 1966 north Finland general population birth cohort. Am J Psychiatry 1998; 155:(3):355-364.

SCIENTIFIC AND CLINICAL REPORT SESSION 29—RISKS AND MANAGEMENT OF PSYCHOTROPIC DRUGS

No. 86
SEROTONIN SELECTIVITY REDUCES MANIA INDUCTION

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that the use of SSRIs has the potential benefit of high serotonin selectivity in reduction of emergent mania.

SUMMARY:

Background: The use of antidepressants is sometimes associated with emergence of manic episodes in patients with mood and anxiety disorders. It seems that rate of treatment-induced manic switch in patients receiving serotonin selective reuptake inhibitors (SSRIs) is lower than in patients treated by tricyclic antidepressants (TCAs). The aim of the present study was to evaluate the frequency of emergent mania in unipolar depressed patients treated with the highly selective serotonin reuptake inhibitor citalopram in comparison to placebo and TCAs.

Method: Data from post-marketing computerized adverse events reports, three placebo controlled trials, and four double-blind trials comparing citalopram to TCAs were analyzed.

Results: Of 4,629 subjects treated with citalopram, 25 manic episodes were reported (0.54%). In the double-blind trials compared with placebo, citalopram (N = 682) induced mania in one subject (0.1%), while compared with TCAs (N = 389) manic switches occurred in five patients (1.3%) ($X_2 = 4.70$; df = 1; $p = 0.03$).

Conclusions: Despite the limitations of the nature of the study, database analysis, it seems that the high selectivity of citalopram to the serotonin transporter is associated with significantly reduced frequency of treatment-emergent manic episodes.

REFERENCES:

1. Levy D, Kimhi R, Barak Y, et al: Antidepressant associated mania: a study of anxiety disorders patients. Psychopharmacol 1998; 136:243-246.
2. Peet M: Induction of mania with SSRI's and TCA's. Br J Psychiatry. 1994; 164:549-553.

No. 87
RISPERIDONE-ASSOCIATED DYSKINESIA

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EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that risperidone at ≤6 mg. per day can precipitate dyskinesia for the first time or worsen dyskinesia in patients with a history of typical APD-associated dyskinesia.

SUMMARY:

Objective: To determine the incidence and severity of risperidone (RISP) -associated dyskinesia in neuroleptic-naive (NN) patients and patients with intolerance to typical antipsychotic drugs (APDs).

Methods: We prospectively studied two patient populations: 1) acutely psychotic NN inpatients treated with either RISP (N = 34; mean daily dosage 3.2 mg) or oral haloperidol (HAL; N = 241; mean daily dosage 3.7mg); 2) patients with a history of APD-related EPS who were subsequently treated with RISP (N = 40; dosage 1-6mg/day). Patients in both groups were assessed by blinded raters twice weekly during hospitalization and monthly during outpatient treatment. Dyskinesia was diagnosed as AIMS ≥3 for one body part or AIMS ≥2 for at least two body parts.

Results: New-onset dyskinesia developed in two of 34 (5.8%) NN patients treated with RISP and in nine of 200 (4.5%) treated with HAL. Among the 40 patients with previous neuroleptic-induced EPS, 10 developed new-onset dyskinesia on RISP, and another 10 had worsening of their dyskinesia, while only three had reduction of dyskinesia when switched to RISP.

Conclusion: RISP is comparable to HAL in its ability to induce early dyskinesia in NN patients. RISP provokes new onset or worsening dyskinesia in about half of patients with previous neuroleptic intolerance.

REFERENCES:

1. Woerner MG, Sheitman BB, Lieberman JA, Kane JM: Tardive dyskinesia induced by risperidone. Am J Psychiatry, 1996; 153:843.

2. Daniel DG, Smith K, Hyde T, et al: Neuroleptic-induced tardive dyskinesia. Am J Psychiatry, 1996; 153:734.

No. 88
ONDANSETRON, A SEROTONIN ANTAGONIST, IMPROVES TARDIVE DYSKINESIA

Pinkhas Sirota, M.D., *Abarbanel Men Hlth Ctr 6A, 15 Keren Kayemet, Bay Yam 59100, Israel* Tanya Mosheva, M.D., Hertzel Shabtay, M.D., Nir Giladi, M.D., Amos Korcyn, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize that pharmacologic blockade of central 5HT3 receptors may become a strategy to attenuate tardive dyskinesia, and that serotonergic mechanisms are pathogenetically important in the development of tardive dyskinesia.

SUMMARY:

Background: The mechanism for the development of tardive dyskinesia (TD) remains unclear. Serotonin may modulate dopaminergic activity and thus be involved in TD. Ondansetron is a selective 5HT3 receptor antagonist that is now successfully used to prevent nausea and vomiting in cancer patients treated with chemotherapy.

Objectives: The authors conducted a preliminary open-label study to examine the efficacy, tolerability, and safety of ondansetron in patients with tardive dyskinesia.

Methods: We studied 20 patients (five males and 15 females), 42-81 years old (mean ± SD: 69.8 ± 10.1), who met Research Diagnostic Criteria for at least mild tardive dyskinesia. They had stable psychopathology and had been on a stable psychotropic drug regimen for at least six months. All patients met DSM-IV criteria for schizophrenia and provided signed informed consent. Their disease duration was 1-30 years. Ondansetron 8-12 mg/day was administered for 12 weeks. All patients were assessed by four independent investigators who used videotapes of the patients' movements. The scales used for the clinical evaluations were: 1) Positive and Negative Syndrome Scale (PANSS); 2) Abnormal Involuntary Movement Scale (AIMS); 3) Clinical Global Impression Scale (CGI). Evaluations were performed at baseline and every four weeks thereafter until the completion of the study.

Results: Ondansetron caused a statistically significant improvement of TD as measured by AIMS scores ($p = 0.000$). PANSS scores improved significantly ($p = 0.0002$). At the completion of the study a statistically significant correlation was found between the PANSS and AIMS scores ($p < 0.02$). Age and sex did not influence the AIMS scores in all four times of evaluation. There were no hematological or chemical laboratory impairments before or after the treatment with ondansetron.

Conclusions: Ondansetron may be an effective and safe therapy to control tardive dyskinesia and psychotic symptoms in schizophrenic patients. Such a pharmacological strategy may improve patients' mobility and quality of life.

REFERENCES:

1. Zoldan J, Friedberg G, Melamed E: Psychosis in advanced Parkinson's disease: treatment with ondansetron, a 5-HT3 receptor antagonist. Neurology 1995; 45:1305-1308.
2. Rice GPA, Lesaux J, Vandervoert P, et al: Ondansetron, a 5-HT3 antagonist, improves cerebellar tremor. J Neurology and Psychiatry 1997; 62:282-284.

SCIENTIFIC AND CLINICAL REPORT SESSION 30—ANTECEDENTS AND NEW TREATMENTS IN SCHIZOPHRENIA

No. 89
CHILDHOOD ADVERSITY AND ADULT HOMELESSNESS

Carol L.M. Caton, Ph.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, New York NY 10032* Patrick E. Shrout, Ph.D., Alan D. Felix, M.D., Sabina Hirshfield, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be aware of the role of childhood adversity in adult homelessness and recognize the need to carefully monitor the housing status of indigent men with schizophrenia who have had adverse experiences in childhood.

SUMMARY:

Objective: Is childhood adversity a precursor to adult homelessness among the urban poor with and without severe mental illness? We explored this question in two samples of indigent urban adults; people with schizophrenia, and people with no psychotic disorder. Previous studies have lacked carefully defined diagnostic groups and adequate nonhomeless controls to make such a comparison possible.

Method: Data were drawn from two parallel case-control studies of risk factors for homelessness; 1) 400 men and women with DSM-III-R (SCID) schizophrenia or schizoaffective disorder (funded by N.I.M.H.), and 2) 400 men and women with no psychiatric hospitalization history and no psychotic disorder (funded by N.I.D.A.). Literally homeless cases were selected from crisis shelters. Never homeless controls with schizophrenia were attending mental health treatment programs; those without psychotic disorder were applicants for public assistance. Both samples were stratified by gender. Assessment of childhood adversity included foster home placement and an index of family disorganization based on parental pathology, nurturing constancy, financial and residential stability, and family violence.

Results: Adverse experiences in childhood were common in all groups studied. Childhood adversity was associated with adult homelessness only among men with schizophrenia. Compared with their never homeless counterparts, greater numbers of homeless men with schizophrenia experienced foster care placement (OR 4.13, 95% CI = 1.84 to 9.28) and lived in disorganized family settings ($t = -3.35$, $p < .01$).

Conclusions: Childhood adversity is mediated by gender and psychopathology in contributing to the risk of adult homelessness. Clinicians should be aware that a history of childhood adversity among men with schizophrenia may place them at greater risk of homelessness, signaling the need for routine assessment of the home situation and interventions to prevent homelessness.

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2. Herman DB, Susser ES, Struening EL, Link BL: Adverse childhood experiences: are they risk factors for adult homelessness? Am J Public Health 1997; 87:249-255

No. 90
COMPARATIVE EFFICACY OF OLANZAPINE AND HALOPERIDOL FOR PATIENTS WITH TREATMENT-RESISTANT SCHIZOPHRENIA

Alan F. Breier, M.D., *MC 541, Eli Lilly and Company, Lilly Corporate Center DC 0538, Indianapolis IN 46285* Susan H. Hamilton, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the therapeutic role of olanzapine in treating patients with treatment-resistant schizophrenia based on results from a large, double-blind study evaluating the efficacy and safety of olanzapine compared with haloperidol.

SUMMARY:

Background: There is relatively little information regarding the efficacy of newer atypical antipsychotic drugs for patients with schizophrenia who are treatment resistant to neuroleptic agents. Several lines of evidence suggest that a clinical trial of olanzapine in this population is warranted.

Methods: A subpopulation of patients (N = 526) meeting treatment-resistant criteria selected from a large, prospective, double-blind, six-week study assessing the efficacy and safety of olanzapine and haloperidol was examined. Both last-observation-carried-forward (LOCF) and completers (observed cases) analyses were conducted.

Results: Olanzapine demonstrated significantly greater mean improvement from baseline in Positive and Negative Syndrome Scale (PANSS) negative symptoms, comorbid depressive symptoms assessed by the Montgomery-Asberg Depression Rating Scale, akathesia as measured by Barnes Akathesia Scale, and extrapyramidal symptoms as measured by Simpson-Angus Extrapyramidal Rating Scale with both LOCF and completers analyses. In addition, olanzapine was significantly superior to haloperidol for Brief Psychiatric Rating Scale (BPRS) total ($p = .006$), PANSS total ($p = .005$), and PANSS positive symptoms ($p = .017$) scores in completers of the six-week study. Significantly greater response rates were observed in olanzapine-treated (47%) than haloperidol-treated (35%) patients in the LOCF analysis ($p = .008$), but significance was not reached in the completers analysis ($p = .093$). Mean doses ($\pm$SD) of olanzapine and haloperidol were 11.1 $\pm$ 3.4 mg/day and 10.0 $\pm$ 3.6 mg/day, respectively.

Conclusions: Olanzapine was superior to haloperidol for key symptom domains and parkinsonian side effects. Implications of these data for the therapeutics of this severely ill subgroup are discussed.

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No. 91
LOW-FREQUENCY TRANSCRANIAL MAGNETIC STIMULATION IN PATIENTS REPORTING VOICES

Ralph E. Hoffman, M.D., *Department of Psychiatry, Yale Psychiatric Institute, PO Box 208038, New Haven CT 06520-8038* Nashaat N. Boutros, M.D., Robert M. Berman, M.D., Elizabeth Roessler, M.S., Ayse Belger, Ph.D., John H. Krystal, M.D., Dennis S. Charney, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand known effects of transcranial magnetic stimulation (TMS) on brain activation, previous studies of the pathophysiology of hallucinated speech or voices in schizophrenia, and our research findings using TMS to study the mechanism and treatment of these psychotic experiences.

SUMMARY:

Objectives: Prior studies suggest that hallucinated speech or "voices" arise from activation of speech perception areas of the cerebral cortex. Low-frequency transcranial magnetic stimulation (TMS) has been shown to reduce cortical activation. We consequently sought to determine if low-frequency TMS of speech perception brain regions could curtail persistent speech hallucinations in schizophrenic patients.

Methods: One hertz stimulation of left temporoparietal cortex using a CADWELL figure-8 coil was compared with sham stimulation of the same region of the scalp using a double-blind, crossover design. Stimulation was delivered at 80% motor threshold for up to 16 minutes.

Results: Thus far seven patients have completed the protocol. Patients tolerated TMS without significant difficulties. Statistically significant improvements in hallucinations after 16 minutes of active stimulation compared with sham stimulation were demonstrated. Four of seven patients reported complete cessation of voices following active stimulation lasting between 16 hours and seven weeks.

Conclusions: These observations indicate that TMS could advance our understanding of the mechanism and treatment of hallucinated "voices" in patients with schizophrenia.

Supported by NIMH grant MH-50557, a NARSAD Independent Investigator Award, NIH/NCRR/GCRC Program Grant RR00125, the Chrysalis Fund, and the State of Connecticut.

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2. Wassermann EM, Wedegaertner FR, Ziemann U, et al: Crossed reduction of motor excitability by one hertz transcranial magnetic stimulation. Neuroreport (in press)

SCIENTIFIC AND CLINICAL REPORT SESSION 31—OUTCOME STUDIES IN MOOD DISORDERS

No. 92
PSYCHODYNAMIC PSYCHOTHERAPY OF THE SUICIDAL ADOLESCENT GIRL

Philip N. Cheifetz, M.D., *Children's Outpatient, Royal Ottawa Hospital, 1145 Carling Avenue, Ottawa ON K1Z 7K4, Canada* Shelagh MacDonald, MSW,

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the criteria for the successful outcome of psychodynamic psychotherapy with the suicidal adolescent girl and to understand the genesis of the self hate and the mechanisms for its resolution through the process of therapy.

SUMMARY:

The purpose of this report is to highlight the effectiveness of psychodynamic psychotherapy in the treatment of the suicidal adolescent girl. We describe as well the dynamics of the murderous self hate and explore its defensiveness in concealing depressive anxiety,

guilt, shame, and anger that emerge as the therapy evolves. Five adolescent girls were treated with a mixed supportive/expressive approach following assessment for suicidal and self-destructive behaviors. Building on the positive transference and a holding environment, there was an exploration of the relationship to the hated and loved object, most often the mother, with an identification and introjection of the hated part, which had to be destroyed or expelled. Guilt and superego severity were often at work in the genesis of the self-destructiveness. Success of therapy hinged on the identification with the idealized therapist and an acceptance of sadness rather than madness leading to a renewed sense of self-regard through the intersubjective process. A typical vignette is that of a 16-year-old street girl whose suicidality was coupled with overt hostility toward authority. Four months of therapy was associated with an acceptance of earlier losses, i.e., her infantile relationship with her father and a reconciliation with the mother. The paper concludes with a description of the indicators for successful outcome using this modality of treatment.

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1. Brent D., Kolko DJ, Birmaher B, et al: Predictors of treatment efficacy in a clinical trial of three psychosocial treatments for adolescent depression. J Am Acad Child Adolesc Psychiatry 1998; 37:906-914.
2. Holmes J: The changing aims of psychoanalytic therapy. Int J Psychoanal 1998; 79:227-240.

No. 93
BIPOLAR OUTCOME: A 10-YEAR FOLLOW-UP

Joseph F. Goldberg, M.D., *Department of Psychiatry, NY-Presbyterian Hospital, 425 East 61st Street, New York NY 10021* Martin Harrow, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to provide up-to-date, clinically useful information on the prognosis and long-term course of bipolar and unipolar disorders during naturalistic treatment in the past decade.

SUMMARY:

Objective: Syndromal and psychosocial outcome both appear poorer in bipolar disorder patients than has previously been recognized. This report extends prior findings from the Chicago Follow-up Study on the functional outcome of bipolar-manic and unipolar-depressed patients at four successive follow-ups over 10 years.

Methods: 34 bipolar I manic and 89 unipolar-depressed patients (17 psychotic, 72 nonpsychotic) were assessed at index hospitalization and follow-up at approximately 2, 4.5, 7.5, and 10 years. Ratings of work adjustment, rehospitalization, and overall functioning at each assessment were analyzed to compare patients with sustained long-term remissions with those who have an unfavorable or erratic clinical course.

Results: Consistently good functioning was more evident among unipolars than bipolars. Less than half of bipolars had good work performance at each follow-up; unipolars had consistently better work functioning ($p < .05$). Rehospitalization was more frequent among bipolar than unipolar patients throughout the 10-year follow-up period ($p < .05$).

Conclusions: About half of bipolar patients have sustained long-term remissions, while one-quarter to one-third show a declining clinical course. Stable improvement occurs more consistently after hospitalization among unipolar than bipolar patients.

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No. 94
FAMILIES AND THE TREATMENT OF CHRONIC DEPRESSION

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

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the importance of family functioning in the course, outcome, and treatment of patients with chronic depression.

SUMMARY:

Objective: We examined the relationship between family functioning and response to pharmacological treatment in a multisite clinical trial of chronically depressed outpatients.

Method: A subsample of 199 patients recruited for a clinical trial that compared sertraline with imipramine completed family assessments on the perception of their family's functioning.

Results: Most of the patients reported unhealthy scores in seven areas of their family's functioning. However, those who perceived their family's functioning as healthy (particularly their ability to solve problems and to respond to each other effectively) at baseline had better odds of recovering from the depression by the 12th week of follow-up. Using established cut-off scores, we compared patients whose family functioning improved from poor to healthy with patients whose family functioning remained poor throughout the 12-week study period. The odds of achieving full or partial response at 12 weeks for patients whose family functioning improved was significantly greater than for patients whose family functioning remained poor in five out of seven family dimensions. Significant odds ratios ranged from 2.33 to 6.03. In multivariate analyses, family functioning, along with presence of an Axis II disorder and years of education, was significantly related to treatment response.

Conclusion: The association between good family functioning, improvement in family functioning, and response to pharmacological treatment should be pursued further. Treatment implications of these findings suggest that family intervention, in addition to pharmacotherapy, may be helpful in the treatment of patients with chronic depression.

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SCIENTIFIC AND CLINICAL REPORT SESSION 32—CONTROVERSIES IN MANAGED CARE

No. 95
DECLINING MENTAL HEALTH SERVICE USE IN A LARGE CORPORATION

Robert A. Rosenheck, M.D., *NEPEC, VA CT Health Care System, 950 Campbell Avenue, West Haven CT 06516* Benjamin G. Druss, M.D., D. Leslie, M. Stolar, William H. Sledge, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to anticipate adverse effects of declining mental health service use after the implementation of managed care.

SUMMARY:

Objective: This study examines the consequences of reducing mental health services for employees of a large, self-insured, private corporation.

Method: Computerized personnel data on sociodemographic characteristics, sick days, and job performance were merged with claims data on health care utilization and costs from a large U.S. corporation from 1993-1995 (n = 20,814 unique employees accounting for 41,441 employee-years). Multivariate analytic techniques were used to evaluate change in health service utilization and costs over time, and differences in time trends between users of mental health services and other employees.

Results: Mental health service use and cost declined by more than one-third from 1993 to 1995, while non-mental-health service use and cost increased slightly. Mental health service users, however, showed increased use of non-mental-health services during this time, offsetting the mental health service cost reductions. Mental health service users also showed a greater increase in absence and disability days. Total health-related costs (service use costs plus the cost of lost work days) increased by almost $355 among mental health service users compared with a decline of $54 among other employees.

Conclusion: Among employees of a large corporation, reductions in mental health service expenditures were associated with offsetting increases in non-mental-health care. In addition, sick days increased, possibly reflecting adverse effects on employee health.

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No. 96
DISCRIMINATION IN UTILIZATION MANAGEMENT

Lawrence Y. Kline, M.D., *7315 Wisconsin Ave Ste 547W, Bethesda MD 20814-3208*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand that "parity," when applied to the financing of the treatments of the various illnesses, consists of more than equality of days, visits, or dollar limits, but also consists of equality with respect to stringency of criteria use to determine medical necessity.

SUMMARY:

Utilization management is the means used by organized systems of care to determine whether or not to authorize payment for medical services. A variety of criteria may be used to make this decision, but they may not be applied uniformly across the entire spectrum of disease. According to a report to the Center for Mental Health Services of the Department of Health and Human Services, the Hay Group found that whereas utilization management in organized systems results in a savings of 3% of nonmanaged medical and surgical costs, it results in a 25% savings of nonmanaged mental illness and substance abuse treatment costs.

In another report to CMHS, Price Waterhouse found that mental illness and substance abuse treatments are subject to more stringent utilization management than are medical and surgical treatments. In a report to the Educational Foundation of the National Association of Private Mental Health Systems, the Hay Group reported that over the last 10 years, during which utilization management has become the norm for all behavioral health treatments, the total expenditures for these treatments have been cut in half. What are the consequences to society and to patients of these practices? At the same time they have taken place, according to a report in Best's Review, disability payments for mental disorders from 1989 to 1995 have risen 165% in Social Security and as much as 335% in the private sector. Women and younger workers are the primary recipients, and patients are no longer being treated until they are able to return to work. For those who argue that more stringent utilization management has the purpose of preventing greater waste, a report to the Congressional Budget Office suggests otherwise. The author presents two clinical vignettes to demonstrate the effects of adequate and inadequate treatment, the latter as required by utilization management, on the likelihood of patients returning to work. The author concludes that parity will be incomplete until it includes parity with respect to utilization management. He urges that this goal be pursued in legislative, judicial, and public information efforts.

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1. Hay/Huggins Company, Inc.: Mental Health Benefit Value Comparison, September 29, 1997.
2. Price Waterhouse LLP: Analysis of the Mental Health Parity Provision in S. 1028, May 31, 1996.

No. 97
MALPRACTICE LIABILITY AND MANAGED CARE: DEVELOPMENTS

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

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to understand the various legal issues related to physician liability in managed care, to deal with managed care treatment denials in a medically and legally appropriate manner, to participate in a more effective defense should a denial lead to a malpractice suit.

SUMMARY:

Managed care has led to a diminution of the physician's power to determine treatment and, concurrently, an increased susceptibility to physician liability. The situation is aggravated by hold-harmless clauses and gag rules. Courts have held physicians accountable if they did not appeal sufficiently to exhaust all means of overturning negative utilization review determinations. Several lines of approach to liability in physician/insurer/patient relationships have been considered by the courts without changing this fundamental responsibility. Federal ERISA law pre-empting state laws in the arena of managed care further complicates this legal situation and adds to the physician's risk. Bad press for HMOs and perceived inequities have led many states to legislate allocation of responsibility for malpractice. Federal courts have begun to review ERISA provisions and decide precedent cases; modifications of ERISA are under consideration in Congress. This paper summarizes applicable law and reviews recent changes in this rapidly evolving field.

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2. Mariner WM: Liability for managed care decision: the Employee Retirement Income Security Act (ERISA) and the uneven playing field. Am J Public Health 1996; 86:863-869.

SYMPOSIUM 1—CLINICAL AND THERAPEUTIC APPROACH TO BIPOLAR DEPRESSION

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to provide the latest information about the theoretical understanding as well as diagnostic and treatment approaches to bipolar depression.

No. 1A
BIPOLAR I VERSUS BIPOLAR II DEPRESSION: CONTRAST WITH UNIPOLAR

Hagop S. Akiskal, M.D., *Department of Psychiatry, University of CA at San Diego, 9500 Gilman Drive, La Jolla CA 92093-0603*

SUMMARY:

This paper reviews the existing literature on the depressive phase of bipolar disorder. The focus is on whether or not clinical features differentiate between unipolar and bipolar. Studies in the 70s noted the hypersomnic-retarded nature of bipolar depression as opposed to the anxious-agitated features in unipolar depression. Several prospective studies on bipolar transformation in the early 80s testified to these features. There has been remarkable failure to replicate these findings over the past ten years. This is probably due to two reasons. Complex presentations with mixed features have been described in bipolar disorder that would statistically cancel out the anergic features. Furthermore, new data suggest that the bipolar II subtype is associated with a great deal of anxious comorbidity. Therefore, results would differ depending on the proportion of bipolar I and bipolar II included. An NIMH collaborative depression study showed that trait mood lability was a prospective predicter of high sensitivity (91%) and specificity (86%) in bipolar II switching of major depressives. The author submits that uncomplicated bipolar depression is anergic, but mixed states, comorbidity, and temperamental features pathoplastically alter its clinical features.

No. 1B
BIOLOGICAL BASIS OF BIPOLAR AND UNIPOLAR DISORDER

L. Trevor Young, M.D., *Department of Psychiatry, McMaster University, 1200 Main Street W, Rm HSC3G57, Hamilton ON L8N 3Z5, Canada;* Glenda M. MacQueen, M.D., Jun-Feng Wang, M.D.

SUMMARY:

Investigations into the biological basis of mood disorders and their response to treatments have resulted in a substantial body of findings. Earlier studies focused on monoaminergic metabolites and receptor binding, whereas more recent studies have focused on receptor function and downstream events in the signal transduction cascade. It is at this level that differential effects for antidepressants and mood stabilizers have been determined. Furthermore, opposite effects in a number of these measures have been reported in tissues from patients with bipolar disorder and major depression. The author will discuss the current understanding of the biochemical basis of bipolar disorder and major depression including work from his laboratory and others. These data will be used to build a model for understanding state- (mania, depression, euthymia) and diagnosis- (bipolar disorder, major depression) related biochemical effects. This discussion will be used to facilitate the other contributions to this symposium.

No. 1C
ANTICONVULSANTS FOR TREATMENT OF BIPOLAR DEPRESSION

Gary S. Sachs, M.D., *Bipolar Clinic, Massachusetts General Hospital, 15 Parkman Street, WACC-812, Boston MA 02114*

SUMMARY:

Treatment of the depressed phase of bipolar illness presents a dilemma for patients and clinicians. Administration of standard antidepressant medications carries the risk of iatrogenic mania. If effective for treatment of depression, mood stabilizers would be attractive alternatives to standard antidepressant medications.

Lithium is considered a mood stabilizer because double-blind studies demonstrate its efficacy for treatment of bipolar depression as well as its antimania properties. This raises the possibility that other putative mood stabilizing agents such as valproric acid, lamotrigine, and gabapentin may also be effective treatments for bipolar depression. The rationale for using these anticonvulsant medications in the treatment of acute bipolar depression will be reviewed.

Guidelines will be offered for management of refractory bipolar depression that use the following four principles to manage the risk of antidepressant medication: (1) initiate acute phase treatment with mood stabilizing agents, (2) if necessary offer standard antidepressant medications proceeding stepwise from agents with lower risk (bupropion) to higher medications (tricyclics), (3) minimize antidepressant exposure by attempting a gradual taper after appropriate continuation phase treatment, and (4) offer ECT for patients at immediate risk of self harm or unable to tolerate pharmacological interventions.

No. 1D
ANTIDEPRESSANTS VERSUS MOOD STABILIZERS IN THE TREATMENT OF BIPOLAR DEPRESSION

Russell T. Joffe, M.D., *Dean and Vice President, McMaster University Med Center, 1200 Main Street West, Rm 2E1, Hamilton, ONT L8N 3Z5, Canada;* L. Trevor Young, M.D., Janine Robb, R.N., Glenda M. MacQueen, M.D., Irene Patelis-Siotis, M.D.

SUMMARY:

Bipolar depression is a serious disorder with substantial morbidity and mortality from suicide. Although this phase of bipolar illness represents a major therapeutic challenge, there are few controlled data to guide rational clinical treatment decisions. The major issue remains whether mood stabilizers or antidepressants is the preferable approach to the treatment of acute bipolar depression. The limited literature on antidepressant vs. mood stabilizer efficacy will be reviewed. The preliminary data from an ongoing six-week, double-blind trial of a second mood stabilizer vs. an antidepressant, peroxetine, in acute bipolar depression, will be described. To date, 25 subjects with bipolar affective disorder who have had a breakthrough episode while receiving either lithium or divalproex sodium have entered the study. Patients were randomized to receive the addition of either peroxetine or a second mood stabilizer, lithium or divalproex sodium. Analysis of variance using last observation carried forward (LOCF), showed that both the addition of an antidepressant and a second mood stabilizer were effective treatments for acute bipolar depression. There was no significant difference between the two treatment strategies at the end of the six-week trial. However, there were significantly more non-completers in the two mood stabilizer groups.

These preliminary data suggest that either option—two mood stabilizers or the addition of an antidepressant to the current mood stabilizer—may represent suitable options for treatment of bipolar depression. The higher completion rate in the antidepressant group suggests that in usual clinical conditions, antidepressant rather than combined mood stabilizer therapy may be the preferred option.

No. 1E
ECT IN BIPOLAR DISORDER

Charles H. Kellner, M.D., *Department of Psychiatry, Medical University of SC, 171 Ashley Avenue, Charleston SC 29425*

SUMMARY:

ECT remains an important treatment for a significant minority of patients with bipolar disorder who are inadequately responsive to pharmacotherapy. Bipolar depression responds as well to ECT as does unipolar depression. Despite being a powerful antidepressant, ECT is not commonly associated with switching to mania. The literature on ECT-induced hypomania/mania is scant and controversy exists about whether manic symptoms during a course of ECT represent a true switching process or what has been called an "ECT-induced euphoric state." ECT's potent mood-stabilizing (i.e., antimanic as well as antidepressant) effects may explain the low rate of manic switches.

ECT has been used clinically as continuation and/or maintenance therapy for both phases of bipolar disorder, but controlled data demonstrating its effectiveness in this application are lacking and urgently needed. Likewise, data on post-ECT prophylactic pharmacotherapy are limited, but beginning to appear. In a trial with severely depressed inpatients (n = 68, 28% bipolar) Lauritzen et al. compared paroxetine with imipramine for post-ECT relapse prevention and found paroxetine to be superior. As more data are gathered on the safety of concurrent use of ECT and antidepressant medications, it may be possible to further decrease the rate of post-ECT relapse by combining these modalities.

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3. Sachs GS: Treatment refractory bipolar depression in Psychiatric Clinics of North America. Edited by Amsterdam J, Rohan M. Philadelphia, W.B. Saunders, 1996
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7. Lauritzen L, Odgaard K, Clemmesen L, Lunde M, Ohrstrom J, Black C, Bech P: Relapse prevention by means of paroxetine in ECT-treated patients with major depression: a comparison with imipramine and placebo in medium-term continuation therapy. Acta Psychiatr Scand 1996 Oct; 94(4):241–51

SYMPOSIUM 2—PSYCHIATRIC DIAGNOSIS IN DIVERSE POPULATIONS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to better recognize how culture, race, spiritual experience, sexual orientation, and gender identity affect psychiatric diagnosis.

No. 2A
DIAGNOSIS BASED ON SEXUALITY AND GENDER IDENTITY

Dan H. Karasic, M.D., *Department of Psychiatry, San Francisco General Hospital, 1001 Potrero Avenue, Suite 7E, San Francisco CA 94110*

SUMMARY:

Psychiatric diagnosis of mental disorders based on sexual orientation and gender identity have provided controversies for psychiatry for decades, and continue to provide challenges. Psychiatric diagnosis is rooted in prevailing social and cultural norms. Mental disorders are diagnosed based on impairment in social or occupational functioning. The diagnosis of mental disorders in socially stigmatized groups remains problematic, as it may be impossible to determine the intrinsic versus societal contributions to social or occupational impairment. Recognition of this difficulty contributed to the removal of homosexuality and ego-dystonic homosexuality from the DSM. The distinguishing of normal variants in gender expression from psychiatric disease continues to present controversy in the gender identity disorder diagnosis in DSM-IV. The challenge of identifying disease without pathologizing diversity remains for future editions of DSM. Alternatives for gender identity disorder for DSM-V will be presented.

No. 2B
CULTURAL ISSUES AND THE DIAGNOSIS OF BLACKS

Michelle O. Clark, M.D., *Department of Psychiatry, UCSF/SF General Hospital, 1001 Potrero Ave, Room 7B-21, San Francisco CA 94110*

SUMMARY:

People of African descent in the United States (blacks, African Americans) are overrepresented in psychiatric services. Additionally, outcome measures for treatment show they do less well. Studies of diagnostic practice with this special population done in the 1970s revealed a tendency to miss diagnoses or misdiagnose blacks due to cultural phenomena.

This presentation will review some of the history of diagnostic considerations and give examples of correct approaches.

No. 2C
SPIRITUALITY AND MYSTICAL EXPERIENCE IN PSYCHIATRIC PRESENTATION

Elizabeth F. Targ, M.D., *CPMC, 2300 California Street, Ste 204, San Francisco CA 94115*

SUMMARY:

With the inclusion of the new DSM-IV v-code for spiritual or religious problems has come increased discussion both of the role of spirituality in psychopathology and in psychological health. The DSM-IV still gives little assistance in differentiation of certain types of mystical experiences from psychosis, mania, dissociation, and schizotypal personality disorder. The purpose of this paper is to summarize the epidemiology of spiritual beliefs and experience and to specifically discuss the phenomenology and relevance of different types of mystical experiences reported within the psychiatric and community populations. Lack of information about such experience puts the psychiatrist at risk for misdiagnosing psychopathology in a healthy, but spiritually oriented person. In addition, it puts the patient at risk for not getting help or support in the context of a potentially disorienting experience. Lack of consensus between the psychiatric and lay communities has created a communication gap,

such that individuals with spiritual experiences or concerns are avoiding psychiatric help and have available only religious guidance or paraprofessional help that may not address their psychiatric needs. Issues of diagnosis, intervention, and collaboration with pastoral care will be addressed.

No. 2D
CULTURAL ISSUES IN THE DSM-IV

Francis G. Lu, M.D., *Department of Psychiatry, University of CA at SF, 1001 Potrero Avenue, San Francisco CA 94110*

SUMMARY:

DSM-IV introduced major innovations to improve its use with culturally diverse individuals. As stated in the introduction, these include: (1) Age, Gender, and Cultural Considerations sections in the narrative of 90 diagnostic categories, (2) Outline for Cultural Formulation, and (3) Glossary of Cultural Bound Syndromes.

These innovations resulted from the work of a NIMH-sponsored work group on cultures, diagnosis, and care, chaired by Juan Mezzich, M.D., Ph.D. Despite inclusion in the DSM-IV, these features may not be optimally utilized by psychiatrists in their clinical work. Potential barriers include the following: (1) placement of the outline and glossary in Appendix I; and (2) lack of discussion of the age, gender, and cultural considerations in the diagnostic criteria. Potential solutions include continuing education of trainees and psychiatrists, inclusion of these concepts in PRITE and ABPN examinations, and publication of case series such as the one in the journal Culture, Medicine and Psychiatry.

No. 2E
ALLOCATING CARE AMONG DIVERSE PATIENT GROUPS

Jodi L. Halpern, M.D., *Health & Medical Sciences, University of CA at Berkeley, 570 University Hall, Berkeley CA 94720-1190*

SUMMARY:

Decisions about allocating psychiatric treatments are shaped by unexamined values regarding diverse patient populations. With the transition to managed care, treatment is allocated according to whether it is considered medically appropriate or medically necessary. Yet decisions about medical appropriateness and necessity are determined by implicit value judgments regarding whether psychiatric services should meet broader psychosocial goals or narrower biomedical goals. These judgments are being made inconsistently for different patient populations, leading to unfairness in decisions about medical appropriateness. For example, two recent sets of AHCPR practice guidelines determined much broader indications for psychotherapy for cancer pain and much narrower indications for patients with depression. This lecture will use examples of both societal and bedside clinical decisions to show how social values determine the allocation of psychiatric services among diverse populations. It will also offer a paradigm for making more explicit and fair treatment decisions given the inevitable conflicts in values that arise in a pluralistic society at a time of restricted mental health resources.

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2. Adebimpe VR: Overview: white norms and psychiatric diagnosis of black patients. American Journal of Psychiatry 1981;138(3):279–285
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4. Turner R, Lukhof D, Barnhouse R, Lu F: Religious or spiritual problem: a culturally sensitive diagnostic category in the DSM-IV. J Nerv Ment Dis 1995;183:435–444
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SYMPOSIUM 3—SUBSTANCE ABUSE: DEVELOPMENTS FOR THE PRACTITIONER
The American Academy of Addiction Psychiatry

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, participants should be able to improve their skills in managing substance abusers: the dually diagnosed, the nicotine dependent, and both acute and chronic opiate abusers; and to apply these skills to other substance use disorders, as well.

No. 3A
MANAGING THE DUALLY DIAGNOSED PATIENT

Kathleen T. Brady, M.D., *Department of Psychiatry, Medical University of SC, 171 Ashley Avenue, Charleston SC 29425-0742*

SUMMARY:

Psychiatric disorders commonly co-occur with substance use disorders. Recent epidemiologic surveys indicate that individuals with nearly all psychiatric disorders are at least twice as likely as the general population to have a lifetime substance use disorder. Individuals with bipolar affective disorder and schizophrenia appear to be particularly at risk. Fortunately, much recent investigation has focused on the treatment of individuals with dual diagnosis. Pharmacotherapeutic strategies have been identified for individuals with comorbid alcohol, cocaine, or opiate dependence and depression that show promising improvement in both the depression and substance use symptoms. Psychotherapeutic techniques for the management of comorbid post-traumatic stress disorder, schizophrenia, bipolar disorder, and substance abuse disorders are under investigation. Preliminary findings from investigations of pharmacotherapeutic management of comorbid attention deficit disorder and substance use disorder as well as bipolar disorder and cocaine dependence will be discussed.

No. 3B
NEW TREATMENTS FOR SMOKERS

John R. Hughes, M.D., *Department of Psychiatry, University of Vermont, 38 Fletcher Place, Burlington VT 05401-1419*

SUMMARY:

The major roles for psychiatrists in tobacco control are (1) motivate their patients to try to stop smoking and helping them stop, (2) treating first-line failures of patch/gum with more intensive therapies,

and (3) helping patients adjust to smoke-free units. New methods to motivate psychiatric and nonpsychiatric patients to stop smoking include motivational interviewing and reduced smoking. New medications for smoking cessation include nicotine inhaler and buproprion. Medications likely to be marketed soon include mecamylamine+nicotine patches as an antagonistic/agonist combination and nicotine tablets. New behavioral treatments include cognitive therapy of associated depression and reduced smoking prior to cessation. Reduced smoking as an acceptable goal itself is receiving increased empirical support. Issues such as timing of cessation attempts, changes in psychiatric medication levels upon cessation, and quitting smoking while quitting alcohol will also be discussed.

No. 3C
RAPID OPIOID DETOXIFICATION

Thomas R. Kosten, M.D., *237 Ansonia Road, Woodbridge CT 06525*

SUMMARY:

The treatment of opioid withdrawal has been enhanced by the use of clonidine to relieve symptoms and naltrexone to accelerate the process of detoxification from as long as two weeks to as little as one day. This rapid detoxification may be facilitated by varying doses of benzodiazepines, which may be given at extremely high doses to induce anesthesia. Symptom relief occurs through the cyclic AMP second messenger system linkage to the adrenergic and opioid receptors. Resetting the opioid receptor system using naltrexone to accelerate detoxification can be enhanced using the partial opioid agonist buprenorphine, which reduces the severity of withdrawal without extending its duration. Outpatient and inpatient trials using buprenorphine in combination with naltrexone and clonidine have found that successful detoxification can be completed in as little as one day with buprenorphine stabilized patients, and that stabilization on buprenorphine is as rapid and successful as on methadone for heroin addicts. The alternative use of anesthetic doses of benzodiazepines has been associated with significant medical complications and is substantially more expensive. The overall success for outpatient detoxification using buprenorphine in combination with naltrexone and clonidine is better than using clonidine alone, with 85% of patients being transitioned to naltrexone maintenance. Cost savings are substantial compared with methadone tapering.

No. 3D
OFFICE-BASED SUBSTITUTION TREATMENT IN EUROPE

Professor Michael Krausz, Ph.D., *Department of Psychiatry, University Hospital, Martinistr. 52, Hamburg 20246, Germany*

SUMMARY:

Substitution treatment of heroin addicts is now a well-established treatment for drug addicts in most European countries. The settings of this treatment as well as the substances used, e.g., methadone, polamidon, codeine, buprenophine, etc., vary from country to country. Those European countries in which substitution treatment is more easily available have had many interesting experiences with office-based substitution. For example, methadone or codeine maintenance by general practicioners has many advantages, but also limitations, which will be discussed in this presentation. Special topics of interest will be the indication for different substances and experiences with office-based substitution treatment in different European countries, and limitations and advantages of this type of substitution treatment.

REFERENCES:

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2. Hughes JR, Fiester S, Goldstein MG, Resnick MP, Rock N, Ziedonis D: American Psychiatric Association Practice Guideline for the Treatment of Patients with Nicotine Dependence. Am J Psychiatry 1996;153:S1–31
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4. Rounsaville BJ: Can psychotherapy rescue naltrexone treatment of opioid addiction?, in Integrating Behavioral Therapies with Medications in the Treatment of Drug Dependence (NIDA Research Monograph Series Number 150, NIH Publication No. 95-3899). Edited by Onken LS, Blaine JD, Boren JJ. Rockville, MD, National Institute on Drug Abuse. 1995 pp. 37–52

SYMPOSIUM 4—NEW DEVELOPMENTS IN INTERPERSONAL PSYCHOTHERAPY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant will have been informed about new research developments in and formats of IPT.

No. 4A
INTERPERSONAL PSYCHOTHERAPY FOR PTSD FOLLOWING INTERPERSONAL TRAUMA

Janice L. Krupnick, Ph.D., *Department of Psychiatry, Georgetown University, 3800 Reservior Road, NW, Washington DC 20007;* Bonnie L. Green, Ph.D., Jeanne Miranda, Ph.D.

SUMMARY:

This presentation describes the recent adaptation of IPT to a diagnosis and population in which this treatment previously had not been experimentally applied or tested, that is, IPT for current PTSD in low-income, predominantly minority women. The trauma category of interest in this population is interpersonal trauma, defined as a human-perpetrated bodily violation, such as rape, sexual or physical assault or abuse, and/or battering. This adaptation represents the first empirically tested extension of IPT to an anxiety disorder and only the second time this approach has been used in a group format. We selected low-income women for study because they are at high risk for exposure to interpersonal traumas and, once exposed, are unusually likely to develop PTSD. IPT is conceptualized as the treatment of choice for these patients because their traumas are interpersonal in nature and the PTSD diagnosis itself gives rise to interpersonal problems. We will discuss the initial application of the treatment model to a pilot group of women who were recruited from a public sector gynecology clinic. Preliminary results suggest that group IPT for PTSD is a promising approach for the population we are investigating.

No. 4B
INTERPERSONAL AND SOCIAL RHYTHM THERAPY: A MODIFICATION FOR BIPOLAR DISORDER

Ellen Frank, Ph.D., *Department of Psychiatry, Western Psychiatric Inst/Clin, 3811 O'Hara Street, Pittsburgh PA 15213-2593;* David

J. Kupfer, M.D., Holly A. Swartz, M.D., Steve Carter, Ph.D., Debra N. Frankel, A.C.S.W., Patricia R. Houck, M.S.H.

SUMMARY:

Three decades after the introduction of lithium carbonate for the treatment of bipolar I disorder, there is increasing recognition that many patients require more than lithium therapy in order to achieve and maintain a stable remission of symptoms. While many other research groups have directed their efforts toward new pharmacotherapies for this population, we have been interested in whether an adjunctive psychotherapy can decrease time to remission of an acute episode or protect against recurrence. According to our model of bipolar illness, instability can arise in a variety of ways including through stressful life events, particularly those of an interpersonal nature, and through unstable circadian systems, which may be destabilized when daily routines are disrupted or chronically irregular. Interpersonal psychotherapy (Klerman et al., 1984) in its original format provides an excellent means of addressing current interpersonal stressors and of protecting against future ones. We have modified IPT to include a component addressing stability of daily routines or "social rhythms." We are currently studying the efficacy of this treatment as an adjunct to standard pharmacotherapies in the acute and maintenance treatment of bipolar disorder. We will describe the content of this treatment and report our findings to date in over 150 bipolar I subjects who have been randomly assigned to either IPSRT or an intensive clinical management approach for four to six months of acute and continuation treatment and two years of maintenance treatment.

No. 4C
INTERPERSONAL PSYCHOTHERAPY WITH BPD

Laurie A. Gillies, Ph.D., *Department of Psychiatry, University of Toronto, 250 College Street, Rm G1014, Toronto ON M5R 3B7, Canada;* Jacqui B. Brunshaw, M.C., Adrienne T. Chin, B.A.

SUMMARY:

Interpersonal psychotherapy treatment (IPT) efficacy was assessed in 13 females (with one dropout) who met criteria for a DSM-III-R diagnosis of BPD on both the Structured Clinical Interview for the DSM-III-R (SCID-II) and the Diagnostic Interview for Borderlines-Revised (DIB-R). The patients had a mean total score on the DIB-R of 8.8, indicating severe pathology. Most of the patients had at least one Axis I diagnosis, most commonly, major depressive episode (mean number Axis I diagnosis = 1.4, SD = .70). Treatment consisted of 12 weekly individual therapy sessions followed by monthly maintenance sessions for four months. There was a significant decline in overall levels of borderline pathology for patients treated with IPT as measured by the DIB-R from pretreatment to post-treatment; total DIB-R scores decreased from a mean of 8.8 to 5.6 ($p < 0.0001$). A minimum score of 8 represents the cut-off score for diagnosis of BPD on the DIB-R. A mean of 5.6 post-treatment represents a meaningful reduction in clinical symptomotology. While not statistically significant, there were changes in the expected direction in general symptomology (as measured by the SCL-90), trends in social and interpersonal functioning (as assessed by the SAS-R and the IIP), and depression (on BDI scores).

No. 4D
INTERPERSONAL PSYCHOTHERAPY FOR DYSTHYMIC DISORDER

John C. Markowitz, M.D., *Department of Psychiatry, Cornell University Med College, 445 East 68th Street, Ste 3N, New York NY 10021;* James H. Kocsis, M.D., Nina L. Miller, Ph.D., Kathleen F. Clougherty, M.S.W.

SUMMARY:

Dysthymic disorder has long been misunderstood, misdiagnosed, and mistreated. Pharmacotherapy has now emerged as a proven treatment for this lingering and debilitating mood disorder. The evidence for psychotherapy is less clear, but encouraging.

This presentation will describe the development of a randomized, controlled, ongoing study, funded by the NIMH and the Nancy Pritzker Foundation, of acute (16-week), crossover, and continuation (six-month) phase treatments of IPT, supportive psychotherapy (SP), sertraline, and sertraline plus IPT. Related studies compare IPT and SP as treatments for double depression and for primary dysthymia with secondary alcohol abuse.

No. 4E
SPECT CHANGES WITH INTERPERSONAL PSYCHOTHERAPY VERSUS VENLAFAXINE FOR DEPRESSION

Stephen D. Martin, M.B., *Research Unit, University of Durham, Cherry Knowle Hosp/Stockton Rd, Sunderland SR2ONB, United Kingdom;* Santock S. Rai, M.B., Elizabeth Martin, B.Sc., Mark Richardson, B.Sc., Anna Barnes, B.Sc., Robert Royal, B.Sc., Julia Davies, B.Sc.

SUMMARY:

Objective: To test that the antidepressant venlafaxine and interpersonal psychotherapy (IPT) both reverse SPECT abnormalities in depression after six weeks parallel group treatment.

Method: A total of 28 new episode males and females aged 30–55 with DSM-IV major depression, HamD>18, and drug naive or antidepressant naive for at least one year were studied. After baseline 99m Tc HMPAO SPECT, Tesla MRI, and psychometric ratings, patients were randomized with some selection to minimize bias against psychotherapy. Thirteen patients had one hour weekly sessions of IPT from a supervised therapist. Fifteen patients took 37.5 mg BD of venlafaxine. SPECT and ratings were repeated at six weeks with SPM 96 analysis of variance.

Results: Both treatment groups improved substantially. The venlafaxine patients showed angular gyrus and dorsolateral prefrontal cortical (DLPFC) normalization ($p < 0.01$), while IPT patients had DLPFC and limbic central cingulate normalization ($p < 0.01$).

Conclusions: Treatment-specific reversal of biological brain abnormalities on SPECT in IPT for depression is a new finding. Frontolimbic pathology is consistent with other studies. Venlafaxine may effect prefrontal stimulation with noradrenaline-enhanced serotoninergic tone, while IPT may mediate cingulofrontal projections by psychotherapeutic enhancement of mood through interpersonal interaction.

REFERENCES:

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3. Klerman GL, Weissman MM, Rounsaville BJ, Chevron ES: Interpersonal Psychotherapy of Depression. New York, Basic Books, 1984
4. Markowitz JC: Psychotherapy of dysthymia. American Journal of Psychiatry 1994;151:1114–1121

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SYMPOSIUM 5—THE ROLE OF PSYCHOTHERAPY IN TODAY'S PSYCHIATRY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to facilitate the use of psychotherapy in psychiatric practice.

No. 5A
PSYCHOTHERAPY: FROM FIFTY YEARS AGO TO NOW

Paul Chodoff, M.D., *George Washington University, 1904 R Street, N.W., Washington DC 20009-1031*

SUMMARY:

When I began practice, post World War II, dynamic psychotherapy was the gold standard treatment for most psychiatric disorders. Included were many of the Axis I anxiety and depressive disorders (then labeled neuroses), a variety of sexual dysfunctions, even to some extent schizophrenia and serious affective disorders, and psychosomatic afflictions. The principal reasons for the leading treatment role of psychotherapy was the high esteem in which psychoanalysts and derivative psychotherapists were held, the absence of other effective treatment modalities, and certain economic factors.

Today the situation is very different. Other forms of treatment, principally medication and behavioral approaches, now compete with or are replacing dynamic psychotherapy for many psychiatric disorders, thus raising the question, "What is the appropriate role for psychotherapy in today's psychiatry?". This will be the subject of the following presentations and discussions.

No. 5B
INTERPERSONAL THERAPEUTICS FOR SCHIZOPHRENIA

William T. Carpenter, Jr., M.D., *Department of Psychiatry, MD Psychiatric Research Ctr, PO Box 21247, Baltimore MD 21228*

SUMMARY:

A spirited development of insight-oriented, exploratory psychotherapy for schizophrenia resulted in an influential view of psychosocial environmental factors as pathogenic. Psychodynamic formulation and mutative interpretation was idealized as therapy. Family theory led to increasing engagement with parents in treatment. An ideologic and political collision course with an emerging family-based advocacy movement and isolation within psychiatry was assured by demands for efficacy evidence and the growing thralldom with biology.

The demise of psychodynamic leadership in schizophrenia therapeutics was followed by a period of atheoretical interpersonal clinical care and the preeminence of pharmacotherapy. Psychiatry vacated the field, leaving a leadership void for two major tasks: defining and testing interpersonal therapeutics, and integrating psychosocial treatment with pharmacologic treatment.

Cognitive and learning theory and concepts relating to stress and coping provide a framework for integrated therapeutics. Controlled clinical trials have documented efficacy for some interpersonal therapies with robust effects on symptom reduction and relapse prevention. As with pharmacotherapy, effects on cognition, volitional, function, and quality of life is modest.

No. 5C
PSYCHOTHERAPIES FOR NONPSYCHOTIC DISORDERS

Arnold M. Cooper, M.D., *Department of Psychiatry, Cornell-NY Hospital, 50 East 78th Street, #1C, New York NY 10021;* Barbara L. Milrod, M.D.

SUMMARY:

A variety of psychotherapies have been shown to be effective in the treatment of anxiety and depressive disorders, either alone or combined with medication. Some of these therapies have been manualized and subject to rigorous clinical trials. In addition to the use of specific psychotherapies for classified Axis 1 nonpsychotic disorders, there are a vast number of patients whose psychological disturbance does not clearly fit into DSM categories. These patients, handicapped in significant areas of life performance, may be the major beneficiaries of more complex psychodynamic psychotherapies. Although these treatments have rarely been subjected to empirical research, they are derived from a theory of mind and are increasingly available to clinical study. These issues will be discussed.

No. 5D
PSYCHOTHERAPY OF PERSONALITY DISORDERS

Glen O. Gabbard, M.D., *Department of Psychiatry, Menninger Clinic, PO Box 829, Topeka KS 66601-0829*

SUMMARY:

To a large extent personality disorders continue to be diagnostic entities where psychotherapy is indicated. There is a growing treatment literature suggesting that psychotherapy is effective in the treatment of many of the Axis II disorders. Some of the research literature suggests that the length of treatment may be a critical ingredient in making significant changes in personality disorders. Nevertheless, despite the empirical data available, many insurance companies and managed care companies continue to argue that Axis II conditions should not be covered by third parties because there is no evidence that improvement occurs with psychotherapy. At the same time that advances are being made in the psychotherapy of personality disorders, there is also a growing literature suggesting that medications may be helpful for certain aspects of personality that are best designated as "temperament." Hence, in many cases, we now see a combination of psychotherapy and medication as the optimal treatment for certain Axis II conditions.

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3. Busch F, Cooper AM, Milrod B, Shapiro T: Manual of Panic Focused Psychodynamic Psychotherapy. Washington, D.C., American Psychiatric Press, Inc, 1997
4. Gabbard GO: Psychotherapy of personality disorders. Journal of Practical Psychiatry and Behavioral Health 1997;3:327–333

SYMPOSIUM 6—LIFE CYCLE: THE PSYCHOANALYTIC PERSPECTIVES
The American Psychoanalytic Association and the American Academy of Psychoanalysis

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize the normal as well as pathological intrapsychic configurations throughout the life cycle.

No. 6A
JUVENILE PRECURSORS OF CHARACTER DISORDERS

Clarice J. Kestenbaum, M.D., *Department of Psychiatry, NYSPI, 15 West 81st Street #14B, New York NY 10024-6022*

SUMMARY:

The DSM-IV describes personality disorders that are well established by young adulthood. There are symptom patterns, discernible in childhood and adolescence, however, that clearly distinguish the various personality disorders from one another. The three Cluster A disorders within the schizophrenia spectrum share cognitive dysfunction quite different from Cluster B disorders that are characterized by excessive emotionality, impulsivity, and interpersonal instability. Anxiety is the chief characteristic of the Cluster C group.

The biological basis for the 10 AXIS II disorders and their relationship to AXIS I disorders are discussed in terms of environmental stressors. Case vignettes of children and adolescents at risk for future psychopathology are presented.

No. 6B
YOUNG ADULTS WITH PERSONALITY DISORDERS

Eric R. Marcus, M.D., *4 E 89th St, New York NY 10128-0636*

SUMMARY:

Personality develops throughout the life cycle. In young adults, with personality disorders, normative psychosocial challenges can stress personality defenses, causing lower functioning, increased anxiety and, in those predisposed, depressions. Specific life challenges in the growing adult and their psychodynamic interaction as stressors in the various typical personality disorders will be described. The interaction with depression will be discussed. Psychodynamically based treatments, alone and in combination with medication, will be described with specific techniques and goals for different personality disorders in this age group.

No. 6C
WOMEN'S INTERNAL AND EXTERNAL CONFLICTS ABOUT CAREERS

Jean B. Miller, M.D., *Department of Psychiatry, Boston University, 105 Salisbury Road, Brookline MA 02146*

SUMMARY:

Over the past 25 years there have been a series of explanations about women's experience in the workplace, along with accompanying psychological implications. The most recent explanation is based on relational psychodynamic theory. It suggests that many women approach work with an underlying belief system based on values and work methods different from those prevailing in most institutions. These beliefs have been elucidated in recent studies. However, when they clash with traditional workplace values, women experience psychological consequences, which can reverberate with other internal psychological issues.

No. 6D
ON FALLING IN LOVE: A PSYCHOANALYTIC AND PHENOMENOLOGIC STUDY

Richard D. Chessick, M.D., *Department of Psychiatry, Northwestern University, 9400 Drake Avenue, Evanston IL 60203-1106*

SUMMARY:

After a brief review of Freud's varying comments on the phenomenon of "falling in love," I will study and describe this state both from a psychoanalytic and a phenomenologic viewpoint. Emphasis will be on the complexity of the phenomena as well as the creative aspects of it. Focus will be on an effort to understand what the lovers seek, such as the repair of a disturbance of narcissistic equilibrium, fusion with incestuous objects, and the solution of what the philosopher and psychiatrist Karl Jaspers called "boundary situations."

The personal illusions and the drive derivatives as well as the unconscious and narcissistic sources found in passionate love will be explored from a clinical point of view. The relationship between passionate love and death that is so common in the literature on the subject, will be outlined and, above all, the creative aspects of "falling in love" will be discussed. This approach to love views it as an ego function, an act of the creative imagination, in contrast with Freud's more id-related explanation involving a re-finding of incestuous objects. The specific conditions that need to be met for what appears to be phenomenologically a "mysterious leap" and the particular creative aspects involved in the often sudden onset of passionate love will be explored. The source of the data for this study are both from the author's forty years of psychoanalytic clinical experience and additional professional background in philosophy and the humanities.

No. 6E
CHARACTER PATHOLOGY AND MID-LIFE CRISIS

Steven T. Levy, M.D., *Emory Univ Psychoanalytic Inst, 1701 Upper Gate Drive NE, Atlanta GA 30332*

SUMMARY:

Mid-life changes often significantly disrupt neurotic compromise formations that are part of stable character structure. The loss of beauty or special physical density may undermine narcissistic equilibrium, physical infirmity may render impossible masochistically based activities requiring endurance, and self-sacrifice enforcing professional obsolescence may disturb power relations including domination and control of others, leading to personality breakdown and the emergence of seemingly new psychopathology. Case examples will be presented to illustrate how much psychopathology of mid life, including psychotic disorganization, can be related to life cycle changes that upset long standing and relatively adaptive characterological solutions to internal conflict. More optimal responses to such life changes will also be described.

No. 6F
THE RESONANT RELEVANCY OF INFANCY TO OLD AGE

Stanley H. Cath, M.D., *36 Brunswick Road, Arlington MA 02174-8008*

SUMMARY:

A basic tenet of human experience is that from infancy on, all animals and humans solve the terror of helplessness/abandonment by turning to their earliest attachment figures. Should they not be found comforting or available, some reasonable approximation of them in reality or fantasy may be sought and found. I submit, life long, we "choose-seek" to be comforted, accompanied or guided by those of the same and/or opposite gender whose qualities, characteristics, behaviors, smells, outlines, or voices bring echoes, even in the obverse, (perverse?), of those earliest attachments. To the best of my knowledge, the resonant relevance of these observations of the infants' unique sensitivities to these original states-conditions linked to the characteristics of the earliest attachments only recently carefully delineated by such researchers as Bowlby, Ainsworth, Sander', and Main) has never been appreciated as equally applicable to the unique sensitivities in the final or senescent phases of life. First, I will try to illustrate how and why these long-term correlations should be considered primary guideposts or core determinants in our specific recommendations for short-or long-term psychotherapy. Then I will report on some transference-countertransference reenactments in which my elder patients described their sense of coherence or well being in relationship to my role as an accompanying therapist in this most trying time of life.

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3. Fletcher J: Rotational Practice: Gender, Power and the "New" Organization. Cambridge, MA, MIT Press, 1999, forthcoming
4. Chessick R: Emotional Illness and Creativity. Madison, CT, International Universities Press, Psychosocial Press Division, 1999

SYMPOSIUM 7—PRACTICING AND MEASURING QUALITY CARE FOR SCHIZOPHRENIA

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to integrate assessment tools, clinical data, and external measures of quality for the treatment of schizophrenia in routine psychiatric settings. Participants will be able to apply principles of and data regarding evidence-based medicine to the treatment of patients with schizophrenia.

No. 7A
THE USE OF MEASURES IN CLINICAL CARE

Diana O. Perkins, M.D., *Department of Psychiatry, Univ of NC School of Medicine, CB 7160, Neurosciences Hosp., Chapel Hill NC 27599*

SUMMARY:

The Handbook of Psychiatric Measures, developed by the APA, is an evidence-based guide to educate clinicians in evaluating, interpreting, and using measures. Envisioned as a "toolbox" with instructions for psychiatric measures, it covers various domains of assessment including symptoms, functioning, and outcomes. The handbook provides clinicians in mental health settings with a guide to available measures that are useful in the clinical care of patients or for the interpretation of treatment and services research.

The project responds to challenges and opportunities presented by health care reform, managed care, and patient needs. Public and private entities are developing methods for measuring and reviewing psychiatric care that may not reflect good research or the perspective of clinicians. Mental health providers and patients are held to "criteria" for the determination of access to services or for inclusion in care networks. Many clinical and policy issues are affected by the selection and application of measures: eligibility determination, outcomes assessment, risk adjustment, quality assurance, utilization review, and practice guideline-related activities.

How to choose, use, and interpret measures for clinical use with schizophrenia is the presentation's focus. Topics include goals of assessment, implementation issues, interpreting psychometric data, and the selection of measures for specific uses.

No. 7B
WHAT'S REALLY GOING ON IN THE TREATMENT OF SCHIZOPHRENIA?

Phillip S. Wang, M.D., *Brigham & Women's Hospital, 221 Longwood Avenue Suite 341, Boston MA 02115;* Joyce C. West, M.P.P., Deborah A. Zarin, M.D., Harold Alan Pincus, M.D.

SUMMARY:

Practice-based data collected through APA's Practice Research Network (PRN) regarding the clinical characteristics and treatment patterns for patients with schizophrenia spectrum disorders will be presented.

Methods: Through the 1997 Study of Psychiatric Patients and Treatments, the PRN gathered information on the sociodemographic, clinical, treatment, setting, and system characteristics of 1,245 psychiatric patients. Patterns of care, including use of antipsychotic and other medications, were identified.

Results: Sixteen percent (n = 186) of patients had a diagnosis of schizophrenia or other psychotic disorder. A total of 58.9% of these patients were male. Ninety-five percent of the patients with schizophrenia were on at least one APM at the time of the survey, 15% were on two, and 2% were on three or more. Seven percent of patients were on clozapine, 24% were on risperidone, and 23% were on olanzapine, reflecting an extremely rapid rise in the use of these newer agents. In addition, almost half of patients had ever been on risperidone and nearly all had ever been on a conventional APM. The independent effects of several patient, psychiatrists, treatment setting, and health system factors on the probability of using newer APM agents were identified in multivariate models.

Conclusion: These nationally generalizable data provide a current characterization of psychiatric practice patterns for the treatment of schizophrenia.

No. 7C
SCHIZOPHRENIA AND PRACTICE GUIDELINES

John S. McIntyre, M.D., *919 Westfall Road, Suite 210, Rochester NY 14618*

SUMMARY:

The American Psychiatric Association's practice guideline project is committed to the promotion of evidence-based psychiatry to improve patient care. APA practice guidelines are designed to result in documents that are both scientifically sound and clinically useful to psychiatrists by adhering to a development process that ensures clinical consensus, using standards from the Institute of Medicine and the American Medical Association. Well constructed guidelines offer a critical review and synthesis of a rapidly expanding treatment

literature; a framework for clinical decision making and within it, recommendations for treating a "typical" patient with a given diagnosis; and consideration, in light of research data, of the implications of specific clinical features for treatment recommendations.

The foundation for treatment of each disorder is psychiatric management, which is combined with specific treatments (pharmacologic and psychosocial) in order to establish and maintain a therapeutic alliance, educate the patient and family regarding the disorder and its treatments, monitor clinical status, enhance adherence to a treatment plan, and prevent relapse.

The Practice Guideline for the Treatment of Patients with Schizophrenia reviews and evaluates the efficacy of pharmacologic treatments, psychosocial treatments, and electroconvulsive therapy for patients with schizophrenia. The formulation and implementation of an individual treatment plan is discussed within the context of the specific phases of illness.

No. 7D
DOES TREATMENT FOR SCHIZOPHRENIA CONFORM WITH PRACTICE GUIDELINES?

Joyce C. West, M.P.P., *Quality Improvement, American Psychiatric Assoc., 1400 K Street, N.W., Washington DC 20005;* Deborah A. Zarin, M.D., Phillip S. Wang, M.D.

SUMMARY:

Evidence-based practice guidelines are increasingly being utilized in the public and private sectors to improve the quality of care provided to patients as well as to monitor quality of care through clinical practice profiling and "report card" indicators assessing conformance with guidelines. Data will be presented assessing the extent to which treatment for schizophrenia spectrum disorders provided by a nationally representative sample of psychiatrists conforms with established evidence-based practice guidelines developed by the APA. Data on patient, health plan, and psychiatrist factors associated with conformance with the guidelines will also be presented.

Methods: Nationally representative data from 154 patients with schizophrenia spectrum disorders collected through the 1997 APA Study of Psychiatric Patients and Treatments was analyzed to assess conformance with practice guidelines. Logistic regression analyses identified patient, health plan, and clinician factors associated with conformance.

Results: Rates of conformance varied with the recommendations. Use of appropriate psychopharmacologic treatment was greater than 95% for all patients and 100% for patients with comorbid major depressive disorder. Use of psychosocial treatments, case management, and vocational rehabilitation varied with patient and health plan factors.

Conclusions: Clinical and policy implications, including the utility and limitations of using evidence-based practice guideline conformance measures to assess quality of care, will be discussed. Implications for quality improvement of the patient, health plan, and clinician factors associated with nonconformance will also be discussed.

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SYMPOSIUM 8—DR. KARL KAHLBAUM'S CENTENNIAL SYMPOSIUM ON CATATONIA

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant will receive copies of catatonia rating scales, will be able to recognize motor signs of catatonia, and be aware of the use of lorazepam to treat catatonia.

No. 8A
LIFE AND WORK OF DR. KARL LUDWIG KAHLBAUM

Peter Braunig, M.D., *Department of Psychiatry, Univ Liepzig Lehrkrankenhaus, Dresdner Str 78, Chemnitz, Germany;* Stephanie Kruger, M.D.

SUMMARY:

Objective: Assess history and impact of Kahlbaum.

Method: Review of archives, monographs, original photographs from Kahlbaum's clinic and other historical materials.

Results: Karl Ludwig Kahlbaum was born in 1928 in Dierschau, Eastern Germany. He studied medicine, mathematics, and basic sciences. After his university years he worked in a large psychiatric clinic in Eastern Prussia and briefly taught psychiatry at the University of Königsberg. He bought his own hospital in Görlitz (Silesia) in 1867, because he did not achieve the academic career he had hoped for. In the following 20 years, Kahlbaum developed the hospital into an exemplary psychiatric clinic famous beyond German borders. He integrated arts, musical, and vocational therapy into psychiatric treatment. Kahlbaum was an industrious worker. He was married twice, and one of his sons managed his hospital until 1943.

Conclusions: Kahlbaum's influence on 19th century psychiatry was small. His ideas inspired Kraepelin and he thus paved the way for modern diagnostic conceptualizations, which remain valid even today. He was the first to distinguish between psychoses with and without organic etiology. He coined the terms "paraphrenia," "dysthymia," "cyclothymia," and "hebephrenia." In 1874, he wrote his most famous work, the monograph Catatonia, or tension insanity.

No. 8B
DR. KARL KAHLBAUM'S CATATONIA REVISITED

Brendan T. Carroll, M.D., *Department of Psychiatry, VA Medical Center, 17273 State Route 104, #116A, Chillicothe OH 45601*

SUMMARY:

Objective: Assess diagnostic status of catatonia.

Method: Literature review and synthesis from Kahlbaum to contemporary writers.

Results: DSM-IV separates catatonia according to presumed etiology: bipolar, major depression, schizophrenia, and arising from a general medical condition. The presence of catatonia has always held diagnostic and prognostic value, even if it were ignored. Kahlbaum's description of catatonia includes careful documentation of phenomenology and the course of the illness. Lacking effective treatments in his time, Kahlbaum documented the natural history of the illness. That catatonia appears as a modifier of other psychiatric illnesses after 100 years is due to the following: (1) untreated catatonia has a similar short-term course and outcome regardless of etiology; (2) ascertainment bias differentiates acute from chronic catatonias; (3) cohort effects are due to etiologic, infectious, and other changes in populations of catatonic patients; and (4) treatment effects reduce the incidence of catatonia and the frequency of episodes.

Conclusions: The natural history of catatonia is episodic, may have few other psychotic signs, may have periods of remission and may, in some cases, be associated with the disorganized subtype of schizophrenia. The literature of the past 100 years that support these statements will be presented in this symposium.

No. 8C
SPECT, fMRI AND MAGNETOENCEPHALOGRAPHICS IN CATATONIA: PATHOPHYSIOLOGY AND MECHANISMS

Georg Northoff, M.D., *Department of Psychiatry, O. Guericke Univ Magdeburg, Leipziger Str 44, Magdeburg 39120, Germany*

SUMMARY:

Objective: Catatonia is a psychomotor disturbance that can be characterized by behavioral, affective, and motor abnormalities responding quite well to the GABA-A potentiator lorazepam. However, pathophysiological mechanisms of psychomotor and gaba-ergic disturbances in catatonia remain unclear.

Methods: First, studies of r-CBF in catatonia are reviewed and our study correlating r-CBF with neuropsychological investigation is presented. Then emotional activation studies in fMRI/MEG in catatonia with and without lorazepam are discussed. Finally, a hypothesis of gaba-ergic cortical dysfunction is elaborated.

Results: Studies of r-CBF showed right fronto-parietal dysfunction in catatonia correlating quite well with neuropsychological deficits in visuo-spatial and attentional functions. fMRI/MEG studies revealed orbitofrontal cortical dysfunction with abnormal modulation by lorazepam during negative emotional processing in catatonia. Cortical motor function revealed no abnormalities in fMRI or MEG.

Conclusions: Catatonia may be considered as a psychomotor rather than a primary motor disorder. Functional connections and gaba-ergic modulation of right orbitofrontal-parietal pathways may be central in pathogenesis of psychomotor disturbances in catatonia.

No. 8D
CATATONIC SUBTYPES AND RELATION TO OTHER MOTOR SYNDROMES

Andrew J. Francis, Jr., M.D., *Department of Psychiatry, SUNY Stony Brook, Health Sciences Center T-10, Stony Brook NY 11794*

SUMMARY:

Objective: Define catatonic subtypes using operational criteria.

Method: We used the 23-item Bush-Francis catatonia 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. Several recent cases of prolonged catatonia with medical complications were identified. We defined novel operational criteria for excited vs. retarded catatonia. The data were compared with Kahlbaum's cases and more recent reports.

Results: We found support for the syndrome 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 and treatment opportunities. Acute and chronic catatonia as well catatonia in NMS were similar in motor features, and overlap with parkinsonism and dyskinesia in chronic cases was minimal.

Conclusions: Catatonia can be reliably diagnosed and subtyped. Subtypes may have different pathophysiology and treatment response.

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SYMPOSIUM 9—COLLECTIVE APPROACHES TO THE CONTROL OF AFFECTIVE DISORDERS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the end of the symposium participants will have knowledge of the different public health approaches for controlling affective disorders in the general population and the results of international research experiences.

No. 9A
TREATMENT OF AFFECTIVE DISORDERS: CONTRIBUTIONS FROM SERVICES RESEARCH

Kathryn M. Magruder, Ph.D., *SVS Research BR, NIMH Division EP & SVS, 5600 Fisher Lane, Rm. 10C-06, Rockville MD 20857*

SUMMARY:

Mental health services research is increasingly recognized as an important tool in the translation of research findings to the benefit of public mental health. Nowhere is this more salient than in the treatment of affective disorders where there are numerous well researched approaches and new treatments becoming available at a rapid pace. This presentation will describe four domains of treatment research, with examples of findings as well as needed studies related to affective disorders. The four domains are: (1) efficacy research, where the aims are to determine whether a particular treatment or intervention has a specific measureable effect and to answer questions concerning the safety and dosing of the intervention; (2) effectiveness research, where the aim is to expand the generalizability of a promising intervention by studying its measurable effects where it is delivered in actual practice settings, with typical patients, as administered by typical providers; (3) practice research, where the aim is to study how and which treatments or services are provided to individuals within service systems, including variations in care and factors that

impinge upon the delivery of the treatment or intervention; and (4) service systems research, which addresses larger organizational, financing, and policy questions.

No. 9B
SUICIDE IN THE COUNTRIES OF CENTRAL AND EASTERN EUROPE

Norman Sartorius, M.D., *Department of Psychiatry, University of Geneva, 16-18 Blvd de St. Georges, Geneva CH1205, Switzerland*

SUMMARY:

The major political changes that occurred in Eastern Europe at the end of the 1990s have affected all aspects of the life of the populations living in the area. It was, therefore, of interest to explore whether a major societal upheaval of that type influences rates of suicide in the countries concerned.

Official statistical returns were used in comparison with rates in the period immediately preceding and immediately following the political changes. The same comparison years were taken for a number of countries in Western and Northern Europe.

An increase of suicide rates in Eastern European countries (in comparison with previous years) was noticed. The increase was not evenly distributed across age groups. There were also differences in the rates for males and females. In the same period suicide rates in other parts of Europe showed a trend of decrease for most age groups.

No. 9C
AFFECTIVE DISORDERS AND PRIMARY CARE IN ENGLAND

Rachel Jenkins, M.D., *Institute of Psychiatry, WHO Collaborating Center, De Crespigny Park/Denmark Hill, London SE5 8AF, England*

SUMMARY:

The implications of affective disorders in primary care stem from their burden, their cost to society, the actual and potential availability of specialist care, and the unique positioning of the primary care team.

This presentation will describe England's response over the last few decades to this issue—its health service research program, its human resources development and training strategy, the development of good practice guidelines, and the encouragement and facilitation of training for GPs, primary care nurses, and others. It will also describe primary care developments for affective disorders in occupational health settings, prisons, and schools.

No. 9D
INITIATIVE ON AFFECTIVE DISORDERS AT PAN AMERICAN HEALTH ORGANIZATION AND THE WORLD HEALTH ORGANIZATION

Ivan D. Montoya, M.D., *WHO/PAHO, 525 23rd Street, NW, Washington DC 20037;* Itzhak Levav, M.D.

SUMMARY:

It has been estimated that general practitioners fail to diagnose 45% to 90% of psychiatric disorders and that a large proportion of diagnosed patients do not receive adequate treatment. This may be due to factors associated with the health system, the patient, or the GPs' clinical practices. The aim of continuing medical education (CME) on depression for GPs is to improve their knowledge, attitudes, and practices for diagnosing and treating patients with depression. Collective initiatives, such as the Defeat Depression Campaign to control the prevalence of depression, have been implemented in some countries. However, there is limited published information about the evaluation of these programs. The purpose of this presentation is to describe the initiative on affective disorders of the Pan American Health Organization/World Health Organization (PAHO/WHO) and the results of the field trials of the World Psychiatric Association CME Program on Depression for GPs. The initiative on affective disorders was adopted by Resolution CD40R19 of the WHO/PAHO Directive Council on September 26, 1997, to promote the participation of member states in developing activities to control the prevalence of depression in the Americas. It involves continuing education programs for health-related professionals such as general practitioners, nurses, the clergy, psychologists, psychiatrists, hair stylists, and bartenders. The first program is being tested in field trials with GPs in Argentina, Brazil, Chile, Colombia, Costa Rica, and Peru. Results from this trial will be presented.

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SYMPOSIUM 10—GENETIC DISSECTION OF THE NERVOUS SYSTEM AND ITS DISORDERS
Collaborative Session with the National Institute of Mental Health

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the significance of genetic factors in the development of severe mental disorders.

No. 10A
GENETIC DISSECTION OF THE NERVOUS SYSTEM AND ITS DISORDERS

Aravinda Chakravarti, *Department of Genetics, Case Western Reserve Univ, 10900 Euclid Avenue, Cleveland OH 44106-4955*

SUMMARY:

Genetic factors contribute to virtually every human disease by conferring susceptibility or resistance, affecting the severity or progression of disease, and interacting with environmental factors that modify disease course and expression. Much of current biomedical research is based upon the expectation that understanding the genetic basis of disease will revolutionize diagnosis, treatment, and prevention. New, state-of-the-art genetic and genomic technologies provide great opportunities to study the genetic basis of the nervous system and the diseases that afflict it, such as schizophrenia, depression, Alzheimer's disease, and autism. These include, but are not limited to, new quantitative methods to identify disease susceptibility genes, DNA microarrays to study gene expression, and techniques for efficient genome-wide mutagenesis that precede high-throughput behavioral phenotyping in the mouse. This workshop will present an overview of new methodologies, tools, and technologies currently being

applied to dissect the genetic basis of the nervous system, complex behaviors, and severe brain disorders in humans and in different experimental systems. Discussion will focus on the utility of translating findings from basic genetic research into new clinical realities (e.g., by identifying targets to guide new drug development).

No. 10B
NEUROGENETIC PATHWAYS IN ALZHEIMER'S DISEASE

Rudolph E. Tanzi, Ph.D., *149 13th Street, Charlestown MA 02129*

SUMMARY:

Half of early-onset Alzheimer's disease (AD) is caused by mutations in the *APP, PSEN1,* and *PSEN2* genes. Inheritance of the *APOE-ϵ4* allele contributes to risk for AD in approximately 60% of late-onset cases. Alterations in these genes result in increased accumulation of the peptide Aβ, the main component of senile plaques. In a search for additional AD genes, we have identified regions of interest on several chromosomes. We have shown that a deletion polymorphism in the α2-macroglobulin (*A2M*) gene on 12p is associated with AD and contributes to risk in up to 30% of cases. α2-M has also been implicated in the clearance/degradation of Aβ. The majority of AD with onset < 50 involves mutations in the presenilins that not only lead to increased Aβ, but also render cells more susceptible to apoptosis. To investigate the biochemical mechanisms underlying the initiation of apoptosis (activation of caspases) by mutant presenilins, we have developed a system to study apoptosis in H4 human neuroglioma cells and assess aberrant caspase activation. Studies of AD genes may lead to the development of therapies aimed at the prevention and/or treatment of AD by inhibiting the accumulation of Aβ and by regulating aberrant caspase activation in brain.

No. 10C
GENETIC DISSECTION OF COMPLEX BEHAVIORS IN THE MOUSE

Maja Bucan, Ph.D., *Department of Psychiatry, Univ. of Pennsylvania, 415 Curie Bldg. CRB, Philadelphia PA 19104*

SUMMARY:

The limited availability of appropriate animal models has hindered research in complex neuropsychiatric illnesses. Pharmacologic and surgical manipulations have been used to induce behaviors that simulate aspects of human disorders in laboratory animal models; however, these models represent phenocopies and do not reflect genetic causes of aberrant behavior in the animal. Our approach involves (1) the identification of behavioral traits that can be modeled in rodents, (2) identification of mouse mutants with anomalies in these simple behavioral traits, (3) the isolation of genes that underlie these traits and the investigation of their relevance to the same or similar traits in humans. A screen for behavioral mutations in mice involves a set of assays: "zero" maze (anxiety), rotarod (neuromuscular function), analysis of the acoustic startle response (sensory motor gating), wheel running activity, and EEG/EMG scoring of sleep patterns (rest/activity and sleep patterns). In addition, deletion complexes are being generated around several genes known to play an important role in behavioral and neurodevelopmental processes (Dpp6, Hdh, Htr5a, Adra2c, Drd5, Gabr - cluster). The ability to create and analyze deletion complexes rapidly, as well as to map novel behavioral mutations within these complexes, will facilitate systematic functional analysis of genes that control behavior in mice, as well as identification of corresponding genes in humans.

No. 10D
MOLECULAR GENETIC STUDIES OF AUTISTIC DISORDER

Edwin H. Cook, Jr., M.D., *Child & Adolescent Psychi, MC 3077, 5841 S Maryland Ave, Chicago IL 60637-1463*

SUMMARY:

Autism is influenced by complex, yet strong genetic factors. The strongest evidence for genetic factors comes from twin studies that show a high concordance for autism in monozygotic twins and relatively small concordance in dizygotic twins. The strong decrease in risk from monozygotic twins to dizygotic twins and siblings suggests two or more genes interact to contribute to autism susceptibility. The recurrence risk to siblings (4.5%) is 45 to 90 times greater than the population risk (0.05% to 0.1%), providing further evidence for a complex and strong genetic contribution. Several chromosomal abnormalities have been identified in autism, including Fragile X syndrome, Down syndrome, and Turner's syndrome. More recently, duplications of the Prader-Willi/Angelman syndrome region of proximal 15q have been reported in patients with autism. Parent of origin of such proximal 15q duplications may contribute to risk for autism. Because of the similarity of the phenotype of 15q11-13 duplications to typical autism, linkage analysis has been conducted in autism and linkage and linkage disequilibrium has been reported to markers on 15q11-13. Several genome-wide screens are underway, with the first full report suggesting a potential susceptibility locus on 7q.

No. 10E
GENETICS IN A POST-GENOMICS ERA: APPLICATIONS TO PHARMACOGENETICS

Geoffrey Duyk, M.D., *Exelixis Pharmaceuticals, 260 Littlefield Avenue, San Francisco CA 94080*

SUMMARY:

The success of the human genome project has enabled the mapping and cloning genes associated with complex human disease. The availability of this information and technology will improve diagnostic specificity, aiding the design in therapeutic trials as well as the analysis of response to therapeutic intervention. Furthermore, the same tools can be used to systematically analyze nondisease-associated genetic factors and the impact on treatment. The implication of these approaches for the study and treatment of psychiatric disease will be discussed.

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SYMPOSIUM 11—CHILDHOOD PRECURSORS OF PERSONALITY DISORDERS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be familiar with data from longitudinal studies that help identify children

at risk to develop personality disorders in adult life. Since the severe personality disorders can be quite disabling, identification of early high-risk behavior patterns may suggest strategies for prevention.

No. 11A
FOLLOW-UP STUDIES OF CHILDHOOD AND ADULT PERSONALITY DISORDERS

Joel F. Paris, M.D., *Department of Psychiatry, SMBD Jewish General Hospital, 4333 Cote Ste-Catherine Road, Montreal, PQ H3T 1E4, Canada*

SUMMARY:

Thirty-three years after its publication, Robins' work on the precursors of antisocial personality provides a standard that research on other Axis II disorders has not yet reached. This knowledge is the basis of diathesis-stress theories that can account for the temperamental and experiential factors leading to antisocial personality.

Determining the early precursors of the other personality disorders is crucial for four reasons: (1) to validate diagnostic categories, (2) to separate the effects of temperament and experience, (3) to determine the developmental pathways to PDs, (4) to plan early intervention strategies for vulnerable children.

Up to now, theories about PDs have depended on data drawn from retrospective studies of adult patients. This type of research suffers from serious problems in recall bias, and an inability to separate temperament from trauma. Such methods can, at best, suggest hypotheses about the childhood experiences that precede disorder.

Although longitudinal research can be expensive, it is essential. We need three types of long-term follow-up strategies: (1) clinical studies of children at risk, to parallel those of Robins, (2) large-scale community studies, (3) studies of twins whose temperament can be assessed in infancy.

The presentation will review examples of current research programs making use of each of these strategies.

No. 11B
CHILDHOOD TEMPERAMENT, ENVIRONMENT AND ADULT PERSONALITY DISORDERS

Patricia Cohen, Ph.D., *NYS Psychiatric Institute, 1051 Riverside Drive, New York NY 10032;* Jeffrey G. Johnson, Ph.D., Stephanie Kasen, Ph.D.

SUMMARY:

Longitudinal data from a random sample of nearly 700 persons studied from early childhood to adulthood are used to test a vulnerability-precipitant model of personality disorder. Previous analyses have shown a relationship between temperament in childhood and persistent adolescent personality disorder (Bernstein, Cohen, et al. 1996). In the current study these analyses are extended to early adulthood and the potential precipitating effects of negative life events and circumstances are examined. Early childhood temperament is shown to predict symptoms of Clusters A and B personality disorders over a 17-year period. Both early childhood poverty and adolescent negative life experiences predicted these symptoms as well. Cluster C did not relate significantly to the early childhood risks. Effects of temperament and environment were independent. The distinctions between life experiences as reflecting maladaptive personality facets, as influencing the onset and course of personality disorder, and as interacting with earlier temperament are illustrated and discussed.

No. 11C
THE COURSE, BIOLOGY AND SOCIAL CORRELATES OF CONDUCT DISORDER

Daniel S. Pine, M.D., *Child Psychiatry, Columbia University, 722 West 168th Street, Unit 78, New York NY 10032*

SUMMARY:

Objective: This presentation uses insights from biological and social research to evaluate the relationship between conduct disorder and antisocial personality disorder.

Method: A series of longitudinal studies conducted by the author's and other's research groups is reviewed. These studies examine the relationships between biological and social risk factors for conduct disorder while considering the moderating effect of biology on course.

Results: Reviewed studies support three conclusions. First, biological measures identify children with conduct problems who are most at risk for antisocial personality disorder. Studies with various biological factors support this conclusion, particularly neuropsychological and autonomic measures. Second, social and biological risk factors tend to co-aggregate, and social factors can affect the relationship between biology and behavior. Studies on the serotonergic system and on autonomic control provide the strongest support for this conclusion. Third, the combination of social and biological variables is a particularly robust predictor of stable conduct problems. Studies on perinatal risk factors most consistently support this conclusion.

Conclusions: There are complicated relationships among biological risk factors, social adversity, and the course of conduct disorder. Biological variables may identify children with conduct disorder who are most at risk for antisocial personality disorder.

No. 11D
PERSONALITY AND PROXIMAL PROCESSES

Stephen J. Donovan, M.D., *NY State Psychiatric Institute, 1051 Riverside Drive, New York NY 10032*

SUMMARY:

The term "proximal processes" is of interest to clinicians and policy makers. It refers to the concrete components of a sufficient cause of an outcome and therefore suggests points of intervention. Here we examine a personality disorder with a clear developmental component from this perspective.

Severe adult antisocial behavior and child/adolescent disruptive disorders are so well correlated that DSM-IV requires early teenage conduct disorder to diagnose antisocial personality disorder (ASPD). Conversely, conduct disordered youth are statistically at risk for a wide variety of bad outcomes (ASPD, career addiction, jail, early death). But what daily ("proximal") interactions could link oppositional childhood tantrums probabilistically to later bullying and still later to antisocial personality traits? The Oregon Youth Study proposes "coercion" as the invariant part of this trajectory (Dishion, French, et al. 1995).

The model postulates socialization is demanding. If parents, teachers, and the school system reduce socialization demands when confronted with oppositional/defiant attitudes (whining, tantrums), they will reinforce coercive behavior. The future antisocial child learns that contingent rage is an especially powerful way to control the immediate environment. Repeated over thousands of interactions, in a widening developmental context (home, school, schoolyard), the child learns coercion is adaptive. Attachment theory is important in explaining why all children do not follow this antisocial trajectory.

While coercion theory highlights reinforcement of tantrums, it also implies pathological aggression facilitates tantrums, a point of pharmacological intervention. It also implies that tracking aggressive

kids into the same classroom reinforces coercive behaviors, suggesting an intervention on the policy level.

No. 11E
BEHAVIORAL INHIBITION IN CHILDREN AT RISK FOR ANXIETY DISORDERS

Dina R. Hirshfeld, Ph.D., *Department of Psychiatry, Mass General Hospital, 15 Parkman Street, WAC 812, Boston MA 02114;* Jerrold F. Rosenbaum, M.D., Joseph Biederman, M.D., Stephen V. Faraone, Ph.D., Jerome Kagan, Ph.D., Nancy Snidman, Ph.D.

SUMMARY:

The temperamental trait "behavioral inhibition to the unfamiliar" (BI) has been proposed as an early precursor to anxiety disorders, has proven to be moderately stable, detectable very early in life, and under some genetic control. To further investigate BI as an early temperamental characteristic of children at risk for panic disorder, we compared 135 children of parents with panic disorder, 43 children of parents with major depression, and 75 children of normal control parents. Children, ages 21 months to six years, matched for age and gender were evaluated blindly at the Harvard Infant Study Laboratory. Rates of BI in children of panic disorder probands were significantly higher than in children of controls. Children of parents with age of onset of panic disorder earlier than age 21 had highest rates of BI. Comparisons among groups using global ratings of BI and summary scores based on factor analysis of standardized behavioral variables confirmed these patterns of association. BI has higher prevalence in children of adults with panic disorder versus controls. Further studies are necessary to determine the specificity of this association and whether children who exhibit BI are at elevated risk for Axis I or Axis II disorders. The possible association between BI and Cluster C personality disorders, in particular avoidant PD, will be discussed.

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SYMPOSIUM 12—SOMATOFORM DISSOCIATION AND TRAUMA

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant will be able to recognize post-traumatic dissociative and somatoform symptoms and understand their interrelationship, thereby improving differential diagnosis and treatment of them.

No. 12A
SOMATOFORM DISSOCIATION IN VETERANS AND EMERGENCY SERVICE WORKERS

Charles R. Marmar, M.D., *Department of Psychiatry, Langley Porter Psych. Inst., 401 Parnassus Ave./Box F-0984, San Francisco CA 94143;* Daniel S. Weiss, Ph.D., Thomas Metzler, Suzanne Best, Alain Brunet, Kumar Vedentham

SUMMARY:

Recent studies suggest that a history of trauma and a tendency toward dissociation may be found in patients with somatoform disorders. More recently studies of combat veterans, sexual assault survivors, and emergency services personnel suggest that individuals who respond to traumatic stressors with dissociative reactions are at risk for chronic somatic symptoms. New data will be presented on 430 police, fire, EMT-paramedic, and emergency road workers who responded to the 1989 I-880 Cypress structure freeway collapse, which resulted from the Loma Prieta Bay Area earthquake. The associations of critical incident exposure; peritraumatic dissociation; general dissociation; somatic symptoms; and intrusive, avoidant, and hyperarousal symptoms of PTSD were determined. It was predicted that higher levels of dissociation at the time of trauma and general dissociative tendencies would be associated with higher levels of somatic symptoms. This prediction is supported by the findings that peritraumatic dissociation as measured by the Peritraumatic Dissociative Experiences Scale is strongly associated with somatization symptoms as measured by the SCL 90-R ($r = .41$; $p < .0001$), and the finding that general dissociative tendencies as measured by the DES are strongly associated with SCL 90-R somatization symptoms ($r = .45$; $p < .0001$). Theoretical implications of these findings for the understanding and treatment of PTSD will be discussed.

No. 12B
DISSOCIATION AND SOMATIZATION COMPARISONS IN SEXUALLY ABUSED AND NONABUSED GIRLS

Frank W. Putnam, Jr., M.D., *BEB, NIMH, 9000 Rockville Pike/10, 3N238, Bethesda MD 20892;* Penny Trickett, Ph.D., Jennie Noll, Ph.D.

SUMMARY:

The prospective, longitudinal study, Psychobiological Effects of Sexual Abuse, examined the relationship of dissociation and somatization in 186 girls, half of whom were sexually abused by a family member and half of whom were non-abused comparison subjects matched on age, race, socio-economic, and parental (one or two parent homes) status. Using the standardized somatic factor from the Child Behavioral Checklist (CBCL), abused girls had significantly more somatic symptoms at Year 1 ($F = 4.8$ (1,141), $p = .03$) and Year 3 ($F = 9.8$ (1,108), $p = .002$) but not at Year 2. A repeated measures ANOVA for Time 1, 2 & 3 evaluations (approximately one year apart) was significant for Group by Time ($F = 5.6$ (2,194), $p = .004$), demonstrating significantly different longitudinal trajectories for somatization over a three-year period. Pain symptoms, particularly headaches, GI, pelvic, respiratory, and limb pain, showed the greatest differences between the two groups. At the Time 1 evaluation, two measures of dissociation, the Child Dissociative Checklist (CDC), a validated, 20-item, parent-report for children, and a dissociation factor derived from the CBCL and used by several research studies, were correlated ($r = .53$, $p = .0001$, $N = 126$) with each other and with the CBCL somatization factor: (CDC: $r = .29$, $p = .001$, $N = 127$); (CBCL Dissociation factor: $r = .25$, $p = .001$, $N = 158$). The CDC ($r = 28$, $p = .001$, $N = 129$), but not the CBCL dissociation factor, was correlated with a somatization factor derived from the Diagnostic Interview for Children and Adolescents (DICA),

a structured DSM-III-R interview. When subjects were divided into high and low dissociators using a CDC cutting score of >= 12, high dissociators had significantly more somatic symptoms ($F = 8.8$, $(1,127)$, $p = .003$). These findings indicate that sexually abused girls have significantly more somatic symptoms than comparison girls, that the two groups follow different developmental trajectories with respect to somatization, and that increased levels of dissociation are significantly related to increased levels of somatization. These finding support the emerging clinical research literature on the relationship of dissociation, somatization, and trauma.

No. 12C
SOMATOFORM DISSOCIATION AND SEXUAL TRAUMA PREDICT PSEUDO-EPILEPTIC SEIZURES BETTER THAN PSYCHOLOGICAL DISSOCIATION

Richard Van Dyck, M.D., *Department of Psychiatry, Valeriuskliniek, Valeriusplein 9, Amsterdam 1075BG, The Netherlands;* Jarl Kuyk, Drs., Philip Spinhoven, Ph.D., Walter V. Emden-Boas, M.D.

SUMMARY:

Dissociative pathology appears to be a central feature in at least some of the patients with pseudo-epileptic seizures (PES). However, dissociative disorders share a number of psychological symptoms, such as amnesia, depersonalization, and fugues with epileptic patients, especially those with temporal lobe epilepsy (TLE). Patients with nontemporal lobe epilepsy (Non TLE; N = 32), with temporal lobe epilepsy (N = 94), and with pseudo-epileptic seizures (N = 65) were compared on general psychopathology (SCL-90), psychological dissociation (DIS-Q), somatoform dissociation (DSQ-20), and reported trauma (TQ). While general psychopathology and psychological dissociation did not differentiate between PES and TLE, both somatoform dissociation and reported sexual abuse did strongly differentiate PES and TLE. These results have implications for the diagnostic procedure and for the understanding of the psychopathology of PES.

No. 12D
LIFE STRESS AND PAIN AMONG METASTATIC BREAST CANCER PATIENTS

David Spiegel, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Room 2325, Stanford CA 94305-5544;* Cheryl Koopman, Ph.D., Lisa Butler, Ph.D., Susan Diamond, C.S.W., Karyn Angell, Ph.D.

SUMMARY:

We explored the hypothesis that one consequence of traumatic and other life stressors would be an exacerbation of somatic symptoms in women with metastatic breast cancer. We studied a sample of 102 women consecutively recruited into a randomized prospective trial of supportive/expressive group therapy. Mean age was 53.1 (SD = 10.8), and mean time from initial breast cancer diagnosis was 46.8 (SD = 34.7) months. Twelve percent were of minority ethnicity. Fifty-four percent were married, 26.5% divorced, 10% never married, 6% widowed, and 3% were separated. Thirty-four percent of the sample scored 20 or above on the IES Intrusion subscale, and 28% scored at or above the same cutoff for the IES Avoidance scale. (Subscale scores at or above 20 indicate a significant stress response syndrome requiring assessment and intervention and that may warrant a PTSD diagnosis.) Avoidance symptoms were associated with smaller emotional support networks. Patients were given the Life Events Scale (M. Horowitz et al., 1977), and they rated their pain on a standard 1–10 linear analog scale (Spiegel & Bloom, 1983). Regression analysis indicated that a prior history of more life stressors was associated with higher pain ratings (beta - .34, $t = 3.3$, $p < .01$). Interactions with measures of social support did not moderate this effect. Interestingly, prior life stress was not associated with total mood disturbance scores on the Profile of Mood States. Thus, life stress seemed to specifically affect somatic rather than psychological symptomatology.

No. 12E
DETECTING SOMATOFORM DISSOCIATION IN TRAUMA SURVIVORS USING THE SCID-D

Marlene Steinberg, M.D., *Department of Psychiatry, University of Mass Medical Ctr, 9 Algonquin Drive, Hadley MA 01035;* Dominic Cicchetti, Ph.D., Bruce J. Rounsaville, M.D.

SUMMARY:

This presentation will describe the range and severity of somatoform dissociative symptoms encountered in the assessment of trauma survivors. Because of their multiform presentation, accurate detection requires familiarity with specialized interviewing techniques and recently developed diagnostic tools. Dr. Steinberg's data are derived from over a decade of research with the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D) (American Psychiatric Press, 1994), a diagnostic instrument that she developed for the assessment of post-traumatic dissociative symptoms and the dissociative disorders. Developed to reduce variability in clinical diagnostic procedures, the SCID-D allows clinicians and researchers to document the presence and severity of five dissociative symptoms (amnesia, depersonalization, derealization, identity confusion, and identity alteration) in patients with a variety of psychiatric disorders. Dr. Steinberg will review (1) the varied manifestations and diagnostically discriminating features of somatoform dissociative symptoms, (2) recent findings on the reliability and validity of the SCID-D in trauma survivors, and (3) the use of SCID-D results for chart documentation, as well as psychological and forensic evaluations. Systematic assessment of somatoform dissociative symptoms allows for early detection of the range of post-traumatic disorders.

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SYMPOSIUM 13—SMOKING CESSATION: A NEW FRONTIER

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant will have knowledge of the potential beneficial effects of nicotine for various psychiatric patients and how these effects complicate cessation efforts at the same time that they improve our understanding of the pathophysiology of both depression and schizophrenia cessation programs specific to psychiatric patients.

No. 13A
SMOKING CESSATION AND THE PSYCHIATRIST

Herbert D. Kleber, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, Unit 66, New York NY 10032*

SUMMARY:

Although smoking is associated with major morbidity and mortality, and most smokers say they would like to stop, only about 2% a year manage to do so on their own. A major reason for this may be the frequent association of smoking and various kinds of psychopathology. If money for smoking cessation treatment becomes available from congressional tobacco legislation, this could markedly improve the situation by involving more professionals in treating these more difficult patients. Currently there is minimal reimbursement for such treatment.

Most psychiatrists, however, lack experience in treating smokers. In spite of substantial evidence that skillful treatment combining behavioral and pharmacologic supports is more successful than either alone, both for smoking cessation and some other addictions, most smokers do not get the benefit of such combined treatment. For patients to benefit from any new legislation, psychiatrists and other health professionals will need to improve their knowledge and skill in treating nicotine dependence.

No. 13B
CONDITIONING, DRUG-SEEKING AND ADDICTION

Barry J. Everitt, Ph.D., *Experimental Psychology, Cambridge University, Downing Street, Cambridge CB23EB, United Kingdom*

SUMMARY:

It is generally agreed that a common effect of stimulants and other drugs, including nicotine, is to increase dopamine levels in the nucleus accumbens. But another important phenomenon for addiction is that formerly neutral stimuli paired with drug rewards can gain motivational significance, induce drug craving in humans, and also control drug-seeking behavior in humans and animals. We have shown that the anterior cingulate cortex, central nucleus of the amygdala (CeN), and nucleus accumbens core (NAC) are critical elements of a neural network underlying such appetitive pavlovian conditioning. However, the effect of conditioned stimuli to control instrumental behavior (i.e., to act as a conditioned reinforcer, CRf) critically depends upon the basolateral amygdala (BLA). Stimulant drugs powerfully potentiate the control over behavior by a CRf and this effect is blocked by lesions of the mesolimbic dopamine system, NAC shell, but not the core, and also by lesions of the CeN, but not the BLA. Using a novel model of cocaine seeking behavior that depends upon the presentation of a drug-associated CS, we have shown that the integrity of the BLA is essential for the acquisition of this behavior. Moreover, drug cues can reinstate cocaine seeking behavior following extinction, an effect that is itself potentiated by self-administered cocaine. These studies have helped to define the neural basis of reinforcement processes and provide a model for evaluating therapeutic strategies aimed at preventing drug-cure mediated craving and drug seeking behavior.

No. 13C
CIGARETTE SMOKING, NICOTINE AND SCHIZOPHRENIA

Gregory W. Dalack, M.D., *Department of Psychiatry, Ann Arbor VAMC, 2215 Fuller Road (116C), Ann Arbor MI 48105;* James H. Meador-Woodruff, M.D.

SUMMARY:

The markedly elevated prevalence of smoking among individuals with schizophrenia has attracted considerable research interest over the past decade. Much of this work has focused on enhancing our understanding of the pathophysiology of schizophrenia based on: (1) the effects of nicotine and smoking on signs and symptoms of schizophrenic illness, and (2) the effects of various pharmacological treatments on symptoms of schizophrenia and smoking behavior in smokers with schizophrenia. In addition, smoking cessation treatments are being studied in the hope of improving the limited cessation rates typically achieved in this population.

In this presentation, I will discuss clinical research evidence suggesting that smoking in schizophrenia may be an attempt to self-medicate signs and symptoms of the illness, and preclinical data supporting a possible role of nicotine in specifically ameliorating negative symptoms. In addition, I will highlight the potential implications of the largely unexplored interactions between the CNS nicotinic receptor family and neurotransmitter systems implicated in schizophrenia.

These findings will be discussed in light of current and potential future alternatives for smoking cessation treatment of smokers with schizophrenia.

No. 13D
SMOKING, SMOKING CESSATION AND MAJOR DEPRESSION

Lirio Covey, Ph.D., *Clinical Psychopharm, NYS Psychiatric Institute, 1051 Riverside Drive, New York NY 10032;* Alexander H. Glassman, M.D., Fay Stetner, M.P.A.

SUMMARY:

Research over the past several years has established an association between cigarette smoking and major depression. This paper reviews findings from multiple clinical and epidemiological studies that have shown the following: (1) persons with a history of depressive disorders are more likely to smoke, to be heavy smokers, and to have difficulty when they try to stop smoking; (2) smokers with history of depression experience withdrawal symptoms more frequently and more severely than do nondepressed persons; and (3) when they do manage to succeed in stopping, smokers with a depression history are at increased risk of experiencing severe dysphoric states, including a new major depression episode. The available data also suggest that the duration of risk for post-cessation depression could last from a few weeks to several months after cessation and that, independently of depression history, persistence of nicotine withdrawal symptoms beyond the normal two- to four-week course, predicts post-cessation depression. These findings indicate that successful nicotine dependence treatment of patients with a vulnerability to depression requires close and extended supervision in order to detect and promptly treat the emergence of post-cessation psychiatric events.

No. 13E
DO TREATMENTS FOR SMOKING CESSATION WORK?

Alexander H. Glassman, M.D., *Clinical Psychopharm, NY State Psychiatric Institute, 722 West 168th Street, New York NY 10032-2603*

SUMMARY:

There is little question that nicotine is addictive and cigarettes can be among the most tenacious of addictions. Nevertheless, there is extensive evidence establishing the efficacy of a variety of treatments. The best documented involves nicotine replacement. In a large number of trials, nicotine replacement by itself essentially doubles the number of smokers who successfully stop, while combining replacement with psychological support triples the odds of succeeding. After approximately six months, about 25% of the treated group have stopped compared with about half in the control group. Unfortunately, this means that although nicotine replacement doubles the success rate, 75% of smokers have returned to cigarettes.

The observation that both smoking initiation and cessation were strongly associated with depression, raised the question of whether antidepressants might aid cessation. A number of compounds have been tested. Interestingly, some antidepressants have been helpful and some have not. Bupropion was originally tested because of its effects on dopamine and has been the most convincingly documented aid to smoking cessation. Nortriptyline is another antidepressant that has been documented to aid in smoking cessation, and it, too, has effects on dopamine, while the SSRIs do not influence dopamine and do not appear useful in smoking cessation. Perhaps most significant is that the combination of buproprion and nicotine replacement seem more efficacious than either treatment alone.

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SYMPOSIUM 14—THE ROLE OF PSYCHIATRISTS IN PALLIATIVE CARE
The Association for Academic Psychiatry

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of the symposium, participants will know about the development of programs with nonpsychiatrists, have knowledge about the psychopharmacology of treatment for pain, understand some of the complex psychodynamics of the request for assisted suicide, and know how they can collaborate with colleagues in evaluating and treating patients.

No. 14A
PALLIATIVE CARE AND MEDICAL EDUCATION

Susan D. Block, M.D., *Ambulatory Care, Harvard Medical School, 126 Brookline Avenue, Ste 203, Boston MA 02115*

SUMMARY:

A national consensus is emerging that the general medical education of physicians for providing appropriate care to patients at the end of life and to their families is deficient. Palliative care experts express particular concern that the psychosocial needs and concerns of patients and their families are inadequately addressed in contemporary practice and medical education. There are major opportunities for psychiatrists to collaborate with colleagues in other fields to educate students, residents, and other faculty about end-of-life care, yet psychiatrists, in general, have not been involved in these efforts. In this presentation, I will review current efforts to improve medical education for care near the end of life, present data about the status of both the formal and informal medical school curricula, and describe student and resident preparation for caring for patients at the end of life. General principles underlying successful education about end-of-life issues will be reviewed and two model programs, one for medical students and one for primary care residents, will be described.

No. 14B
PSYCHOPHARMACOLOGY OF PALLIATIVE CARE: WHAT PSYCHIATRISTS MUST KNOW

William Breitbart, M.D., *Department of Psychiatry, Memorial Hospital, 1275 York Avenue/Box 421, New York NY 10021-6007*

SUMMARY:

Psychiatrists can play an important role in the management of symptoms at the end of life. Common physical and psychological symptoms that occur with advanced cancer or AIDS include pain, fatigue, mood changes, and anorexia/cachexia. Delirium is also a complication of late stage disease, occurring in up to 85% of terminally ill cancer patients.

Psychopharmacological interventions are very effective in the management of these highly prevalent symptoms. This paper will review the prevalence, assessment, and management of these symptoms, which are the basic knowledge of palliative care. Special emphasis will be placed on the role of psychiatry and psychiatric contributions to symptom control in pain, fatigue, mood symptoms, anorexia/cachexia, and delirium. Current concepts of palliative care are expanding beyond a focus on physical symptom control to include psychosocial and spiritual issues. As psychiatrists are increasingly encouraged to join multidisciplinary palliative care and hospice teams, they need to be knowledgeable about the psychopharmacology in order to make a contribution to the physical and psychosocial care of the terminally ill patient.

No. 14C
VIEWS OF OREGON PATIENTS AND THEIR CAREGIVERS ON ASSISTED SUICIDE

Linda K. Ganzini, M.D., *Department of Mental Hlth, Portland VAMC, 3710 SW US Veterans Hosp Road, Portland OR 97201;* Wendy S. Johnston, M.D.

SUMMARY:

Goals: Despite legalization of physician-assisted suicide (PAS), little is known about the attitudes of severely ill patients and their caregivers in Oregon toward PAS. A completed survey of amyotrophic lateral sclerosis (ALS) patients and an ongoing survey of cancer patients will be presented.

Method: In both studies subjects' social support, perception of burden to others, depression, hopelessness, religiousness, level of disability, pain, quality of life, suffering, and interest in PAS were measured. The caregiver's attitude toward PAS for the patient and the caregiver's social support, depression, religiousness, burden, and economic hardship were measured. Caregivers rated the patients' quality of life, pain, and suffering.

Results: In the study of ALS patients, 100 subjects and 91 caregivers participated. Fifty-six percent of subjects wanted the option of PAS and, if legalized, 44% intended to request a lethal prescription. Only one subject wanted assistance in dying within the following month; 82% wanted to keep the prescription available for future use. Interest in PAS was associated with male sex, more education, greater hopelessness, and less religiousness. In 73% of dyads the caregiver and patient agreed in attitudes toward PAS for the ill subject.

Conclusions: Many persons with ALS would consider PAS. Patients with cancer will be compared with ALS patients.

No. 14D
UNDERSTANDING AND TEACHING THE PSYCHODYNAMICS OF PHYSICIAN-ASSISTED SUICIDE

Philip R. Muskin, M.D., *Department of Psychiatry, Columbia University, 622 West 168th Street/MB 427, New York, NY 10032*

SUMMARY:

There is no accurate estimate of how many patients are currently requesting euthanasia or physician-assisted suicide in the United States. Nor do we realistically know how many patients will make such requests as states pass laws that decriminalize the actions of physicians in aiding patients. As more states pass laws that permit physicians to aid in a patient's death, psychiatrists should have the responsibility to help evaluate these requests. To date, much of the focus has been on a patient's capacity for informed consent, or on whether the patient meets criteria for depression. While these are important considerations that must always be evaluated, exploring the psychodynamic meaning of the patient's request has not been a routine component of the thinking in this arena. This presentation will outline the following key dynamics that are potentially contained within such a request and the physician's response: (1) rage and wishes for revenge, (2) splits in the experience of the self, (3) projective identification, (4) patients who experience themselves as already dead. Psychiatrists should have the training to teach their colleagues that an appropriate response to a patient's request to die is not a simple yes or no, but must include the focus on the possible meanings contained within the request. A patient's request to die is a situation that requires the physician to engage in a dialogue to understand what the request means, including, but not limited to, whether the request arises out of a clinically significant depression or inadequately treated pain. Techniques for teaching nonpsychiatrists how to conduct this type of exploration must include the reality and limitations of their training and practical limitations of their time. The presentation will outline the role psychiatrists play as teachers and clinicians in collaborating with their colleagues in the evolving process of physician-assisted suicide.

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SYMPOSIUM 15—UNDERSTANDING AND DEALING WITH SCHOOL VIOLENCE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should become aware of: (1) extent of U.S. school violence compared with other nations, (2) potentials for violence in a particular school, (3) signs and symptoms for a violent act in vulnerable youth, (4) role of psychiatrists and other mental health professionals in assessing and preventing school violence, and (5) effective school violence prevention programs.

No. 15A
MAKING SENSE OF SCHOOL VIOLENCE: WHY DO KIDS KILL?

James Garbarino, Ph.D., *Human Development, Cornell University, N213 MVR, Ithaca NY 14853*

SUMMARY:

Why do kids kill? The outbreak of lethal violence in American schools located in small towns, suburbs, and rural areas in the late 1990s follows upon a similar trend that affected inner city, urban areas in the 1980s and early 1990s. What are the developmental origins of this "epidemic" of violence? This presentation offers an analysis of this phenomenon based upon in-depth interviews with boys incarcerated for murder and other severe acts of violence.

This analysis focuses on two influences that affect the pathways from early childhood to adolescence. The first is the role of disrupted relationships and psychological, physical, and sexual maltreatment in the origins of childhood conduct disorder. The second is the role of "social toxicity" in the environment of children and youth, and to which conduct-disordered children are particularly vulnerable. Elements of social toxicity include the "drug and gun culture," the flooding of youth with violent imagery, the collective shame associated with racism and social class issues, the instability of relationships related to mobility and institutional policies, the decline of basic social trust and the rise of civic cynicism, and the spiritual crisis affecting children and youth in a shallow materialistic culture.

No. 15B
PADUCAH REVISITED: VIEWS OF THE DEFENSE PSYCHIATRIST

Diane H. Schetky, M.D., *PO Box 220, Rockport ME 04856*

SUMMARY:

Dr. Schetky will discuss her experiences consulting for the defense in the school murders that occurred in W. Paducah, Ky. The presentation will focus on striving to do an objective assessment in a high profile case, dealing with the media, and the problems of working

in another state with players with whom one is not familiar. Developmental considerations that need to be weighed in evaluating adolescents charged with homicide will be discussed. Lessons learned from this case will be shared with the audience.

No. 15C
KIDS WHO KILL

Elissa P. Benedek, M.D., *2311 East Stadium, Suite 111, Ann Arbor MI 48104*

SUMMARY:

Although the murder rate in society in general has gone down, the murder rate among adolescents who kill has risen. Society has become increasingly concerned with children who kill other children. In the wake of last year's school violence, forensic child psychiatrists have been called in to evaluate some of these juvenile murderers for competency to stand trial, criminal responsibility, and diminished capacity. This examination is highly specialized and requires a special knowledge base, training, and skills. The conduct of the evaluation and its aftermath will be discussed, as well as the risks/benefits to the psychiatrist conducting the evaluation.

No. 15D
COPING WITH VIOLENCE: THE SCHOOL COMMUNITY

Becky H. Rowan, M.Ed., *Pearl High School, Pearl MS 39208*

SUMMARY:

On October 1, 1997, a 16-year-old student at Pearl High School opened fire in the commons area, killing two students and wounding seven others. Authorities later charged six other students with conspiracy. Administration, faculty, students, and community experienced the emotional aftermath of this violent act. Crisis situations can occur at any time at any school. The recent tragic events at Pearl High School magnified the need for specific training to deal with crisis situations.

Three components of this discussion will include the following: (1) assisting in developing a crisis management plan; (2) formulating proactive strategies to respond to conditions that might lead to a crisis situation; and (3) developing and implementing intervention strategies to assist students, parents, staff, and community when a crisis-provoking event has occurred.

Informing, supporting, and preparing the school community to cope with crises are ongoing processes that should be taking place in schools across our nation. There must be a commitment to help young people think and use methods other than violence in conflict resolution.

No. 15E
IMPLEMENTING AND EVALUATING VIOLENCE-PREVENTION PROGRAMS

Lloyd B. Potter, Ph.D., *CDC, 4770 Buford Hwy, MSK-60, Atlanta GA 30341*

SUMMARY:

Injury is the leading cause of death and morbidity among youth between the ages of 10–19 years in the US. Among adolescents aged 10–14 years, homicide is the third and suicide the fourth leading cause of death. For adolescents aged 15–19 years, homicide is the second leading cause of death and suicide the third. Outcomes from violent behavior have created significant health problems among our youth. This problem is increasingly being addressed by the public health community. In the early 1990s, a significant number of violence prevention programs were being implemented. The majority of these efforts targeting youth were and are based in school settings. Yet we knew little or nothing about the effectiveness of the programs for preventing violent outcomes. The presentation describes the Centers for Disease Control and Prevention's (CDCs) approach and experience in the implementation and evaluation of violence prevention programs based in school settings. The public health approach to prevention, barriers to effective program delivery in schools, and successful strategies are discussed.

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SYMPOSIUM 16—ANATOMY OF JUVENILE VIOLENCE: THE COURT, THE DELINQUENT AND THE PSYCHIATRIST
APA Auxiliary

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the present state of juvenile law and how it pertains to the psychiatric evaluation and treatment of delinquents.

No. 16A
JUVENILE PROSECUTOR AND PSYCHIATRIST: FRIENDS OR FOES

Cathleen Edwards, J.D., *Juvenile, Superior Court, 239 Whalley Avenue, New Haven CT 06510*

SUMMARY:

The role of the juvenile prosecutor is to act as a legal professional who advocates for the interests of society in proceedings against juveniles who commit crimes. As such advocates, prosecutors seek to punish and or/rehabilitate juveniles. Those goals may coincide with or conflict with psychiatric treatment plans for individual juveniles. Because more and more juvenile offenders suffer from serious psychiatric disorders and illnesses, a juvenile prosecutor must understand these diagnoses and oftentimes respond to them either positively or negatively.

The need for secure treatment and removal from society may be paramount to a juvenile prosecutor, while the psychiatrist is seeking settings and programs that enhance the mental well-being of the offender. The psychiatrist and juvenile prosecutor are usually (but not always) able to find some common ground in processes (i.e., court) that require personal accountability and monitoring by outside agencies. The effective handling of cases in juvenile court necessitates communication between psychiatrist and prosecutor.

No. 16B
THE NEED FOR PSYCHIATRIC INFRASTRUCTURE IN JUVENILE JUSTICE

Carl C. Bell, M.D., *Community Mental Hlth Council, 8704 South Constance Avenue, Chicago IL 60617-2746*

SUMMARY:

Children in the juvenile justice system are more likely to have a variety of psychiatric disorders associated with childhood (mental retardation, learning disorders, and attention deficit and disruptive behavior disorders). In addition, they may also suffer from problems related to substance-related disorders, schizophrenia and other psychotic disorders, mood disorders, and anxiety disorders that cause behavior that results in criminal offenses. Further, youth who get incarcerated may be suffering from various impulse control disorders. Dr. Bell will propose that as our ability to diagnose brain disorders improves and as our ability to treat brain disorders with psychotropic medication develops, we need to be mindful that such advances could yield high leverage changes in the juvenile justice population regarding the control of behavior that causes youth to become incarcerated and prevents their rehabilitation. Thus, he will advocate for psychiatric leadership to develop a psychiatric infrastructure in the juvenile justice system for the future.

No. 16C
PREDICTORS OF VIOLENT DELINQUENT RECIDIVISM: AN ASSESSMENT

Roy J. O'Shaughnessy, M.D., *Youth Forensic Services, 3405 Willingdon Avenue, Burnaby BC V5G 3H4, Canada;* Heather M. Gretton, Ph.D.

SUMMARY:

Hare's Psychopathy Checklist has been widely used in adult offender populations as a reliable and effective tool to protect recidivism. The authors used the adolescent version of the PCL-4 in conjunction with other measures in assessing recidivism in two adolescent delinquent populations.

The first population was based on a five-year follow-up study of 220 convicted sexual offenders treated under court order.

The second group was a 10-year follow-up of 175 severely delinquent youth assessed for the courts in 1986. In both populations the mean PCL-R scores were comparable to studies of incarcerated adult offenders. Both groups had high recidivism rates but youth with higher PCL-R scores had significantly higher rates of reoffending, especially violently. The PCL-R was the most robust prediction of recidivism compared with all other variables.

No. 16D
QUESTIONS OF COMPETENCY: CHILDREN IN ADULT COURTS

Debra K. DePrato, M.D., *Department of Psychiatry, LSU School of Medicine, 1542 Tulane Avenue, New Orleans LA 70112-2822*

SUMMARY:

Changes continue to occur in the juvenile justice system, that are important for the psychiatrist involved in the court system to be aware. This paper will focus on those children transferred to the adult court system whose mental competency to stand trial is questioned. An overview of the charges, demographics, specific questions of the court, and the competency findings will be reviewed. Data gathered from competency evaluations and court hearings will be discussed.

Conclusions and recommendations pertinent to those performing these evaluations for the court will be discussed. In addition, systemic and policy issues will be addressed.

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SYMPOSIUM 17—CULTURAL ASPECTS OF PSYCHIATRIC PRACTICE ACROSS THE AMERICAS
The InterAmerican Council of Psychiatric Organizations

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize the cultural dimensions of diagnosis, treatment, and institutional psychiatric practice in the American continent; formulate comprehensive approaches for the management of individual and group psychopathologies including social phenomena such as violence, among American populations; and delineate cultural factors in clinical and epidemiological research lines in this field.

No. 17A
CULTURE AND HISPANIC MENTAL HEALTH IN THE USA

Renato D. Alarcon, M.D., *Department of Psychiatry, Emory University School of Med, 1670 Clairmont Road, Atlanta GA 30033*

SUMMARY:

Culture and psychopathology interact and mutually influence each other along different dimensions with the former being conceived as and playing the following functions: (1) interpretive and explanatory role, (2) pathogenic and pathoplastic agent, (3) diagnostic and nosological tool, (4) protective and therapeutic instrument, (5) management and service element. In the Hispanic population of the United States, these cultural dimensions are compounded by the increasing diversity of ethnic and cultural subgroups, and the different levels of aculturation, geographic locations, religious practices, and socioeconomic characteristics. Some of the traditional elements of Hispanic culture are being eroded and/or modified by the force of the host culture. Nevertheless, some characteristic clinical syndromes (not necessarily labeled as culture-bound syndromes) appear to prevail in these groups, while others show only "tip-of-the-iceberg" type of clinical manifestations. All this emphasizes the need for a culturally competent, pluralistic, comprehensive approach to the multidimensional interactions between culture and psychiatry. The role of cultural psychiatry tenets in diagnosis and treatment extends also to the formulation of public mental health policies to serve large, established as well as emerging Hispanic communities in the U.S. In this context, the role of mental health professionals within a multidisciplinary team needs to be better delineated.

No. 17B
RURAL AND COMMUNITY PSYCHIATRY IN LATIN AMERICA

Carlos Leon-Andrade, M.D., *Department of Psychiatry, Metropolitan Hospital, Casilla 17-16-127 CEQ, Quito, Ecuador;* Roberto E. Chaskel, M.D.

SUMMARY:

Human groups and communities established in the Latin American subcontinent have variously influenced the culture of the population as a whole. These different contributions have created a cultural fusion (mestizaje) that is fluid, continuous, and lasting in spite of socio-economic crises and political conflicts. These cultural factors help delineate modalities of being, thinking, living, loving, and fighting that range from esthetic creativity to the everyday way of life in the subcontinent. They include the different manners of experiencing physical and emotional illnesses, and the explanations of health and disease phenomena. In Latin America, the greatest percentage of the population is made of mestizo and indigenous groups that still maintain close ties to their prehispanic roots; they have experienced, however, a process of cultural amalgamation that, on the one hand, favors the persistence through centuries of an aboriginal medicine loaded with magic and mystical practices, and on the other, also accepts Western approaches in a way that demands a much needed complementation. Rural and community areas of the Latin American subcontinent are a "natural laboratory" for this type of healing practices. This work summarizes the cultural roots determining the nature and course of medical and psychiatric activities in Latin American countries.

No. 17C
SYMPTOMS AS CULTURAL MANIFESTATIONS: A CARIBBEAN PERSPECTIVE

Sharon C. Harvey, M.D., *29 Croton Drive, Husbands, St. James, Barbados W.I.*

SUMMARY:

There is now increasing recognition that the cultural manifestations of psychiatric illness have to be recognized and given validity, and not treated as an interesting oddity that departs from mainstream psychiatry.

The Caribbean, far from being a homogenous group of islands, shows a heterogeneity of cultures, with different histories and dialects. Added to the influences from African, French, Spanish, Dutch, and Portuguese ancestry, are the contributions from the indigenous peoples found in Guyana on the South American mainland, and in a few of the eastern Caribbean countries. Taking the Caribbean as a whole, those of African descent make up the majority of the population and so the influences of this culture have endured in many countries. In Trinidad and Guyana there are significant East Indian populations and so those influences are strong. In the practice of psychiatry in the Caribbean, therefore, it is necessary to bear these factors in mind when presented with psychopathology, and to recognize that the content of the symptoms will not necessarily follow the constructs of a North American or European system. This paper will explore these factors and discuss the diagnostic dilemmas that can result.

No. 17D
PUBLIC PSYCHIATRIC HOSPITAL PRACTICE IN ARGENTINA

Alberto J. Monchablon, M.D., *Gaona 1892, Buenos Aires 1416, Argentina;* Nestor F. Marchant, M.D.

SUMMARY:

The different aspects of psychiatric practice in a public facility in Buenos Aires, Argentina, are presented and discussed. Following a brief video presentation, the discussion centers on the main characteristics of the hospital population, as well as the community to which it serves their diagnostic epidemiology features and treatment approaches. The cultural aspects of these interactions are exemplified by the adaptation of well known diagnostic and clinical instruments, the lexicological variants, the differences regarding the "sick role," explanatory models of illness, and idioms of discomfort experienced and revealed by patients from different geographic origins in the Argentinean republic. From the indigenous people of the northern part of the country to the urban inhabitants of metropolitan Buenos Aires, the psychiatrists in the mental health team do have to adapt their different skills in order to obtain accurate historical material and delineate the most appropriate treatment approaches. Families interact also in very different fashions. The acceptance of medication vis a vis psychotherapy varies as a function of educational levels, religious practices, and cultural and educational sophistication. Comparisons with other population groups in Latin America are also presented.

No. 17E
FORENSIC PSYCHIATRY IN LATIN AMERICA: THE VENEZUELAN EXPERIENCE

Ruben J. Hernandez-Serrano, M.D., *Department of Psychiatry, U Central Venezuela, Apartado 17302 El Conde, 101 Caracas 1015A, Venezuela;* Antonio Pacheco-Hernandez, M.D.

SUMMARY:

The teaching of forensic psychiatry at the Central University of Venezuela and the Institute of Legal Medicine in Caracas since 1974 has emphasized the examination of different aspects of violence and its clinical implication among the population. Medical and postgraduate students of psychiatry, criminology, and law are presented with typical yet complicated cases that have made a particularly interesting impact on the community through exposures by mass media and other sources. These materials are used following appropriate informed consent, and are never used for legal or criminal investigations in spite of some very revealing political facts. Clinical data are supplemented by the Psychiatric State Examination (Wing), and the Questionnaire for Forensic Psychiatric Evaluations and Reports (Hernandez, Pacheco, Gicovate). Students analyze and participate in the decision-making process regarding the legal and psychiatric aspects of each case. The ten most interesting cases are briefly presented in detail to illustrate both the clinical phenomena as well as the teaching/educational approaches. The cases outline a particularly poignant aspect of the practice of forensic psychiatry in Latin America.

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3. Hinton L, Kleinman A: Cultural issues and international psychiatric diagnosis, in International Review in Psychiatry. Edited by Costa de Silva J, Nadelson C. Washington, DC, American Psychiatric Press, 1993, pp 111–129

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SYMPOSIUM 18—VIOLENCE AND MENTAL ILLNESS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should have gained knowledge about the relationship between several key variables and the incidence of violence among mentally ill persons, including delusions, violent fantasies, gender, and neighborhood effects.

No. 18A
DELUSIONS AND VIOLENCE

Paul S. Appelbaum, M.D., *Department of Psychiatry, University of Massachusetts, 55 Lake Avenue North, Worcester MA 01655*

SUMMARY:

When persons with mental illness commit spectacular acts of violence—like the Unibomber or the man who murdered two policemen at the U.S. Capitol—the media often link their behavior to their underlying delusions. Clinical studies and several epidemiologic studies have suggested that there is indeed a connection between delusional ideation and violent behavior, with delusions of persecution and of mind and body control particularly predisposing to acts of aggression.

Data from 328 delusional subjects in the MacArthur Violence Risk Assessment Study, however, present a somewhat different picture. Delusions were screened using the Diagnostic Interview Schedule questionnaire, and assessed in detail with the MacArthur Maudsley Delusion Assessment Schedule. Violence was carefully ascertained over a one-year period following hospital discharge. The presence of delusions per se did not relate to the risk of violent behavior during follow-up, nor did any of the individual characteristics of delusions, including content type and internal structure. In interactions between delusions and substance abuse, the latter accounted for almost all of the additional violence risk. The reasons for the differences between this and previous studies and the implications for clinical prediction and management of violence by delusional patients will be discussed.

No. 18B
VIOLENT FANTASIES, VIOLENT BEHAVIOR AND MENTAL ILLNESSES

Jeffrey J. Davis, Ph.D., *Center for Forensic Psychiatry, PO Box 2060, Ann Arbor MI 48106;* Thomas Grisso, Ph.D.

SUMMARY:

The relationship between violent fantasy and violent behavior has been the subject of much theoretical consideration. The MacArthur project provides an opportunity to explore this relationship among individuals with mental illness at the time of hospitalization and at five follow-up points over the following year. A brief questionnaire assessed the frequency, chronicity, focus, and variability of subjects' recent violent fantasies (RVFs). Results revealed a complex relationship between RVFs, violent behavior, gender, ethnicity, psychopathy, anger, impulsivity, and substance abuse. Approximately 30% of subjects reported RVFs, most of whom had experienced the RVFs for at least three months, had fantasized about a variety of types of harm, and had experienced RVFs while with or watching the object of the fantasies. Women were more likely to fantasize about harming one person, while men were more likely to fantasize about harming more than one person. The base rate of violent behavior among subjects with RVFs was significantly higher (26%) than nonRVF subjects (16%); men demonstrated a greater difference on this dimension than women. The results suggest that the accuracy of violence risk assessment may be enhanced by detailed inquiry about violent fantasies and their characteristics.

No. 18C
WOMEN, MENTAL DISORDER AND VIOLENCE

Pamela C. Robbins, *Policy Research, 262 Delaware Avenue, Delmar NY 12054;* John Monahan, Ph.D.

SUMMARY:

This session will report results from the MacArthur Risk Assessment Study on the prevalence of community violence in a sample of persons discharged from acute psychiatric facilities in the U.S. Over 1,000 male and female civil patients from three acute-care hospitals were assessed on four domains: dispositional risk factors (e.g., demographics), historical risk factors (e.g., prior violence), contextual risk factors (e.g., social support), and clinical risk factors (e.g., delusions). Patient self-reports of violence were augmented by reports from collaterals who knew the patients and from official police and hospital records. Special attention will be paid to the differences between the male and female patients in terms of violence reported and the target and location of the violence. Violent incidents for women were more likely than men to involve family members and to take place in the home. A preliminary look at the factors related to violence and any differences by gender will be presented.

No. 18D
NEIGHBORHOOD CONDITIONS AND PATIENT VIOLENCE: AN ECOLOGICAL APPROACH

Eric Silver, Ph.D., *Policy Research, 262 Delaware Avenue, Delmar NY 12054*

SUMMARY:

This paper combines patient data from the Pittsburgh site of the MacArthur Study (n = 293) with tract-level data from the U.S. Census Bureau to simultaneously examine the effects of individual-level risk factors and neighborhood poverty rates on the violent behavior of discharged patients. Based on a series of multi-level logistic regression models, this study finds: (1) that neighborhood poverty adds significantly to the overall amount of violence committed by discharged patients; (2) the socioeconomic status of individual patients is less predictive of violence than the rate of poverty in the neighborhood; (3) female patients discharged to concentrated poverty areas exhibited more violence (14.6%) than male patients discharged to areas with less concentrated poverty (12.7%); (4) 35% of diagnosed substance abusers discharged to concentrated poverty neighborhoods were violent, compared with 15.1% of those discharged to neighborhoods with less concentrated poverty; and (5) patients scored as psychopaths who were discharged to neighborhoods with concentrated poverty exhibited the highest rate of violence of any group (46.2%). The clinical implications of these findings lie in emphasizing the importance of assessing contextual conditions, as well as individual characteristics, when predicting and managing risk for violence.

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Violence and Mental Disorder: Developments in Risk Assessment. Edited by Monahan J, Steadman HJ. Chicago, University of Chicago Press, 1994
2. Steadman HJ, Mulvey EP Monahan J, Robbins PC, Appelbaum PS, et al: Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. Archives of General Psychiatry 1998;393–401
3. Monahan J, Steadman HJ (eds): Violence and Mental Disorder: Developments in Risk Assessment. Chicago, IL, University of Chicago Press, 1994
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SYMPOSIUM 19—MEDICATION CONTROVERSIES IN BIPOLAR DISORDER

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to know the medications that have either been proved or reputed to be worthwhile in the acute and long-term management of phases of bipolar disorder; understand the strengths and limitations of the evidence for the efficacy and safety of each treatment; formulate a treatment plan that prioritizes among treatment options.

No. 19A
MOOD STABILIZING MEDICATION

Paul E. Keck, Jr., M.D., *Biological Psychiatry, University of Cincinnati, 231 Bethesda Avenue, Cincinnati OH 45267*

SUMMARY:

Following a decade of reliance on lithium in the 1970s, psychiatric patients benefited first from the addition of carbamazepine and then divalproex to the arsenal of mood stabilizing medications. It now appears that a number of new antiepileptics may also have mood stabilizing properties. Clinicians face an increasingly complex decision in selecting among mood stabilizers both for initial therapy of acute manic or depressive episodes, as well as for long-term prevention. Recent reports regarding the "standard" medications further refine their optimal use in terms of suggesting differential benefits in subgroups of bipolar patients. At the same time, some reports have raised both positive and negative new issues regarding efficacy and safety in long-term use. Newer medications have entered widespread use despite an absence of published, randomized controlled trials and little long-term experience. This talk will present a synthesis of the evidence with an expert's opinions regarding how to select among established and newer options for treatment-naive patients; how to sequence and combine medications in subsequent trials for patients with side effects or later-stage breakthroughs; and how to approach the common needs in long-term treatment to add, subtract, or retry various mood stabilizers.

No. 19B
THE ROLE OF ANTIPSYCHOTICS IN BIPOLAR DISORDER

Philip G. Janicak, M.D., *Department of Research, Psychiatric Institute, 1601 West Taylor Street, Chicago IL 60612*

SUMMARY:

There are three potential roles for antipsychotics in the treatment of bipolar disorder: the *sole primary therapy; adjuncts* to other agents; and possibly a unique role for *novel agents such as clozapine, risperidone, and olanzapine,* especially in treating refractory bipolar disorder. Neuroleptics were the primary treatment for acute mania prior to the advent of lithium. Indeed, early studies indicated that as many as half of patients would show substantial benefit. Even today they may be the only effective, as well as viable drug treatment for certain bipolar patients (e.g., maintenance depot preparations in those who are noncompliant).

Antipsychotics probably play their most important role as adjuncts in the treatment of bipolar and related disorders. Important clinical questions include the comparative efficacy of various classes of agents, their optimal dose, adverse effect profiles, and potential for drug interactions.

The role of novel antipsychotics, either as primary or adjunctive treatments for bipolar disorder, has yet to be fully explored. Theories about possible mood stabilizing effects have included their differential effects on dopamine receptor subtypes, greater 5HT antagonism and decreased dopamine antagonism in comparison with neuroleptics, and varying effects on different dopamine tracts. If these observations are confirmed by controlled trials, novel antipsychotics may play an important and perhaps unique role for more severe psychotic and/or refractory bipolar and related disorders. Given the available literature as tempered by clinical experience and the relative risk-benefit ratio, we develop both an acute and maintenance strategy, which emphasize the role of antipsychotics for bipolar disorder.

No. 19C
BIPOLAR DEPRESSION

Gary S. Sachs, M.D., *Bipolar Clinic, Massachusetts General Hospital, 15 Parkman Street, WACC-812, Boston MA 02114*

SUMMARY:

Bipolar depression has received relatively little research attention, and bipolar patients have been excluded from most antidepressant drug trials. The bedrock of pharmacotherapy—mood stabilizing medications—is generally better at preventing and treating mania than depression, leaving chronic or recurrent depression as the fate of many patients. Customary options for treating breakthrough depression or preventing future episodes include psychotherapy; raising the dose of a current mood stabilizer; adding a second mood stabilizer; switching to another mood stabilizer; prescribing an antidepressant; augmenting treatment with agents that by themselves are not generally thought of as antidepressants such as hormones, stimulants or antipsychotics; or providing ECT. Each of these is controversial, and it appears that responses of individual patients are extremely variable. For example, clinical reports describe the tendency for some patients to worsen on antidepressants and others to benefit. While some data suggest that certain antidepressants are less likely than others to cause cycling, comparing existing data is hampered by methodological differences in the reports. There are also little hard data regarding the antidepressant effects of mood stabilizers. This presentation will discuss the range of standard options for treating bipolar depression and how the clinician might choose among these and sequence them for individual patients.

No. 19D
NOVEL TREATMENT STRATEGIES FOR REFRACTORY BIPOLAR DISORDER

Andrew L. Stoll, M.D., *Department of Psychiatry, Brigham and Women's Hospital, Boston MA 02115*

SUMMARY:

This presentation will review the pharmacology and clinical usage of novel drug treatments for bipolar disorder. The safety and efficacy

of various combinations of mood stabilizer drugs will also be reviewed. Recent work regarding possible mechanisms of action of mood stabilizing compounds suggest that inhibition of prosynaptic signal transduction pathways may be a featured comment to all agents with acute and prophylactic efficacy in bipolar disorder. Implications of elucidating the mechanisms of action for mood stabilizers are far reaching. First, safer and more rational combinations of mood stabilizing agents can be devised. Second, new mood stabilizing drugs can be formulated through an understanding of the mechanisms of action of currently used mood stabilizing agents. One example is the Omega 3 fatty acid group of compounds. High concentrations of Omega 3 fatty acids in plasma membranes reduce the signal transduction through inhibition of the hydrolysis of the membrane's phospholipids, which serve as precursors to second messenger molecules. A recently completed double-blind, placebo-controlled trial of Omega 3 fatty acids in 30 bipolar outpatients demonstrated that the Omega 3 fatty acids did have mood stabilizing efficacy in unstable bipolar disorder. The next decade of bipolar research should produce major advances in our understanding and treatment for bipolar disorder.

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2. Janicak PG, Davis JM, Preskorn SH, Ayd Jr. FA: Principles and Practice of Psychopharmacotherapy, Second Edition. Baltimore, MD, William & Wilkins, 1997; pp 452–460
3. Sachs GS: Treatment-resistant bipolar depression. Psychiatric Clinics of North America, 1996;19(2):215–236
4. Stoll AL, Severus E: Mood stabilizers: shared mechanisms of action at postsynaptic signal-transduction and kindling processes. Harvard Review of Psychiatry 1996;4:77–89

SYMPOSIUM 20—THE ETHICS OF SCHIZOPHRENIA RESEARCH

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be familiar with the controversy regarding the ethics of research with schizophrenic subjects, including suggestions for changes in current practices targeted at researchers themselves and at institutional review boards, and of the broader policy issues involved.

No. 20A
OVERVIEW OF THE CONTROVERSY

Paul S. Appelbaum, M.D., *Department of Psychiatry, University of Massachusetts, 55 Lake Avenue North, Worcester MA 01655*

SUMMARY:

The ethics of research with persons with schizophrenia has come in for a good deal of criticism and comment in the last several years. Critics have focused both on the methods used in such research and on the adequacy of informed consent procedures. Those methodologic issues that have raised the greatest degrees of concern include medication washouts, studies in which patients are monitored in a medication-free state, and studies in which symptoms are provoked by pharmacologic probes. Each of these procedures unarguably creates some degree of risk for research subjects. Such risks are usually justified in the research setting by the assumption that competent research subjects have the right to accept some reasonable degree of risk in exchange for whatever benefits they perceive as flowing from research participation, including the knowledge that they have acted altruistically to help others with their illness (even if they themselves will not benefit directly). This basis for research participation by schizophrenic subjects, however, has been challenged by claims that many schizophrenic subjects lack the capacity to make competent decisions about participation, and that informed consent procedures themselves are significantly flawed in failing to disclose to potential subjects the real risks that they may run. A wide array of proposals has been made to correct these perceived problems, ranging from an outright ban on nontherapeutic research with persons with schizophrenia, to restrictions on the use of particular research methods, to greater degrees of external monitoring by persons not directly involved in the research enterprise. The most substantial recent set of recommendations has come from the National Bioethics Advisory Commission, whose comments will be addressed in the following presentation.

No. 20B
AN OVERVIEW OF THE NATIONAL BIOETHICS ADVISORY COMMISSION'S REPORT AND RECOMMENDATIONS

James F. Childress, Ph.D., *Religious Studies, University of Virginia, Cocke Hall, Charlottesville VA 22901*

SUMMARY:

I will discuss the process used in preparing, and the results presented in, the report of the National Bioethics Advisory Commission on "research involving subjects with mental disorders that may affect decisionmaking capacity" (the current working title), which will be released later this year. In particular, as a member of this commission, I will examine the presuppositions and implications of the report and its recommendations, and discuss how the commission believes it has addressed the many important criticisms and suggestions it has received by clarifying, modifying, and altering several of its recommendations.

No. 20C
ETHICAL ISSUES IN CLINICAL RESEARCH: AN INVESTIGATOR'S PERSPECTIVE

Jeffrey A. Lieberman, M.D., *Department of Psychiatry, Univ of NC School of Medicine, 7025 Neurosciences Hosp CB716, Chapel Hill NC 27599*

SUMMARY:

Clinical research has come under increased scrutiny in recent years due to concerns about its safety and ethical basis in decisionally impaired populations, and controversial study designs. These have specifically focused on mental illnesses and the use of drug washout and discontinuation studies, the use of placebo in clinical trials, and pharmacologic challenge studies. Traditionally, the scientific value of such study designs has been evaluated in a complex equation that considers their potential risks for patients, the study's scientific yield, the gravity and nature of the clinical condition under investigation, and the availability of other treatments. This is an evolving process, as in the course of scientific progress the circumstances of any clinical condition and the considerations in determining the ethical justification of a study necessarily change. Consequently, research designs previously considered to be safe and ethically valid may be questioned and need to be changed.

This presentation will discuss these issues as they currently apply to studies of severe mental disorders including schizophrenia, major affective disorders, and dementia.

No. 20D
EVOLVING PROCEDURES TO ADDRESS RESEARCH ETHICS

William T. Carpenter, Jr., M.D., *Department of Psychiatry, MD Psychiatric Research Ctr, PO Box 21247, Baltimore MD 21228*

SUMMARY:

Schizophrenia is the paradigm for an impassioned debate regarding the ethical conduct of research. Key issues have been identified and procedures to assure protection of subjects have evolved. Voluntary and informed consent is the issue of first importance. A potential subject's decisional capacity must be determined, and special procedures are required if persons lacking decisional capacity are research subjects. Developments in dementia research procedures provide a model, and potential application in schizophrenia will be described. However, most schizophrenia studies are conducted with subjects judged to have sufficient decisional capacity for informed consent. New procedures to ascertain capacity, to apply cognitive and learning principles in an educational informed consent process, and to document adequacy of consent will be presented.

Hot spots in the schizophrenia research ethics debate include off-medication studies; pharmacologic probe studies; and at-risk research, which does not offer direct benefit. Safety data from these types of studies will be presented, and methods for reducing risk and enhancing benefit will be described.

New data comparing schizophrenia and control subjects on tests of decisional capacity, the effectiveness of an educational informed consent procedure, and testing the quality of signed informed consent will be presented.

No. 20E
CLINICAL TRIALS OF TREATMENTS FOR SCHIZOPHRENIA

Robert J. Levine, M.D., *Professor of Medicine, Yale University, 18 Sunset Circle, Woodbridge CT 06525*

SUMMARY:

The randomized clinical trial (RCT) is generally recognized as the "gold standard" for determining the efficacy of new (or old) drugs. The primary ethical justification of a RCT is that at the outset the drugs to be compared must be in a state of "clinical equipoise." This means that within the community of clinical experts there is either uncertainty or a controversy about which of the two (or more) drugs to be compared is superior with regard to the balance of risks and benefits it presents. The availability of preliminary data often makes it difficult to support the claim of clinical equipoise required to justify the conduct of a placebo-controlled RCT. With the aim of approximating a state of clinical equipoise at least for the duration of a placebo-controlled RCT, various techniques are employed to minimize the risks of injury to the subjects. These techniques have a tendency to limit either the validity or the generalizability of the data developed by the RCT with regard to efficacy of the drugs. For example, limiting the study population to those whose symptoms are refractory to other drugs may yield results that may not apply to those other patients who have had satisfactory results. Limiting the duration of placebo-controlled RCTs yields results that do not apply to prolonged use of the drugs. These and other risk limiting techniques will be discussed.

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SYMPOSIUM 21—GROUP THERAPY FOR PERSONS LIVING WITH HIV/AIDS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to (1) describe characteristics of group therapy interventions for individuals living with HIV/AIDS and (2) identify psychosocial outcomes that have been found to be improved among persons with HIV/AIDS who have participated in group therapy interventions.

No. 21A
ENHANCING COPING SKILLS IN GROUP PSYCHOTHERAPY FOR PEOPLE WITH HIV/AIDS

Jeffrey A. Kelly, Ph.D., *Department of Psychiatry, Medical College of Wisconsin, 1201 North Prospect Avenue, Milwaukee WI 53202*

SUMMARY:

Objective: Individuals vary in their ability to cope with the challenges posed by living with HIV and AIDS: some cope well while others experience psychological difficulties. This presentation will evaluate and discuss the clinical issues in group therapy that have been shown to promote or prevent successful coping with HIV.

Method: The empirical literature on the effects of group psychotherapy for persons with HIV/AIDS was reviewed. Factors that facilitate or hinder successful coping were examined, including preexisting psychosocial functioning, current medical and symptom status, social support, coping style, and perceived expected benefits of treatment.

Results: Clinical issues encountered in therapy groups for persons with HIV that relate to increased or decreased coping include the coexistence of problems unrelated to HIV/AIDS, HIV serostatus disclosure to others, lifestyle changes related to HIV sexual risk behavior practices, AIDS-related care giving and bereavement stress, establishing social and community supports, adhering to medical treatment regimens, and developing a positive identity as an individual living with HIV.

Discussion: In order to enhance coping skills in group therapy interventions, it is critical to understand and address the identified individual and sociocultural factors that moderate and mediate successful coping with HIV/AIDS.

No. 21B
INTERVENTIONS FOR POSITIVE YOUTH: ARE GROUPS THE RIGHT MODALITY?

Marguerita Lightfoot, Ph.D. *Department of Psychiatry, UCLA, 10920 Wilshire Blvd, Ste 350, Los Angeles CA 90024;* Mary J. Rotheram-Borus, Ph.D., Martha Lee, Ph.D.

SUMMARY:

Background: Changes in health practices and transmission behaviors among youth living with HIV (YLH) were examined in response to receiving preventive interventions.

Methods: YLH aged 13–24 years ($N = 350$; 26.2% African American, 37.4% Latino) were randomly assigned and monitored over 15 months as the YLH received: (1) two intervention modules—"Staying Healthy" and "Act Safe", or (2) standard care.

Results: YLH who attended the Staying Healthy module reported significantly fewer health symptoms and less physical distress, received more social support, reported more positive coping methods, and had higher health-related self-efficacy than YLH randomized to the Lagged Control Group. YLH attending the Act Safe intervention reported significantly fewer sexual partners, fewer HIV negative sexual partners, a lower proportion of unprotected sexual acts, less substance use, and higher self-efficacy for safer sex and reducing substance use than those in the Lagged Control Group. There was also substantial variation in sexual and drug use behavior by small group assignment. The implications of small groups as a modality for prevention programs with youth are reviewed.

Conclusion: Prevention programs should become routine for the infected. Expanded early detection programs are needed.

No. 21C
BEREAVEMENT GROUPS AND DISTRESS AFTER SUBSEQUENT LOSS

Karl Goodkin, M.D., *Department of Psychiatry, Univ of Miami School of Med, 1400 NW 10th Avenue, Rm 806-A, Miami FL 33136;* Nancy T. Blaney, Ph.D., Teri Baldewicz, Ph.D., Jack Burkhalter, Ph.D., Barbara Leeds, Joshua Cohen

SUMMARY:

Objective: To evaluate distress after a subsequent loss following a bereavement support group.

Method: Recently bereaved homosexual men were enrolled into a randomized, controlled trial of a 10-week, once-a-week bereavement support group intervention and followed for two years.

Results: A total of 118 subsequent losses were recorded. Thirty-one (31) were sustained by HIV+ group subjects, 36 by HIV+ controls, 42 by HIV-group subjects, and nine by HIV-controls. Compared with controls, significant reductions in overall distress and grief were found, controlling for serostatus, subsequent loss impact, psychotropic usage, psychosocial service utilization, loss order, and baseline grief and distress levels at study entry. Of the 118 subsequent losses, 50 were at least a second subsequent loss. In the subsample with at least one subsequent loss (n = 68) focused on the loss (for those with > 1) that demonstrated the greatest grief reactivation, we replicated our results for index-loss-induced grief—group subjects showed significantly lower grief level. Subsequent loss impacted functional status significantly less in group subjects on both total (physical and psychosocial) dysfunction and on psychosocial dysfunction alone, controlling as above (adding antiretroviral usage for total dysfunction).

Conclusions: This provides evidence for a group grief inoculation effect undiminished for up to two years.

No. 21D
SUPPORTIVE-EXPRESSIVE GROUP THERAPY FOR HIV/AIDS

Cheryl Koopman, Ph.D., *Department of Psychiatry, Stanford University, MC 5718, Stanford CA 94305;* Jose R. Maldonado, M.D., Cheryl Gore-Felton, Ph.D., Dennis Israelski, M.D., Catherine Classen, Ph.D., Michele Gill, B.Sc., David Spiegel, M.D.

SUMMARY:

Objective: This prospective, randomized clinical trial is evaluating the effects of supportive-expressive group psychotherapy intervention on mood, risk behavior, and health outcomes among HIV-positive women and men assessed at three-, six-, and 12-month follow-ups. We report the preliminary results of examining three-month follow-ups on mood, sexual risk behavior, and pain.

Method: We assessed sexual risk behaviors among 118 persons living with HIV/AIDS, 69 men and 49 women. Their mean age = 41 years (SD = 8 years), 30% African American, 3% Asian American, 3% Latino, 5% Native American, and 59% Caucasian, with 84% of men identifying as gay/bisexual and 71% of the women as heterosexual.

Results: We have assessed 92% of the research participants at the three-month follow-up. In the three-month follow-up assessments, research participants in the group therapy condition showed somewhat greater mean reductions in total mood disturbance, recent unprotected sexual encounters, and pain, compared with those in the education only condition. Participants in the education only condition showed a greater reduction than did those in the group therapy condition in their number of recent sexual partners.

Discussion: These findings suggest that supportive-expressive group therapy may begin within three months of intervention to improve quality of life and risk behavior for persons living with HIV/AIDS. However, group therapy showed no benefit in reducing the number of sexual partners.

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SYMPOSIUM 22—TREATMENT OF SUICIDAL BEHAVIOR IN PERSONS WITH PERSONALITY DISORDERS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to identify strategies to successfully treat suicidal patients who have personality disorders and to recognize the differences between treating the overall personality disorder versus suicidality, and to understand that separate approaches may be required for successful treatment.

No. 22A
SUICIDAL BEHAVIOR IN PERSONS WITH PERSONALITY DISORDERS

Barbara Stanley, Ph.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, Unit 28, New York NY 10032*

SUMMARY:

There is no higher research priority in medicine than the development of treatments for fatal diseases. Strangely, in psychiatry, we

have not clearly emphasized the elimination of premature death as a priority in our treatment development. Although suicide is the ninth leading cause of death with only 2,000 fewer deaths in 1996 than AIDS, there are almost no studies that focus on the identification of treatments that have "anti-suicidal" properties.

Individuals with personality disorders, particularly borderline personality disorder, are at high risk for suicide and suicide attempts. The lifetime suicide rate in this disorder approaches 10%. Despite this figure, the common misconception that suicide attempts in this population are primarily manipulative and attention seeking still exists. Estimates of the incidence of self-mutilation in this population range from 40% to 80%. Self-mutilation is a risk factor for suicidal behavior; 55% to 85% of those who self-mutilate have made at least one suicide attempt. Suicide attempts occur at ten times the rate of completion. Suicidal behavior is a primary reason for medical and psychiatric hospitalization of patients with emotional disorders.

This presentation will review the clinical correlates of suicidal behavior in personality disorders, the differences between suicidal behavior in the context of personality disorders compared with this behavior in Axis I disorders alone, and the misconceptions associated with suicidal behavior in personality

No. 22B
PSYCHOPHARMACOLOGY OF SUICIDAL BEHAVIOR IN PERSONS WITH PERSONALITY DISORDERS

Larry J. Siever, M.D., *Department of Psychiatry, Mount Sinai School of Medicine, 1 Gustave Levy Place/Box 1230, New York NY 10029;* Antonia S. New, M.D., Harold W. Koenigsberg, M.D.

SUMMARY:

Suicidal patients, particularly those with coexisting personality disorders, represent a critical challenge for treating clinicians, not the least of which is their appropriate psychopharmacologic management. Personality disorder patients with suicidal behaviors may not necessarily be compliant with treatment, can overdose on medications, and may not respond quickly to antidepressant administration. A variety of biologic studies suggest reduced serotonergic activity is associated with suicidal behaviors, particularly suicidal behaviors that involve tissue injury. Indeed, new results from a study in our group suggest that prolactin responses to serotonergic agents are associated with significantly more self-mutilating behavior involving tissue destruction whether or not the behavior was made with suicidal intent. Thus, these behaviors might be considered a form of self-directed aggression, which has been associated in personality disorders with allelic variation in the tryptophan hydroxylase gene. Furthermore, recent data from our laboratory suggest that allelic variation in 5-HT_{1b} receptor genes may be associated with impulsive/aggression. SSRIs may be helpful in ameliorating these serotonergic deficits, although preliminary data suggest that the less the serotonergic capacity, the longer the time to response and/or the greater the dose required. Affective instability may in part be mediated by instability or irritability of limbic regions that are mediated by cholinergic agents, as indicated by hyperresponsiveness to both cholinergic agents and local anesthetics. Mood stabilizers may be helpful in reducing limbic irritability and thus diminish the affective irritance to suicidal behavior.

No. 22C
PSYCHOTHERAPY OF SUICIDAL PATIENTS WITH PERSONALITY DISORDERS

Marsha M. Linehan, Ph.D., *Department of Psychiatry, University of Washington, Guthrie Hall, Rm 119/Box 351525, Seattle WA 98195-1525*

SUMMARY:

The purpose of this presentation is to review the psychotherapy treatment literature for suicidal patients with personality disorders. While there have been remarkably few controlled trials, the available research provides some direction for the clinician who is treating the suicidal patient. There have been 17 published studies evaluating psychosocial interventions for suicidal patients. Five of these studies, all of which were conducted with outpatients, demonstrated a greater decrease in suicide attempts in the experimental treatment. This included one study with only patients who had borderline personality disorder. These interventions were primarily cognitive-behavioral in approach. This presentation will review the similarities in the successful treatment interventions and make recommendations based on these findings for the clinician treating suicidal patients.

No. 22D
CLINICAL MANAGEMENT OF THE SUICIDAL PERSONALITY DISORDERED PATIENT

Rebecca A. Dulit, M.D., *Department of Psychiatry, New York Hospital, 21 Bloomingale Rd, Rm 134-1 S, White Plains NY 10605*

SUMMARY:

The management of a suicidal patient is one of the most challenging and stressful tasks for the clinician. The ever-present possibility of death generally evokes intense emotions in therapists and many clinicians avoid working with suicidal patients. This can lead to compromised care for this group. In order to treat suicidality successfully, the psychiatrist must diagnose and treat underlying psychopathology, often using a combination of therapeutic modalities including psychotherapy and pharmacotherapy, and environmental manipulation, such as hospitalization. The appropriate treatment depends on the nature of the psychiatric illness, the degree and nature of suicide risk, and the nature of the relationship between the clinician and patient. This presentation will focus on (1) the impact of the suicidal patient on the therapist, and (2) the impact of the therapeutic relationship on the suicidal patient. Obstacles to successful treatment will be identified and recommendations about management of the patient-therapist relationship will be made. Stages of treatment with an accompanying theoretical model will be presented, and the appropriate intervention at each stage will be described.

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SYMPOSIUM 23—SUBSTANCE ABUSE AND COMORBIDITY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to (1) recognize the issues of etiology, assessment, and treatment of comorbid psychiatric disorders and substance abuse; (2) assess

suitability for a variety of treatment approaches; and (3) implement appropriate pharmacological and/or psychosocial intervention.

No. 23A
TREATMENT OF PTSD AND SUBSTANCE USE DISORDERS

Kathleen T. Brady, M.D., *Department of Psychiatry, Medical University of SC, 171 Ashley Avenue, Charleston SC 29425-0742*

SUMMARY:

Recent data from both epidemiologic studies and studies of individuals in treatment indicate that post-traumatic stress disorder (PTSD) and substance use disorders commonly co-occur. Prevalence data from the studies addressing this issue will be presented. The appropriate treatment of individuals with comorbid PTSD and substance use disorders remains controversial. While one approach has been to defer treatment of trauma-related issues in individuals during substance abuse treatment, recent data indicate that untreated PTSD can worsen the course of substance use disorders. Data from clinical trials in individuals with PTSD indicate that exposure therapy is effective in individuals with PTSD who do not have a substance use disorder. Exposure therapies are thought to be contraindicated for substance users because of the belief that they may precipitate relapse. In this presentation, the controversies in the appropriate treatment of comorbid PTSD and substance use disorders will be discussed. The development of specific pharmacotherapeutic and psychotherapeutic treatments for individuals with comorbid substance use and PTSD will be described. Preliminary outcome data on the use of an exposure-based cognitive-behavioral therapy manual for individuals with comorbid PTSD and cocaine dependence will be presented.

No. 23B
EVALUATION OF DEPRESSION IN SUBSTANCE ABUSE

David M. McDowell, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, Unit 66, New York NY 10032;* Frances R. Levin, M.D., Edward V. Nunes, M.D., Herbert D. Kleber, M.D.

SUMMARY:

Drug and alcohol problems often exist alongside depression. This segment of the symposium will focus on the difficulties in treating individuals with both cocaine dependence and depression. Taking an accurate history is vital and should include (1) precipitating events, (2) onset and pattern of drug use over the patient's lifetime, (3) positive and negative consequences of drug use for the patient, and (4) onset and course of psychiatric comorbidity in relation to course of substance use. It is often the patients with comorbid psychiatric symptoms who are the most difficult to keep abstinent. It has been hypothesized that features of the history and presentation can indicate if a comorbid condition is primary or independent of substance use and warrants specific treatment. These include (1) depression that is chronologically primary, (2) depression that persists during past periods of abstinence, (3) chronic psychopathology, (4) emergence of depressive symptoms during periods of stable substance use, (5) positive family history of similar depression, and (6) uniqueness of the psychiatric symptoms. A flexible approach to the etiology of dual diagnosis is recommended, one that is open to the possibilities that either disorder may be primary or coexisting independently. Focus will be on treatment and etiology of this comorbidity.

No. 23C
DIAGNOSIS AND TREATMENT: SUBSTANCE ABUSERS WITH ADHD

Frances R. Levin, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, Unit 66, New York NY 10032;* David M. McDowell, M.D., Suzette Evans, Ph.D., Herbert D. Kleber, M.D., Andrew Sia, B.A.

SUMMARY:

Attention-deficit-hyperactivity disorder (ADHD) is a disorder characterized by inattention, hyperactivity, and impulsivity. Adults with ADHD are at greater risk for having a substance use disorder than adults who do not have additional psychopathology. Similarly, adult ADHD is overrepresented among substance abusers seeking treatment. The diagnostic assessment can be complicated by factors that may lead to both under- and over-diagnosis of the disorder. Some commonly asked questions include: (1) Should a patient be considered to have ADHD if they cannot recall having ADHD prior to the age of 7 but can remember having impairing symptoms while in elementary school? (2) How can other psychiatric disorders, e.g., bipolar illness, be distinguished from adult ADHD? Approaches to handle such questions will be presented. Once the diagnosis is established, both targeted pharmacologic and nonpharmacologic treatment strategies may need to be implemented if this subgroup is to succeed in substance abuse treatment. An overview of these therapeutic approaches will be discussed. Further, the current controversies regarding the use of certain pharmacologic approaches for substance abusers with adult ADHD will be discussed.

No. 23D
DUAL DIAGNOSIS: SCHIZOPHRENIA AND SUBSTANCE ABUSE

Douglas M. Ziedonis, M.D., *Department of Psychiatry, RW Johnson Medical School, 675 Hoes Lane, Room D349, Piscataway NJ 08854*

SUMMARY:

Most individuals with schizophrenia use alcohol, nicotine, or other drugs. Substance use disorders are common and the combination presents special challenges for diagnosis and treatment. This comorbidity may reflect self-medication, as well as a biological susceptibility to both disorders. Dual-diagnosis treatment is more effective when traditional substance abuse and mental health treatment approaches are integrated and address differences in severity of both illnesses. The presentation will discuss critical treatment matching factors including motivation. Strategies to better engage the low-motivation patient into treatment will be reviewed, including how to modify traditional motivational enhancement therapy, 12-Step, and relapse prevention. The progressive stages of dual recovery will be reviewed, including different models. The recommended psychotherapeutic approach varies according to the stage of recovery. Polysubstance abuse, dual diagnosis, and other compulsive activites are often complicating factors that require adaptations in the treatment. Pharmacotherapy strategies will also be reviewed, including the psychiatric and addiction medications.

No. 23E
AXIS II IN DRUG ABUSERS: RELATION TO AXIS I

Bruce J. Rounsaville, M.D., *Department of Psychiatry, Yale University, 34 Park Street, Room S202, New Haven CT 06519;* Roel Verheul, Ph.D., Henry R. Kranzler, M.D.

SUMMARY:

Diagnosing Axis II disorders in drug abusers is a particular challenge because what appear to be enduring pathological personality

traits may in fact be transient symptoms of substance use disorders or of other comorbid Axis I disorders. Using the Structured Clinician Interview for DSM-III-R (SCID), we obtained Axis I and Axis II diagnoses on 370 patients in treatment for substance use disorders at treatment entrance and at one-year follow-up. Both Axis I (56%) and Axis II (57%) diagnoses were diagnosed in a majority of patients. Current Axis I anxiety and mood disorders were strongly associated with all three personality diagnosis clusters. For individual pairs, the strongest associations were of social phobia with avoidant and schizotypal personality disorders, and of major depression with borderline personality disorder. At one-year follow-up, improvement of substance use disorders was associated with improvement of mood/anxiety disorders but not with improvement in Axis II pathology. However, improvement of mood/anxiety disorders was associated with "improvement" in Axis II pathology, particularly for Cluster C disorders, which are characterized by traits highly similar to those of Axis I mood/anxiety disorders.

Findings from this study suggest the importance of both Axis I and Axis II disorders in drug abusers as well as the need to carefully distinguish transient mood/anxiety states from more enduring Cluster C (avoidant, dependent, obsessive-compulsive) personality traits.

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SYMPOSIUM 24—BIOLOGY OF EATING DISORDERS: CLINICAL IMPLICATIONS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to identify biological disturbances found in the eating disorders (including anorexia nervosa, bulimia nervosa, and binge eating disorder), and have a better appreciation of the biological contributions to the development and maintenance of these disorders.

No. 24A
PERTURBATIONS IN METABOLIC RATE IN PERSONS WITH ANOREXIA NERVOSA

Laurel Mayer, M.D., *Department of Psychiatry, NY State Psychiatric Institute, 1051 Riverside Dr. Unit 98, New York NY 10032;* B. Timothy Walsh, M.D., Michael Rosenbaum, M.D., Rudolph J. Leibel, M.D., Richard N. Pierson, M.D.

SUMMARY:

Purpose: To determine if weight-restored patients with anorexia nervosa have disturbances in resting energy expenditure (REE).

Methods: REE and body composition were measured in 11 patients with anorexia nervosa and nine control women. Patients were tested before and after weight gain. Control subjects were tested at usual body weight and after losing 10% of body weight.

Data and Results: REE/FFM of patients at low weight (27.1 ± 3.0 kcal/day/kg) was significantly different from the mean REE/FFM of control subjects at usual weight (31.3 ± 5.0 kcal/day/kg) ($p = 0.001$), but not from the mean REE/FFM of control subjects at reduced weight (27.4 ± 4.5kcal/day/kg) (p = NS). The mean REE/FFM of weight-restored patients (34.3 ± 5.2kcal/kg/day) was significantly higher than that of controls at usual body weight (31.3 ± 5.0 kcal/day/kg) ($p < 0.05$).

Conclusions: Following normalization of body weight, patients with anorexia nervosa have an REE/FFM significantly higher than controls. This suggests (1) a potential physiologic explanation for the observed clinical difficulty patients experience in maintaining a normal weight, and (2) although it does not appear that patients with anorexia nervosa suffer from a primary disturbance in resting energy expenditure, they may develop one during the course of the illness, which contributes to its perpetuation.

No. 24B
METABOLIC SIGNALS AND BODY WEIGHT IN PERSONS WITH BULIMIA NERVOSA

David C. Jimerson, M.D., *Department of Psychiatry, Beth Israel Deaconess Med Ctr, 330 Brookline Avenue, Boston MA 02215-5491;* Barbara E. Wolfe, Ph.D., Eran D. Metzger, M.D., Jeffrey M. Levine, M.D.

SUMMARY:

Objective. Patients with bulimia nervosa, although in a normal weight range, may experience a physiological predisposition toward additional weight gain. Thus, previous studies have shown significantly lower metabolic rate, thyroid hormone levels, and sympathetic nervous system activity in patients than in controls. In that serum leptin concentrations may be correlated with metabolic rate, the current study is evaluating serum thyroid hormone and leptin concentrations in relationship to body weight in bulimia nervosa.

Methods. Subjects included 19 women (age 23.6 ± 3.8 years, mean ± s.d.) with bulimia nervosa, 21 women (24.9 ± 4.1 years) in remission from bulimia nervosa, and 21 healthy female controls (22.9 ± 3.4 years). Subjects were studied after overnight fast and bedrest during the follicular phase of their menstrual cycle.

Results. Body mass index was not significantly different for the three subject groups (21.7 ± 2.2, 21.8 ± 2.0, and 21.5 ± 2.0 kg/m^2, respectively). In comparison with controls, women with bulimia nervosa had significantly reduced levels of serum triiodothyronine ($p < .05$) and free thyroxine ($p < .001$). Leptin values for the three study groups will be presented in relationship to thyroid hormone levels, body weight, and percent body fat.

Conclusions. Metabolic signals may play a role in a physiological tendency toward weight gain in some patients with bulimia nervosa, potentially contributing to preoccupation with body weight and recurrent dieting behaviors.

No. 24C
EATING BEHAVIOR IN PATIENTS WITH EATING DISORDERS

Michael J. Devlin, M.D., *Clin Psychopharmacology, NY State Psychiatric Institute, 330 Brookline Avenue, New York NY 10032-2603*

SUMMARY:

Characterizing the disturbances of eating behavior among individuals with eating disorders allows us to generate informed hypotheses

concerning the underlying pathophysiology of these illnesses. One approach to describing the abnormal eating of patients with bulimia nervosa (BN) and binge eating disorder (BED) has been to observe eating under controlled circumstances. Studies conducted over the past decade have provided important evidence that lends support to several biological hypotheses.

Early studies demonstrated that patients with these disorders could reproduce their eating binges in a laboratory setting. Studies using multiple-item meals (i.e., an array of typical binge and non-binge foods) permitted estimates of the magnitude of eating binges in patients with BN and demonstrated that patients do not preferentially binge on high carbohydrate foods, as had previously been theorized. Multiple-item meal studies in BED confirmed that obese binge eaters eat differently than equally obese non-binge eaters and demonstrated that the degree of obesity as well as the presence of BED influences the amount consumed. Studies using single-item meals have allowed precise measurement of rate of eating and rate of development of satiety and other eating-related perceptions over the course of binge and non-binge meals.

No. 24D
GASTRIC FUNCTION IN PERSONS WITH BULIMIA NERVOSA

Ellen Zimmerli, Ph.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, New York NY 10032;* B. Timothy Walsh, M.D., Harry Kisseleff, Ph.D., Janet Guss, B.A.

SUMMARY:

This presentation will review studies of gastric and intestinal function in patients with bulimia nervosa that may help explain disturbances in the development of satiety.

Several studies indicate that patients with bulimia nervosa have an enlarged stomach capacity and diminished release of cholecystokinin (CCK), a hormone secreted by the intestine that promotes the development of satiety. These abnormalities may contribute to the difficulty patients experience in ending a meal before an excessive amount of food has been consumed. We have recently initiated studies of gastric function in bulimia nervosa using a barostat. This machine uses an air-injection system and feedback mechanism to measure volume while maintaining constant pressure in a bag that is inserted into the stomach. When the stomach dilates, air is injected into the bag to maintain pressure; when the stomach contracts, air is aspirated. This device permits the measurement of the relaxation of the stomach, which occurs in response to the introduction of food. We will present new data related to the hypothesis that enhanced gastric reflex relaxation is responsible for the enlarged gastric capacity seen in bulimia nervosa.

No. 24E
ORBITAL FRONTAL SEROTONIN CHANGES IN RECOVERED BULIMICS

Walter H. Kaye, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Room 1086, Pittsburgh PA 15213;* Carolyn Meltzer, M.D., Julie L. Price, M.D., Claire McConaha, B.S.N>, Guido Frank, M.D.

SUMMARY:

Bulimia nervosa (BN), which tends to occur in adolescent women, is characterized by extremes of eating, mood, and impulse control. To avoid the confounding effects of pathologic eating behavior, we studied women after long-term recovery (>1 year no bingeing or purging, normal weight, and regular menstrual cycles) from BN. Subjects were compared with healthy volunteer women.

Recovered BN women had increased levels of CSF 5-HIAA compared with control women (117 ± 33 vs 73 ± 15 pmol/ml; $p \leq .0001$), but normal CSF, HVA, and MHPG concentrations. We used the radio ligand [^{18}F]altanserin, a 5-HT_{2A} receptor antagonist, with positron emission tomography (PET) to assess 5-HT_{2A} receptor binding. We found that recovered BN women had diminished binding of [^{18}F]altanserin to 5-HT_{2A} orbital frontal post-synaptic receptors. Increased CSF 5-HIAA may be a consequence of increased extracellular 5-HT, which may, in turn, account for the reduction of [^{18}F]altanserin binding at the 5-HT_{2A} postsynaptic receptor. That is, increased extracellular 5-HT may compete with [^{18}F]altanserin for binding to and/or down regulate 5-HT_{2A} postsynaptic receptors. We also found that recovered BN women had mild to moderate negative moods, obsessions with perfectionism and exactness, and exaggerated core eating disorder symptoms compared with healthy volunteer women.

Persistent serotonergic and behavioral abnormalities after recovery raise the possibility that these psychobiological alterations may be trait related and contribute to the pathogenesis of BN. In human and nonhuman primates, disturbances of both the orbital frontal cortex and serotonin neuronal activity have been implicated in disorders characterized by either behavioral overcontrol or dyscontrol. These findings raise the possibility that extremes of control and dyscontrol in BN may be related to 5-HT alterations in the medial orbital frontal cortex.

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SYMPOSIUM 25—DEMONSTRATING PSYCHIATRY'S IMPACT ON MEDICAL CARE AND COST

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the scientific and political necessities of demonstrating medical (C-L and primary care) psychiatry's impact on the quality and cost of medical care in both primary and tertiary care settings. The participant will learn about a variety of cost-offset, cost-benefit, and cost-effectiveness studies at the medicine/psychiatry interface.

No. 25A
PROVING MEDICAL PSYCHIATRY IS WORTH ITS COST

Jonathan F. Borus, M.D., *Department of Psychiatry, Brigham and Women's Hospital, 75 Francis Street, Boston MA 02115-6195;* Ar-

thur J. Barsky III, M.D., Lisa A. Carbone, M.D., Alison Fife, M.D., Gregory L. Fricchione, M.D., Sarah L. Minden, M.D., Rais A. Khan, M.D.

SUMMARY:

With today's great cost pressures on academic medical centers, any service that does not earn its own way is in jeopardy. Although appreciated by our med/surg colleagues, medical (C-L and primary care) psychiatry services rarely cover their costs and often find themselves in the position of having to convince financially strapped hospital administrators that psychiatry makes a difference by both improving the quality and impacting the cost of general medical care. At Brigham and Women's Hospital we have found our administrators unimpressed by literature reports of medical offset in studies performed elsewhere ("all politics is local") and have been asked to demonstrate such cost impact at our hospital. We describe methodologic and practical issues we have encountered in conducting a series of studies (retrospective, case-control, prospective, and naturalistic "stealth") over the past five years of the impact of our C-L and outpatient services' work with med/surg patients and their physicians. The findings of these studies and the intertwining scientific and political processes necessary to maintain support for medical psychiatry are explored.

No. 25B
COST-OFFSET FROM PSYCHIATRIC INTERVENTIONS IN MEDICINE

James J. Strain, M.D., *Department of Psychiatry, Mt. Sinai School of Medicine, 1 Gustave Levy Place, New York NY 10029*

SUMMARY:

Cost-offset studies have been undertaken in several medical/surgical settings that demonstrate the cost benefits from psychiatric intervention. In a controlled comparison study (Strain, et al) of 241 elderly hip fracture patients admitted to two separate university hospitals (Mt. Sinai in New York City, Northwestern in Chicago), patients in the group that experienced a psychiatric liaison intervention at admission and throughout the hospitalization were discharged two days sooner, had no rehospitalizations, and fewer rehabilitation days ($p = <.05$). At Mt. Sinai and Northwestern a $20,000 psychiatric intervention resulted in savings of $167,000 and $57,000, respectively. Mental and physical status were improved in the intervention group compared with the controls. Elderly patients with psychiatric comorbidity (Fulop, et al) remained in an acute general hospital two days longer than those with medical/surgical disorders only, resulting in a $1,200 increase in hospital bill per patient. Somatization patients (Smith, et al) showed decreased health care utilization and improved well-being after a psychiatric intervention compared with those receiving standard treatment ($p-<.05$).

Psychiatric interventions in medical/surgical patients who have psychiatric comorbidity result in significant cost offset and improved mental and physical status. These studies will be summarized to suggest future research to examine cost benefit from psychiatric interventions.

No. 25C
PREDICTORS OF DELIRIUM FOLLOWING ABDOMINAL AORTIC ANEURYSM

Sarah L. Minden, M.D., *Department of Psychiatry, Brigham and Women's Hospital, 75 Francis Street, Boston MA 02115;* Lisa A. Carbone, M.D., Arthur, J. Barsky III, M.D., Jonathan F. Borus, M.D., Alison Fife, M.D., Gregory L. Fricchione, M.D., John Orav, Ph.D.

SUMMARY:

We studied the frequency of delirium among patients undergoing surgical repair of abdominal aortic aneurysm (AAA) and whether preoperative depression and/or cognitive impairment were associated with post-operative delirium and slower return of functioning. Thirty-five consecutive consenting patients were assessed before surgery, daily while in hospital, and at one and six months post-op with the Beck Depression Inventory (BDI), Telephone Interview for Cognitive Status (TICS), Charlson Index, CAGE, SF-36, Confusion Assessment Method (CAM), and Memorial Delirium Assessment Scale (MDAS). The delirious and nondelirious patients were compared for severity of depression, length of stay, and functional status at one and six months. Twenty-three percent of patients developed delirium after surgery. Preoperative BDI scores (total, somatic, and psychological subscales) correlated significantly with post-operative delirium and with poorer functioning at one and six months on SF-36 scales. Preoperative CAGE and TICS scores did not correlate with post-operative delirium. Post-operative delirium correlated with longer hospital stay and poorer functioning at one and six months. Since preoperative depression predicted delirium and contributed to slower return to preoperative level of functioning, identification and treatment of patients with depression prior to surgery might reduce the incidence of post-operative delirium and the associated longer hospital stay and slower recovery period.

No. 25D
MENTAL DISORDERS IN PRIMARY CARE AND MEDICAL UTILIZATION

Lisa A. Carbone, M.D., *Department of Psychiatry, Brigham & Women's Hospital, 75 Francis Street, Boston MA 02115-6110;* Arthur J. Barsky III, M.D., John Orav, Ph.D.

SUMMARY:

We describe two approaches evaluating the impact of psychiatric disorders within a teaching hospital-based primary care setting. First, we examined a random sample of 112 primary care referrals (32 men, 80 women; mean age 38 years) to outpatient psychiatry over a one-year period, and ascertained their medical utilization in the year prior and the year following their first outpatient psychiatry appointment. Second, we compared the utilization of depressed and nondepressed medical outpatients in the same primary care setting. The 18-item RAND MHI was administered to consecutive primary care visitors with a questionnaire about psychiatric treatment and use of psychotropic medications; a MHI cut-off of 15 was used to identify clinically significant depression, and medical utilization in the previous year was obtained from the hospital MIS. In the 389 patients studied (115 men, 274 women; mean age 43 years), depression was highly significantly correlated with emergency department visits and outpatient psychiatric visits. A consistent trend of increasing utilization was seen in hospitalizations, emergency visits, and non-mental health visits, with patients without depression having the fewest, those with depression receiving psychiatric services having an intermediate amount, and those with untreated depression having the highest utilization of medical care.

No. 25E
COST-OFFSET VERSUS COST-EFFECTIVENESS: WHICH PARADIGM FOR PSYCHIATRIC TREATMENT TRIALS

Wayne J. Katon, M.D., *Department of Psychiatry, University of Washington, Box 356560, Seattle WA 98195;* Mike Von Korff, M.D.

SUMMARY:

The cost-offset literature that was largely developed in the 1960 to 1980 era suggested that psychiatric treatment of medical patients with distress or DSM-IV psychiatric disorders would lead to overall medical cost savings. Higher mental health costs for psychosocial interventions would be offset by lower medical costs. Most of these data, however, were collected prior to the managed care era and the highest savings in medical costs were in aging patients and in medical inpatient days. In the era of managed care, inpatient days have been markedly decreased for any medical condition and most surgeries are done in ambulatory surgery settings.

Almost all new medical or surgical treatments and technologies are more expensive than older treatments, and their effectiveness is measured by cost effectiveness and incremental cost-effectiveness equations. Cost effectiveness measures the cost of a new treatment over the effectiveness. Effectiveness can be measured in symptoms, function, or years of life, but a qualy measure is recommended so that the cost per qualy can be compared against other new treatments and technologies. Cost-effectiveness equations were developed for large samples but psychiatric studies have begun to apply these equations to effectiveness studies with samples in the 100 to 200 range. Statisticians have critiqued this application because direct costs typically have high standard deviation and wide confidence intervals. These issues will be critically addressed in this presentation.

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SYMPOSIUM 26—NEW TREATMENT TARGETS IN SCHIZOPHRENIA

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant will be able to identify new targets for therapeutic intervention in schizophrenia and describe strategies to assess and treat negative symptoms, cognitive deficits, suicidality, substance abuse, and to alleviate family burden for patients with schizophrenia.

No. 26A
PHARMACOLOGICAL TREATMENT OF NEGATIVE SYMPTOMS

Robert W. Buchanan, M.D., *Department of Psychiatry, Maryland Psychiatric Research, PO Box 21247, Baltimore MD 21228-5567*

SUMMARY:

The traditional emphasis of pharmacological research and treatment has been on the development of effective agents for the reduction of positive symptoms. The growing appreciation of the adverse impact of negative symptoms on social and occupational functioning has led to an increased focus on the pharmacological treatment of these symptoms. However, the majority of previous studies have been limited by the failure to address a series of methodological issues.

In this presentation, a model for investigating the pharmacological treatment of negative symptoms, which places particular emphasis on the importance of isolating persistent negative symptoms, will be proposed. The results of studies with clozapine and new generation antipsychotics and adjunctive agents will be examined in the framework of this model, and the significance of the results will be critically evaluated in light of the methodological limitations of each study.

No. 26B
COGNITIVE DEFICITS AS TREATMENT TARGETS

James M. Gold, Ph.D., *Department of Psychiatry, MD Psychiatric Research Center, PO Box 21247, Baltimore MD 21228*

SUMMARY:

Patients with schizophrenia demonstrate marked deficits across a number of cognitive functions. Certain cognitive functions appear to be differentially related to aspects of functional outcome. This presentation will present data on the role of cognitive impairment in vocational outcome in schizophrenia, and present a conceptual model for the selection of functionally relevant cognitive treatment targets. The literature on cognitive effects of conventional and new generation antipsychotics will be reviewed. This literature suggests that conventional antipsychotic agents have limited cognitive costs or benefits, with some evidence that new generation compounds may offer cognitive benefits that fall short of a normalization of cognitive performance. Thus, even highly effective symptomatic treatment offers limited cognitive benefit, suggesting that the enhancement of cognitive functioning in schizophrenia will require a different pharmacological approach. A practical, brief, office-based method for assessing cognitive effects of treatment manipulations will be presented.

No. 26C
DEPRESSION AND SUICIDALITY AS TARGETS FOR INTERVENTION IN SCHIZOPHRENIA

Wayne S. Fenton, M.D., *Research, Chestnut Lodge Hospital, 500 West Montgomery Avenue, Rockville MD 20850;* Jennifer Crumlish, Ph.D.

SUMMARY:

Suicide is the single largest cause of premature death among individuals with schizophrenia. Furthermore, epidemiologic data indicate that nearly 80% of patients with the diagnosis of schizophrenia will experience a major depressive episode at some time during their lifetime. Data on suicidal behaviors in schizophrenic patients indicate that (1) suicidal ideation is common, but often not communicated, (2) compared with patients with other diagnoses, suicide attempts are often unexpected, (3) up to 75% of patients who die from suicide have seen an apparently unsuspecting clinician within 72 hours of death. The reduction of morbidity and mortality in schizophrenia should include depression and suicidality as targets for both psychopharmacologic and psychosocial treatment. Data on the efficacy of several new pharmacologic agents suggest the possibility of a primary antidepressant effect that may be associated with a reduction in long-term risk of suicidal behaviors. Data on the efficacy of specific psychosocial interventions are not available, although longitudinal studies of risk factors allow identification of high-risk cohorts and high-risk periods. Patients in actuarially defined high-risk groups may benefit from more intensive psychosocial support and clinicians' active efforts to evaluate and elicit suicidality during high-risk periods.

No. 26D
APPROACHES TO SUBSTANCE ABUSE IN SCHIZOPHRENIA

Fred C. Osher, M.D., *University of Maryland, 701 West Pratt Street, 3rd Flr, Baltimore MD 21201;*

SUMMARY:

The co-occurrence of substance use disorders among persons with schizophrenia is well documented in clinical literature. While there has been wide variability of prevalence estimates, the weight of the evidence indicates that the rate of co-occurring substance use disorders is substantially greater than that in general populations (more than four times in the ECA study). Little doubt remains that having co-occurring schizophrenia and substance use disorders is associated with poor outcomes. These include increases in psychiatric symptoms, housing instability and homelessness, medical problems including HIV infection, aggressive and criminal behavior, incarceration, institutionalization, noncompliance with treatment, use of high-cost emergency services, and death. Recent efforts to provide integrated treatment to this subpopulation offer hope that many of the worst outcomes can be averted for the majority of persons with dual diagnoses. Etiologic explanations of the high prevalence rates will be discussed. Principles of care, as well as theoretical and practical treatment strategies, will be presented.

No. 26E
THE NEED AND CHALLENGE OF PROVIDING SERVICES TO FAMILIES

Lisa B. Dixon, M.D., *Department of Psychiatry, University of Maryland, 701 West Pratt Street, Rm 476, Baltimore MD 21201;*

SUMMARY:

The American Psychiatric Association Practice Guidelines and Schizophrenia Patient Outcomes Research Team (PORT) each recommend that families of persons with schizophrenia receive education, support, and help with crises. Family psychoeducational intervention studies with rigorous experimental designs have demonstrated that such programs reduce patient relapse. Some of these programs have also been demonstrated to enhance family well-being. However, PORT data suggest that these programs are rarely delivered to families. Only 31% of patients in treatment who have family contact interviewed in the schizophrenia PORT reported that their families received any education or assistance. While access to effective family intervention is often limited within inadequately funded mental health systems, peer-based programs such as the National Alliance for the Mentally Ill (NAMI) Family to Family Program and the Journey of Hope have been developed. These programs may partially fill in gaps in available services. Our data suggest that they are widely supported by state mental health authorities. Although rigorous data about their effectiveness are limited, such peer-based programs share elements and treatment principles in common with interventions of established efficacy such as providing support, education, and problem-solving skills training as recommended in the PORT treatment recommendations. The mandate to provide families with appropriate services to improve patient outcomes, reduce family burden, and enhance family well-being is a critical current challenge for administrators, clinicians, and payors.

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SYMPOSIUM 27—PSYCHIATRIC WORKFORCE: ISSUES AND CHALLENGES

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to appreciate the magnitude of the psychiatric workforce problem, the underlying assumptions, and their political solutions.

No. 27A
WORKFORCE ASSUMPTIONS: INTERNATIONAL PERSPECTIVE

James H. Scully, Jr., M.D., *Department of Psychiatry, University of South Carolina, 3555 Harden Street Extension, Columbia SC 29203;* Nyapati R. Rao, M.D.

SUMMARY:

Workforce projections are based on either the "need" model or "demand" model. Need-based models have used data from epidemiology and clinical practice and lead to shortage scenarios. Demand-based models are based on payers and managed care and lead to oversupply scenarios. Data from other counties may also be useful. Most developed countries have national health insurance with more central controls and fewer psychiatrists per population than the U.S.

No. 27B
DEFINITION OF A PSYCHIATRIST FOR THE NEW MILLENNIUM

Allan Tasman, M.D., *Dept of Psych & Behav Sci, Univ of Louisville, 500 S Preston St/Bldg A Rm 210, Louisville KY 40292-0001;* Nyapati R. Rao, M.D.

SUMMARY:

One way of estimating the number of psychiatrists needed is by arriving at a consensual definition from the field of knowledge and skills that a psychiatrist should possess with the assumption that such knowledge and skills will influence the way the psychiatrist practices. However, the knowledge and skills deemed important for a psychiatrist continue to change. In 1980, Langsley and Hollender, after surveying psychiatric practitioners and educators, found that a psychiatrist was a clinician whose main skills were in evaluating and treating psychiatric disorders in the context of a one-on-one relationship. A similar survey conducted in 1999 by Langsley and Yager found that greater importance was ascribed by the field to descriptive or bilogical psychiatry and the long-term therapies were

deemphasized. Much has changed since this survey was done and it is germane to reexamine the definition of a psychiatrist. The APA's workforce workgroup recently conducted a survey of the field to understand its current priorities. Dr. Tasman will present the results of the survey and discuss its implications for workforce deliberations.

No. 27C
ESTIMATING WORKFORCE REQUIREMENTS BASED ON PATIENTS' NEEDS

Larry R. Faulkner, M.D., *Office of the Dean, Univ of SC School of Medicine, Columbia SC 29208;* Nyapati R. Rao, M.D.

SUMMARY:

This paper will present a five-step method for estimating psychiatric workforce requirements that is based on patients' needs. Estimates of data pertinent to each step will be used to calculate the total psychiatric workforce requirements for the United States. The method will also be used to estimate the hours of psychiatric service per patient per year that might be available under current psychiatric practice and under a managed care scenario. Depending on the assumptions about data at each step in the method, the total psychiatric workforce requirements for the U.S. population range from about 3,000 to 350,000 full-time equivalent psychiatrists. The key to psychiatric manpower estimation lies in clarifying the assumptions that underlie the specific method used.

No. 27D
PHYSICIAN MALDISTRIBUTION AND THE ROLE OF THE INTERNATIONAL MEDICAL GRADUATES

Nyapati R. Rao, M.D., *Department of Psychiatry, Brookdale Hospital, One Brookdale Plaza, Brooklyn NY 11212*

SUMMARY:

It is stated that the U.S. is suffering from a physician excess, which is being caused by the continued entry of international medical graduates (IMGs) into the U.S. It is believed that these IMGs essentially follow the footsteps of their USMG counterparts in the choice of their specialty and the location of their practice. It is reported that IMGs materially assist in the safety net function of the U.S. health care system by predominantly practicing in inner-city and rural areas. If they are not available to perform this function, there will be serious consequences to the delivery of health care to underserved populations. Psychiatry is especially vulnerable because IMGs constitute 25% of the membership of the APA and approximately 45% of all psychiatry residents. In this presentation, the author will discuss the results of a survey of professional activities of over 100 psychiatrists who graduated from 1968–97 from a residency training program in psychiatry located in an inner-city hospital. The results of this survey will provide the backdrop for an examination of the physician maldistribution problem.

No. 27E
MANPOWER ISSUES: CANADA'S EXPERIENCE

Nady El-Guebaly, M.D., *Foothills Hospital, 1403 29th Street N.W., Calgary AB T2N 2T9, Canada*

SUMMARY:

As in the U.S., human resource issues in Canada remain an ongoing concern. A recent practice profile survey comparing data in both countries identified that psychiatrists in Canada have a higher proportion of female psychiatrists (31.8% vs. 25.1%) and they are slightly younger (49 yrs vs. 51.7 yrs). They work similar hours weekly but spend less time in administrative activities. The progressive curtailment in immigration and overall residency positions is resulting in an aging cohort and enhanced maldistribution. In many cities, regionalization of services has resulted in a migration to private offices and resulting strain on public mental health services. Ongoing attempts to alleviate issues such as maldistribution as well as optimizing the role of the psychiatrist will be presented.

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SYMPOSIUM 28—PSYCHIATRY IN THE SECOND DECADE OF THE HIV PANDEMIC

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to (1) recognize and understand the mechanisms of neurocognitive disorders associated with HIV infection; (2) understand the impact of new antiretroviral therapies on neuropsychiatric disorders; (3) recognize, evaluate, and treat mood disorders associated with HIV; (4) understand the importance of chronic psychiatric disorders, including substance use disorders and chronic mental illness, on susceptibility and transmission of HIV disease.

No. 28A
MECHANISMS AND IMPACT OF HIV NEUROCOGNITIVE COMPLICATIONS

Igor Grant, M.D., *Department of Psychiatry, UCSD & VA Medical Center, 9500 Gilman Drive, La Jolla CA 92093-0680;* Robert K. Heaton, Ph.D., Eliezer Masliah, M.D., Ronald O. Ellis, M.D., J. Allen McCutchan, M.D., J. Hampton Atkinson, Jr., M.D.

SUMMARY:

Neurocognitive disturbances continue to represent one of the most common forms of complication observed at various stages of HIV disease. These complications range from frank dementia (HIV-associated dementia, HAD), and include the less severe syndrome of minor cognitive motor disorder (MCMD), as well as asymptomatic neuropsychological impairment. Although neuronal loss occurs in severe HIV-CNS complications, the actual pathologic basis of the milder forms of neuropsychological impairment may involve damage to the dendritic arbor related either to excitotoxic injury, metabolic

disturbance provoked by abnormal cytokine milieu, or some combination of these influences.

With the advent of PCR techniques to measure plasma and CSF viral burden, the possibility arises of using CSF HIV RNA concentration as an indicator of central nervous system complications. The introduction of highly active antiretroviral treatment regimens, usually involving three drug combinations, has clearly reduced peripheral viral load, and improved both survival and quality of life. It remains an open question whether some of the newer agents—e.g., protease inhibitors—penetrate the blood brain barrier sufficiently to be effective against the neurological aspects of HIV infection.

Despite the fact that neuropsychological findings may be mild in nature, they can have significant impact on everyday life and adaptation, including adherence to treatment, automobile driving ability, quality of life, and even long-term survival.

No. 28B
MOOD DISORDERS IN HIV INFECTION

Constantine G. Lyketsos, M.D., *Department of Psychiatry, Johns Hopkins University, 600 North Wolfe St, Osler 320, Baltimore MD 21287;* Glenn J. Treisman, M.D., Marc Fishman, M.D., Joseph M. Schwartz, M.D., Heidi E. Hutton, Ph.D.

SUMMARY:

Mood disorders, both major depression and mania, are serious accompaniments of HIV infection and AIDS. Population studies suggest that 8% to 10% of HIV-infected patients suffer from current major depression, while clinical studies indicate that 4% to 6% of AIDS patients suffer from a manic syndrome. Rates of major depression and mania are much higher in primary care clinics for HIV-infected persons (20% to 25% for major depression and 8% to 10% for bipolar disorders and mania). Evidence also suggests that the prevalence of depression and mania increase in later stages of HIV infection, around the time of AIDS. The HIV infection itself has been implicated as a cause of the latter. Mood disorders are associated with the continued practice of HIV risk behaviors, with poor adherence to HIV treatment regimens, and with substance abuse. Evidence-based treatment for HIV-associated mood disorders is effective as reported from a wide range of studies. Treatment reduces mental suffering, improves functioning, reduces substance abuse, and improves adherence with HIV medication regimens. This presentation will review data on the epidemiology and treatment of mood disorders in HIV-infected patients.

No. 28C
PSYCHIATRIC ASPECTS OF SUBSTANCE USE DISORDERS AND HIV

Steven L. Batki, M.D., *Department of Psychiatry, University of CA at San Fran, 1001 Potrero Avenue, San Francisco CA 94110*

SUMMARY:

Substance use is a major contributant to the AIDS epidemic, and drug users are increasingly represented among HIV-infected patients. Psychiatric disorders are common, and substance use adds to the complexity of diagnosis and clinical management. Psychiatric symptoms can be endogenous or due to HIV, medications, or drug and alcohol use. Assessment and treatment of psychiatric disorders must take into account three broad elements: medical aspects of HIV disease, substance use, and psychiatric symptoms. Both psychosocial and pharmacological interventions are necessary to address these issues. In addition to psychotherapy, psychosocial treatment needs to include risk reduction counseling and intensive substance abuse counseling. Pharmacological intervention is often essential to managing substance abuse, as in the case of methadone. Pharmacotherapy is also frequently needed for the treatment of psychiatric symptoms, whether primary or secondary to substance abuse or HIV. Finally, pharmacological management of pain is crucial. Pharmacotherapy must take into account drug-drug interactions, the increased sensitivity to adverse effects in patients with HIV, difficulties in adherence to medication regimens, misuse or abuse of medications, and other factors such as diagnostic uncertainty. Guidelines will be presented to assist in the management of the HIV-positive patient with substance use disorders and psychiatric problems.

No. 28D
HIV/AIDS AND THE SEVERELY MENTALLY ILL

Alan Berkman, M.D., *Epidemiology, Columbia University, 601 West 168th Street, #32, New York NY 10032;* Ezra S. Susser, M.D.

SUMMARY:

HIV/AIDS has emerged as a leading cause of mortality and morbidity for men and women with severe mental illness (SMI) in urban areas. Conversely, a substantial portion of persons living with HIV have severe mental illness as a comorbid condition that impacts on the management of their disease. Epidemiological research in urban areas has documented high HIV seropositivity rates in psychiatric inpatients, outpatients, and the homeless mentally ill. Risk behavior studies have documented high-risk sexual activities by a majority of both men and women with SMI, and a lifetime history of injection drug use by 20% to 25% of the men. Social and economic deprivation, as well as cognitive impairment and emotional instability, contribute to these high rates of risk behaviors.

Our team in New York City has successfully applied social skills training to the goal of sexual risk reduction among men with SMI, and we are developing a similar approach for women. Additionally, we are studying the feasibility of incorporating testing and treatment of common sexually transmitted diseases into psychiatric outpatient care. We hope that the combination of behavioral and biomedical interventions will result in a practical and effective strategy for reducing HIV infection among this vulnerable population.

No. 28E
ANTIRETROVIRAL THERAPY OF HIV COGNITIVE DISORDERS

J. Hampton Atkinson, Jr., M.D., *Department of Psychiatry, UC San Diego, HNRC 2760 Fifth Ave, Ste 200, San Diego CA 92103;* Scott Le Tendre, M.D., Ronald O. Ellis, M.D., Robert K. Heaton, Ph.D., J. Allen McCutchan, M.D.

SUMMARY:

Background: Elevated CSF HIV RNA levels are associated with neurocognitive impairment in AIDS. This study investigates the role of CSF HIV RNA as a tool for monitoring antiretroviral effects on the central nervous system.

Methods: In an open-label clinical trial of highly active antiretroviral therapy, 16 adults with HIV-associated minor cognitive motor disorder (MCMD) or dementia, who clinically required a new antiretroviral regimen, were treated with at least two new agents and followed for 12 weeks with neuropsychological testing and measurements of HIV-1 RNA in plasma and CSF. Clinically significant change in neurocognitive function was defined as an average improvement of 0.5 standard deviation units relative to age- and education-adjusted neuropsychological test norms.

Results: Of 16 evaluable subjects (median CD4 count = 190), 50% achieved at least a 0.5 log change in their plasma and CSF RNA. Thirty-one percent of subjects showed clinically significant improvement, 21% deteriorated, and 48% had no change in neurocognitive function. Change in CSF HIV RNA was correlated with change

in neurocognitive score (R = 0.53, p = 0.05) but plasma RNA was not (R = 0.17, p = 0.5). Those with greater than median decrease in CSF RNA were more likely to show significant improvement (Fisher's Exact Test, p = 0.03).

Conclusions: Change in HIV RNA level in CSF, but not plasma, is correlated with change in neurocognitive function. These data support the use of CSF HIV RNA as a monitoring tool in HIV-infected patients with neurocognitive disorder.

No. 28F
PSYCHIATRIC VECTORS OF INFECTIOUS DISEASE

Glenn J. Treisman, M.D., *Department of Psychiatry, Johns Hopkins School of Med, 600 North Wolfe Street, M4-119, Baltimore MD 21287;* Constantine G. Lyketsos, M.D., Marc Fishman, M.D., Joseph M. Schwartz, M.D., Paul R. McHugh, M.D.

SUMMARY:

The HIV epidemic has illuminated the intense risk of untreated psychiatric disorders. The studies described by this symposium demonstrate the comorbid impact of substance abuse disorders, mood disorders, severe mental illness, and dementia both in propagating risk behaviors for HIV infection and complicating treatment, course, and outcome. Of particular importance in managing this epidemic is the nature of Highly Active AntiRetroviral Therapy (HAART)—complex antiretroviral regimens that suppress the infection in more than three quarters of patients able to strictly follow their treatment regimen. Viral suppression increases quality of life, longevity, and function. Effective treatment also decreases immune dysfunction and infection risk to partners. Untreated psychiatric disorders have a negative impact on compliance with medical treatment. Therapeutic optimism is necessary in persuading patients to engage in the complicated task of treatment of both their psychiatric disorders as well as their HIV infection. Outcome studies suggest that the risk for this epidemic will be reduced by this coherent approach.

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SYMPOSIUM 29—DEPRESSION SUBTYPES IN THE GENERAL HOSPITALS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to 1) demonstrate the prevalence and incidence of depression in physically ill patients, 2) outline the various screening methods for detection of depression in this population, 3) delineate the role of the psychiatrist as consultant in the management of depression and other psychiatric disorders, 4) alert the psychiatrist to the frequency of relapse and recurrence after the first episode, and 5) improve antidepressant treatment of patients with major depression in primary care.

No. 29A
MOST FREQUENT DEPRESSIVE DISORDERS IN A GENERAL HOSPITAL

Rodolfo D. Fahrer, M.D., *University of Buenos Aires, J. Salguero 2436, 8 Piso, Buenos Aires 1425, Argentina;* Enrique Ortie-Fragola, M.D.

SUMMARY:

It is well known that depression has a negative effect on the development and prognosis of somatic diseases. However, in spite of their high prevalence among inpatients in general medicine wards, depressive disorders are usually misdiagnosed by the nonpsychiatric physician. This presentation gives the results of a study carried out by the Department of Mental Health, University Hospital, School of Medicine. Objectives are: (1) to determine the magnitude of the phenomenon of misdiagnosis of depressive disorders by the general physician, (2) to evaluate the usefulness of the screening method for detection of depression in general medicine, (3) to establish the most frequent type of depressive disorder and its clinical and psychosocial characteristics, and (4) the therapeutic approach: pharmacologic and nonpharmacologic intervention.

No. 29B
THE CONSULTATION-LIAISON PSYCHIATRIST AND DEPRESSION IN THE GENERAL HOSPITAL

Don R. Lipsitt, M.D., *Mount Auburn Hospital, 330 Mount Auburn Street, Cambridge MA 02238*

SUMMARY:

Consultation-liaison (C-L) psychiatrists in the general hospital are asked to see large numbers of patients for "depression." Only a small percentage of these patients have classic DSM-IV major depression or bipolar illness. Most general hospital patients are referred for a variety of subsyndromal and other depressive constellations that accompany medical illnesses of all sorts, either as dysphoric reactions to hospitalization, fear, or as part of the illness itself. Some depressions are quite self-limited, other longer-lasting depressions are undetected, and some depressions are treated by nonpsychiatrist physicians without consultation. The C-L psychiatrist has an excellent opportunity to demonstrate the interrelatedness of mind and body, the subtlety of some depressive symptoms, and management with both pharmacologic and nonpharmacologic interventions. Opportunities abound to demonstrate to postgraduate physicians and medical students the fine points of distinguishing dementia, delirium, pseudodementia, and depression. This presentation will discuss how the general hospital setting provides a special soil for the C-L psychiatrist to cultivate an appreciation in both patients and physicians of

the utility of psychiatric consultation and management of depression and other psychiatric comorbidities.

No. 29C
RELAPSE AND RECURRENCY AFTER THE FIRST DEPRESSIVE EPISODE

Gerardo Heinze, M.D., *Mexican Insti of Psychiatry, Calzada Mexico Xochimilco 101, Mex Dist Federal 14370, Mexico;* Valerio Villamil, M.D., Jose Cortes, Ph.D.

SUMMARY:

This study included 385 major depression patients diagnosed according to DSM-IV criteria. All patients who attended the outpatient service for at least two years after receiving diagnosis of the index episode (1995–1997) were included. The variables considered in this study were gender, age, comorbidity of the major depression episode according to Axis I and II, number of relapses and recurrences previous to the index episode, and number of relapses and recurrences after the index episode. In 51% of the patients, the index episode was the first episode, in 37.4% it was a recurrence, and in 5.5% it was a relapse. The main comorbidity of Axis I in the index episode was anxiety disfunction in 43% of the patients. Abandonment of the treatment predicts a new episode (odds ratio = 1.86, p = 0.002). Age, gender, and comorbidity of Axis I and II were not predictors of relapse or recurrence. The accumulated probability of a recurrence is 10.1% after three months and 37.3% after 24 months.

No. 29D
FIRST-EPISODE AFFECTIVE DISORDERS WITH PSYCHOTIC FEATURES: OUTCOME

Mauricio F. Tohen, M.D., *MC 541, Eli Lilly and Company, Lilly Corporate Center DC 0538, Indianapolis IN 46285;* Ross J. Baldessarini, M.D., John Hennen, Ph.D., Stephen M. Strakowski, M.D., Carlos A. Zarate, Jr., M.D., Andrew L. Stoll, M.D.

SUMMARY:

Objective: Major affective syndromes with psychotic features are the most prevalent idiopathic psychotic disorders. However, these disorders are rarely studied for treatment response and outcome from illness onset. This study presents two-year outcome data for first-episode affective disorder patients with psychosis.

Method: Extensive assessments at first-lifetime hospitalization (1989–96) and up to 24-months follow-up of 219 subjects yielded outcomes defined by syndromal recovery (lack of DSM-IV current episode) and functional status (vocational and residential status equal to or greater than baseline). Time-to-symptomatic-recovery was assessed by survival analysis and predictors of recovery were identified by multivariate Cox (time to recovery) or logistic (functional recovery) regression.

Results: Syndromal recovery was reached by 49% of subjects within three months, and 95% within 24 months from hospitalization (median = 99 days). Syndromal time-to-recovery rates did not differ significantly by sex or initial illness severity. However, syndromal recovery occurred earlier in patients with onset age greater than 40, were married, had relatively high baseline occupational levels, after short hospitalization or with functional recovery; and occurred later in patients diagnosed with unipolar depression with psychotic features or with onset age less than 26. Functional recovery (37%) was 2.5-times less likely than syndromal recovery and 63% of syndromally-recovered patients had not recovered functionally by two years.

Conclusions: Syndromal recovery was attained by most psychotic affective patients within two to six months after initial hospitalization, but only about one third attained functional recovery by 24 months, indicating that these very common psychotic illnesses carry a grave functional prognosis from the initial episode.

No. 29E
COMORBIDITY FACTORS IN DEPRESSIVE ILLNESS

Pedro Ruiz, M.D., *Department of Psychiatry, University of Texas, 1300 Moursund Street, Houston TX 77030*

SUMMARY:

Depression is an illness that frequently is observed as a comorbid condition with other medical and/or psychiatric disorders. The understanding of this comorbidity factor is a key and central issue in the diagnosis and treatment of patients hospitalized in general hospitals, as well as in ambulatory primary care settings. In this presentation, a review of the most commonly observed depression comorbidity incidences will be presented and analyzed. Hopefully, this type of presentation and discussion will lead to a better understanding of these comorbidity factors and also to a better diagnostic formulation and management of patients suffering from these depressive comorbid conditions. Emphasis will also be given not only to the presence of these depressive conditions in medical illness but in psychiatric illness as well. Given the fact that we are currently diagnosing and treating these comorbid depressive conditions within a managed care framework, it is of vital importance that we know well how to identify and manage them in a most cost-effective fashion.

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2. Tohen M, Stoll A, Strakowski S, Faedda C, et al: The McLean first-episode psychosis project: six-month recovery and recurrence outcome. Schizophrenia Bull 1992;18:273–282
3. Cummings JL: Depression and parkinson's disease: a review. American Journal of Psychiatry, 1992;149:443–454
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SYMPOSIUM 30—THE NEUROSCIENCE OF SEVERE MENTAL DISORDERS
Collaborative Session with the National Institute of Mental Health

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the evidence relating severe mental disorders to neurobiological factors.

No. 30A
EARLY DEVELOPMENTAL EVENTS IN THE REGIONAL IDENTITY OF THE CEREBRAL CORTEX

Pat Levitt, Ph.D., *Neurobiology, University of Pittsburgh, 3550 Terrace St. E1440 BST, Pittsburgh PA 15261;* Kathie Eagleson, Ph.D.

SUMMARY:

In the cerebral cortex, the specification of anatomically and functionally distinct areas establishes a framework that is critical for the formation of appropriate circuits. We have been investigating the molecular mechanisms that control early decisions impacting on the specification of regions of the forebrain that comprise limbic circuits.

These areas are involved in cognition, autonomic regulation, learning, and memory. Our studies implicate specific interactions between growth factors and extracellular matrix in regulating the fate of cortical progenitors. Activation of different members of the erbB receptor family on non-limbic progenitors induces the expression of the limbic system-associated membrane protein (LAMP), a member of the Ig superfamily of cell adhesion molecules that mediates the formation of limbic circuits. This results in permanent, abnormal expression of LAMP by sensory cortical neurons. Most intriguing, a subpopulation of non-limbic cortical progenitors is refractory to stimulation by the ligand that activates erbB3 and erbB4 receptors, while all progenitors respond to activation of the EGF (erbB1) receptor. These studies suggest that a highly complex molecular system has evolved in which intrinsic progenitor cell heterogeneity and regulated environmental signals collaborate to promote specific cell fates at appropriate times in development. Supported by National Institutes of Mental Health MERIT award MH45507.

No. 30B
DEPRESSION: ADVANCES IN POSTMORTEM HISTOPATHOLOGY

Grazyna Rajkowska, Ph.D., *Dept. of Psychiatry, Univ. of Missippi Med. Ctr., 2500 North State St., Jackson MS 39216;*

SUMMARY:

Pharmacological and neuroanatomical studies are beginning to establish that depressive disorders are brain diseases with unique neuropathological features. Profuse neurochemical research suggests that the disruption of monoaminergic neurotransmitter pathways may be critical in the pathophysiology of major depressive disorder (MDD). The prefrontal cortex is hypothesized to be a site of cellular pathology, since this region is a recipient of extensive monoamine projections originating in the brainstem nuclei. Until recently, there have been no systematic histopathological studies on MDD, although neuroimaging studies indicate reduced frontal lobe volume and altered metabolism in MDD. Using an unbiased morphometric method, we found that postmortem brains of MDD subjects had decreased cortical thickness, neuronal sizes, and neuronal and glial cell densities in the rostral orbitofrontal region. Reductions in glial cell density were more prominent in the caudal orbitofrontal and dorsolateral prefrontal cortices. Changes in cell parameters were correlated with the duration of depression in specific layers. These results reveal that MDD is a psychiatric disorder with a distinct cortical histopathology. Our data provide neuroanatomical basis to understand the neuroimaging findings and dysfunctional neuronal circuits in MDD. Parallel studies on cyto- and chemoarchitecture of monoaminergic brainstem nuclei evaluating the same subjects will be outlined. Critical issues such as the precise neuroanatomical localization, the specificity of cortical histopathology with respect to MDD and, properly diagnosed subjects will be addressed.

No. 30C
FUNCTIONS OF THE AMYGDALA IN ATTENTION AND COGNITION

Michela Gallagher, Ph.D., *Johns hopkins University, 3400 North Charles St., Baltimore MD 21218*

SUMMARY:

The amygdala complex has long been implicated in emotion. This presentation will extend that concept to include a role for the amygdala in several aspects of attention and in representational processes tied to motivationally significant cues. Each of these functions depends on the operation of separate amygdala subsystems that interact in different ways with cortex. The basolateral amygdala, in concert with an orbital region of prefrontal cortex, is involved in the acquisition and representation of reinforcement value. The amygdala central nucleus, by contrast, contributes to attentional processing by way of its influence on the basal forebrain cholinergic neurons that innervate posterior cortical regions. These systems provide circuitry that potentially connects the processing of emotional information with other cognitive functions.

No. 30D
EMOTION, MEMORY AND THE BRAIN

Joseph E. LeDoux, Ph.D., *Center for Neural Sci., NY Univ. School of Medicine, 6 Washington Place, New York NY 10003*

SUMMARY:

Considerable progress has been made in elucidating the brain pathways involved in detecting and responding to threatening stimuli, and learning about novel threats. The pathways involve transmission of information from sensory processing areas in the thalamus and cortex to the amygdala. The lateral nucleus of the amygdala receives and integrates sensory information and sends the outcomes of its processing to the central nucleus, both directly and by way of intervening synapses in the amygdala. The central nucleus, in turn, is the interface with motor systems controlling fear responses of various types (behavioral, autonomic, endocrine). Sites of plasticity within this circuitry, and the cellular mechanisms involved, have also been identified. We are beginning to uncover the neural mechanisms, from systems to cellular levels, underlying emotional processing, including emotional learning and memory, at least within the fear system. These advances may lead to more refined definitions of emotional disorders, and hopefully new, more specific approaches to treatment.

REFERENCE:

1. Morphometric methods for studying the prefrontal cortex in suicide victims and psychiatric patients: Annals of the New York Academy of Sciences 1997;863:253–264

SYMPOSIUM 31—DRUG-INDUCED MOVEMENT DISORDERS IN OLDER ADULTS

EDUCATION OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand (1) drug induced movement disorders in older patients, (2) use of typical and atypical antipsychotics in older patients, (3) incidence and risk factors of tardive dyskinesia, in older patients, (4) role of ethnicity in tardive dyskinesia, (5) spontaneous and drug induced Parkinsonism in Alzheimer's disease patients.

No. 31A
AN OVERVIEW OF COMMON DRUG-INDUCED MOVEMENT DISORDERS

Sanjay Gupta, M.D., *Department of Psychiatry, Olean General Hospital, 2221 West State Street, Olean NY 14760*

SUMMARY:

This presentation will provide an overview of the movement disorders in older patients. Movement disorders may be classified into hypokinetic disorders (akinesia and bradykinesia) and hyperkinetic disorders, which involve excessive motor activity in the form of involuntary movements. Basal ganglia anatomy and physiology will be briefly reviewed, as many of the movement disorders are thought to result from basal ganglia dysfunction.

The differential diagnosis of various choreiform movement disorders such as spontaneous orofacial dyskinesias, edentulous orodyskinesias, senile chorea, and tardive dyskinesia (TD) will be discussed. Assessment, monitoring, and management strategies of TD will be reviewed.

No. 31B
TARDIVE DYSKINESIA: TYPICAL VERSUS ATYPICAL ANTIPSYCHOTICS

Dilip V. Jeste, M.D., *Department of Psychiatry, University of CA at San Diego, 3350 La Jolla Village Drive, San Diego CA 92161;* Laurie Lindamer, Ph.D., Jonathan P. Lacro, Pharm.D., Hoang A. Nguyen, M.D., Michael Caligiuri, Ph.D., Mihaela E. Petersen, M.D., M. Jackuelyn Harris, M.D.

SUMMARY:

Objective: To study the cumulative incidence of and risk factors for tardive dyskinesia (TD) with conventional and atypical antipsychotics in older psychiatric outpatients.

Design: Prospective longitudinal.

Participants: Over 450 middle-aged and elderly (mean age 65 years) patients with schizophrenia, dementia, mood disorders, or other conditions with psychotic symptoms or severe behavioral disturbances. The patients did not meet criteria for TD, and many were early in the course of drug treatment at study entry.

Measurements: Mini-Mental State Exam, Brief Psychiatric Rating Scale, Simpson-Angus scale for extrapyramidal symptoms, and Abnormal Involuntary Movement Scale were administered at baseline, one month, three months, and every three months thereafter. The diagnosis of TD was based on specific research criteria. The interrater reliability of the rating scales used was high. Medications were used in an individualized fashion, employing the lowest effective doses.

Results: Survival analysis revealed that patients treated with conventional neuroleptics had an approximately 30% cumulative incidence of TD with one year of treatment. The most significant predictor of TD risk was cumulative amount of conventional neuroleptics. The risk of TD was significantly lower with atypical antipsychotics such as risperidone.

Conclusion: The atypical antipsychotics are significantly safer than the conventional neuroleptics in terms of TD in a high-risk group of older patients.

No. 31C
PROSPECTIVE STUDY OF TARDIVE DYSKINESIA IN THE ELDERLY

John M. Kane, M.D., *Department of Psychiatry, Hillside Hospital, 75-59 263rd Street, Glen Oaks NY 11004-1150*

SUMMARY:

This study was designed to determine the incidence of tardive dyskinesia in elderly patients beginning treatment with antipsychotic medication and to identify risk factors for tardive dyskinesia development in this age group.

Method: A total of 261 antipsychotic, drug-naive patients age 55 or above were identified at the time they were starting antipsychotic treatment. Patients were examined at baseline and at three-month intervals. The cumulative rate of tardive dyskinesia was 25% at one year and 34% and 53% at two and three years, respectively. Increased risk of TD was associated with history of ECT treatment, increased mean and cumulative antipsychotic dosage, and presence of early occurring extrapyramidal side effects. Patients participating in this study were treated with conventional antipsychotics.

Conclusion: Tardive dyskinesia rates in older individuals are three to five times higher than that observed in younger individuals.

No. 31D
DYSKINESIA AND ETHNICITY IN ELDERLY SCHIZOPHRENIA PATIENTS

William B. Lawson, M.D., *Department of Psychiatry, Roudebush VAMC, 1481 West 10th Street (116A), Indianapolis IN 46202;* Craig N. Karson, M.D.

SUMMARY:

Elderly schizophrenic patients scoring in the dementia range on neuropsychological testing had been reported to have a greater risk for developing tardive dyskinesia. In view of the increased risk of tardive dyskinesia in African Americans, we studied 151 elderly (>60 y.o.), Caucasian (78%) and African American (22%) schizophrenic patients. Subjects were from a state psychiatric hospital, a Veterans Administration Medical Center (VAMC) neuropsychiatric facility, and various nursing home facilities. Seventy percent of these schizophrenic patients scored in the dementia range on neuropsychological testing. The demented patients were more likely to have tardive dyskinesia. Dementia was more common in African Americans, but this difference disappeared when educational level was controlled. African Americans were also more likely to have tardive dyskinesia (67% vs. 44%; Chi Square = 4.4, $p < .05$). African Americans were on a nonsignificant higher mean dose of antipsychotic. In a subsequent study of demented elderly in nursing homes *without* schizophrenia, no ethnic differences in movement disorders were seen. Ethnicity appears to be an additional risk factor for the development of tardive dyskinesia in schizophrenia. Additional research needs to be done to determine if well-documented ethnic differences in treatment may be responsible.

No. 31E
NEUROLEPTIC-INDUCED PARKINSONISM IN ALZHEIMER'S DISEASE

Robert A. Sweet, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 Ohara Street, 12th Floor, Pittsburgh PA 15213-2593;* Benoit H. Mulsant, M.D., Jules Rosen, M.D., Bruce G. Pollock, M.D.

SUMMARY:

When typical neuroleptics are used in the treatment of psychosis and agitation in patients with Alzheimer's disease (AD) they demonstrate only moderate efficacy. Moreover, neuroleptic-treated AD patients develop parkinsonian symptoms at neuroleptic doses that are low relative to usual therapeutic doses, with nearly universal parkinsonian symptoms when doses exceed 200 mg CPZE/day. We and others have hypothesized that neuroleptic efficacy in AD may be limited, in part, because neuroleptic treatment is interrupted by the development of neuroleptic-induced parkinsonism. This presentation will review data from a series of studies that demonstrate that AD patients have higher rates of spontaneous extrapyramidal symptoms than similarly aged neuropsychiatric controls diagnosed with major depression or schizophrenia. When compared with elderly neuropsychiatric controls diagnosed with psychotic major depression, AD patients are more sensitive to the development of neuroleptic-induced parkinsonian symptoms, despite use of lower neuroleptic doses for briefer durations in the AD group. Finally, preliminary data addressing possible biologic correlates of the sensitivity to neuroleptic-induced parkinsonism among AD patients will be presented. Specifically, we are currently examining whether there is selective loss of dopamine receptors subserving motor, but not psychotic, symptoms in AD subjects. We will also present preliminary data regarding selective dopamine receptors in the subgroup of AD patients with cortical Lewy bodies.

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3. Lawson WB: Clinical issues in the pharmacotherapy of African Americans. Psychopharmacology Bull 1996;32:275–281
4. Sweet RA, Mulsant BH, Pollock BG, Rosen J, Altieri LP: Neuroleptic-induced parkinsonism in elderly patients diagnosed with psychotic major depression and dementia of the Alzheimer type. American Journal of Geriatric Psychiatry 1996;4:311–319

SYMPOSIUM 32—VIOLENCE, SOCIAL CHANGE AND WOMEN'S HEALTH
The World Psychiatric Association's Task Force on Violence

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize the impact of violence and social change on women's health and to make appropriate preventive and treatment interventions.

No. 32A
SOCIAL AND CLINICAL ASPECTS OF BATTERED WOMEN SYNDROME

Tatyana Dmitrieva, *Serbsky Institute, Kropotinskaya 23, Moscow 119839, Russia;* E. Kachaeva

SUMMARY:

Domestic violence against women is a burning problem in Russia and reflects clinical and social factors. It is hidden in statistical items, which guarantee that the problem stays invisible. The clinical picture of battered women syndrome is presented by different depressive symptoms. Meanwhile the problem also includes criminal aspects because a woman, being exposed to violence in the family, becomes a source of violence herself. This shows the necessity of the prevention of suicide as well as of serious violent crimes (murder of children and close relatives) caused by morbid "altruistic" motivation. Thus, the problem integrates in the WHO general scientific concept of "violence cycle."

No. 32B
BROKEN HEARTS: ISCHEMIC HEART DISEASE, DEPRESSION AND GENDER

Donna E. Stewart, M.D., *Women's Health, The Toronto Hospital, 200 Elizabeth Street, EN 1-222, Toronto, ONT M5G 2C4, Canada;* Susan E. Abbey, M.D., M. Irvine, Z. Shner, P. Daly, S. Bisaillon

SUMMARY:

Women are much more likely than men to die after their first myocardial infarction and to be underdiagnosed, undertreated, and have a poorer quality of life. This study examined over 50 men and women admitted to a Canadian intensive coronary care unit (CICU) with myocardial infarction or unstable angina who completed a self-report questionnaire on demographics, symptoms, risk factors, and depression (BDI).

Forty percent of the patients were women. The average age was 62.7 years (SD ± 10.38) with no gender difference. Women reported significantly more symptoms than men in the month prior to and at the time of CICU admission including shortness of breath, fatigue, numbness or tingling, sweating, nausea, "battery losing power," lightheadedness, chest pain into neck and jaw, faintness, and left arm pain without chest pain ($p = .05$). At the acute event, over 42% of patients of both sexes waited over three hours before seeking medical care. Women were more likely than men to have their symptoms occur without physical or emotion stress ($p = .02$), and to score in the depressed range on BDI (51.8% vs. 40.7%) ($p = .05$). Nine of ten patients who died scored high on BDI.

As heart disease is the leading cause of death in North American women, it is vital that we identify the early symptoms and comorbid conditions such as depression, which may affect outcomes. Better education of women and their doctors is required to improve diagnosis and prognosis in coronary artery disease.

No. 32C
VIOLENCE AGAINST WOMEN IN EGYPT: A READING IN THE EGYPTIAN CONTEXT

Aida Self El Dawla, M.D., *Okasha Hospital, 3 Shawarby Street, Cairo, Egypt*

SUMMARY:

The author reviews the findings of a field research undertaken by two nongovernmental organizations in Egypt on 450 women and 100 men. The research methodology involved a questionnaire, a checklist, and 10 personal in-depth interviews with 10 women of variable social class and educational level. The research aimed to investigate the prevalence of exposure to violence in the studied sample, whether in the domestic sphere, in the workplace, or in the public space. It also looked into women's perception of violence against them, challenging the widespread notion that violence against women is an accepted cultural norm in our context. A checklist of several forms of domestic violence, both physical and psychological, was given out to married women in the sample to investigate their own exposure.

Results of the research indicated that women's exposure to violence was not a rare incidence, at least within the sample studied, that violence extended through the different spaces of existence of women, from the private to the public, and within the various relations: daughter, wife, sister.

Results of the male sample provided support to the findings from the women sample. The findings also revealed that exposure to violence cuts across social class and education, challenging the notion that violence against women is a problem of the poor and underprivileged. Many of the women, however, expressed emotional or cognitive acceptance for that behavior. Several factors determine a woman's reaction to her exposure to violence, some of which will be discussed in the paper.

No. 32D
GLOBAL VIOLENCE AGAINST WOMEN AND CHILDREN

Marianne C. Kastrup, M.D., *Huidoure Hospith, Brondebyosterves 160, Copenhagen 2650, Denmark*

SUMMARY:

An increasing number of people are likely to be subject to various kinds of violence during their lifetime. Women and children represent vulnerable groups who, for several reasons, are in a less favorable position—also with respect to risk for violation. Violence may be related to and take its origin in several conditions including govern-

mental human rights violations, refugee status, civil strife, gang crime, and domestic malfunctioning.

Of particular concern is the widespread documentation of organized violence against women and children, ranging from simple harassment to the most severe forms of torture. Worldwide the consequences hereof represent a major public health problem with a severe psychiatric component.

An overview will be given regarding the epidemiology of human rights violations, the most prevalent methods used, the sequelae to mental and physical health, and the rehabilitative models developed. Preventive measures on primary, secondary, and tertiary levels will be outlined.

No. 32E
VIOLENCE: A GLOBAL PUBLIC HEALTH, BEHAVIORAL HEALTH AND PRIMARY CARE CHALLENGE

Eliot Sorel, M.D., *Department of Psychiatry, George Washington Sch of Med, 2021 K Street NW, Suite 206, Washington DC 20006-1003*

SUMMARY:

Violence has become a global public health challenge. The consequences of the violence epidemic have affected women and children significantly. Homicide is the leading cause of death for young American males ages 15–24.

The violence epidemic has challenged emergency medicine, public health, psychiatry, and primary care medicine to develop new diagnostic, preventive, and treatment interventions. It also challenges the professions to cross-specialty collaboration and complementarity regarding research, training, treatment, and services.

Policymakers and the media until recently have focused primarily on the legal and law enforcement aspects of violence and its consequences. Enhanced communication, collaboration, and education of policymakers and the media by health care professionals and advocates are now resulting in innovative policy initiatives in the United States.

The author presents a public health model responsive to the violence epidemic and its traumatic *sequelae*. It is buttressed by epidemiologic, etiologic, and primary, secondary, and tertiary prevention concepts applicable across cultures, the life cycle, and genders.

REFERENCES:

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3. Sorel E: Urban violence in the United States. Social Psychiatry 1994;1:8–11
4. Stewart DE, Robinson GE: Violence and women's mental health. Harvard Review of Psychiatry 1996;4:54–57
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SYMPOSIUM 33—UNDERSTANDING SCHOOL VIOLENCE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the causes of school violence as well as various solutions proposed for this important problem.

No. 33A
TRENDS IN SCHOOL VIOLENCE

Kathleen M. Fisher, Ph.D., *Department of Nursing, Penn State University, 20 Briarcrest Square, Hershey PA 17033*

SUMMARY:

School violence captured the attention of the media over the last two years. Forty people were killed on school property during the 1997–1998 school year.

While the media has focused attention on this problem, the question remains—is school violence more of a problem than in previous years? How big of a problem is it?

Fifty-seven percent of public schools reported one or more problems with crime or violence during the 1996–1997 school year. A total of 100,000 students carry a gun to school every day. While these data are alarming, there is no significant change from 1989 to 1995 in the number of students who reported being robbed, or who experienced physical attacks at school. The 40 deaths at school are about the same as for the 1992–1994 school years. Nonviolent crimes continue at about the same rate as in 1989.

The statistical trends of violence in our public schools as well as youth homicide rates over the last decade will be examined.

No. 33B
A TYPOLOGY OF SCHOOL VIOLENCE

Lois T. Flaherty, M.D., *University of Pennsylvania, 770 Lantern Lane, Blue Bell PA 19422-1612*

SUMMARY:

The high prevalence of violence exposure among inner-city youth has been recognized for over 10 years. More recently the consequences of this exposure in terms of psychiatric morbidity, perpetuation of a cycle of violence, and impaired academic functioning have been recognized, and various interventions have been developed to address the problem. School violence can be understood both as a problem of the social environment of the schools as well as a problem of violence-prone individuals and those youngsters likely to be victimized. This presentation will focus on the characteristics of schools and of high-risk youngsters that predispose to higher rates of violence and violence exposure. It will discuss the implications for intervention based on what we know about risk and will briefly summarize the types of interventions that have been tried.

No. 33C
BIOLOGICAL AND CULTURAL CAUSES OF VIOLENCE

Paul A. Kettl, M.D., *Department of Psychiatry, Penn State University, PO Box 850, Hershey PA 17033-0850*

SUMMARY:

The search for a cause for the perplexing problem of violence in children has largely focused on psychological factors within the child and his family. However, a small amount of data also exists that supports the notion of physiological and cultural factors in the genesis of violent behavior.

In this presentation, we will examine the data on biological factors that could predispose to violence. Of the many factors studied, circulating low serotonin levels and the presence of psychiatric disorder (attention deficit disorder, mental retardation, schizophrenia, bipolar disorder, and substance abuse) are associated with higher rates of violent behavior.

Culturally, the experience of violence through the media is a prominent social cause of violent behavior. Children spend more time watching television than any other waking behavior. The content

of that television entertainment is often violent with no clear cause or message of punishment for the perpetrator. The use of a television history in a clinical interview with a violent child will be explored.

No. 33D
VIOLENCE PREVENTION IN CHICAGO PUBLIC SCHOOLS

Carl C. Bell, M.D., *Community Mental Hlth Council, 8704 South Constance Avenue, Chicago IL 60617-2746;* Sue Gamm, Ph.D., Paul Vallas, Phillip Jackson

SUMMARY:

The three components of the Chicago Board of Education's Safe Schools/Safe Neighborhoods initiative will be presented: (1) school-based programs consisting of CPS Bureau of Safety and Security, metal detectors, surveillance cameras, security personnel, Light-house/after school programs, summer school programs, character education, ROTC programs, uniform discipline code, zero tolerance, church/school partnership, Operation S.A.F.E. (Schools Are For Education), Safe Bet, S.M.A.R.T. (Saturday Morning Alternative Reach Out and Teach) program, school uniforms, truancy prevention, alternative schools, and crisis intervention; (2) community center programs/routes to and from school consisting of parent patrols, parent attendance officers, interfaith partnership service programs, CPS local hiring programs (Parents as Teachers First), community service programs, Safe Passage, mayor's summer employment program, Chicago Park District Program, library Razzle Dazzle Summer Reading, Violence Prevention Task Force, and adult education program; and (3) Summer Safe Schools, Safe Neighborhoods consisting of Interfaith Partnership, violence intervention program specialists, job referral and training program, peace marches and rallies, media campaign, and community forums on violence (anti-violence and conflict resolution training. Each program will be briefly summarized with the numbers of students in each program and some preliminary outcome results.

No. 33E
PROBLEMS OF AND SOLUTIONS FOR SCHOOL VIOLENCE

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

SUMMARY:

The murders of children and teachers in schools by other children has caused a "panic" reaction in the United States, with enormous backlash from conservatives who now want to try 10-year-olds as adults and incarcerate everyone. The reaction in state capitals of mostly rural states is to forget the problems of urban children. In general there is a blanket over-reaction to these unusual and rare incidents.

The American Psychiatric Association Task Force on the Psychiatric Aspects of Violence has reviewed this matter and details of their discussions will be brought forward. In addition, a dialogue with the attorney general of the State of Pennsylvania will be outlined so that a better understanding of what psychiatrists have to deal with will be an important part of this talk. In addition, there is some suggestion about the psychological problems of children in schools that contribute to violence and certainly the ultimate solution—which consists of better parenting, a reduction of corporal punishment, and more love in the home—needs to be promulgated in our country.

Solutions such as school-based interactive discussions of at-risk children, identifying at-risk children, and better cooperation between and among agencies will be discussed.

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4. Bell CC: Community violence violence: causes, prevention and intervention. Journal of the National Medical Association 1997;89(10):657–62

SYMPOSIUM 34—CULTURAL AND LANGUAGE CONSIDERATIONS IN DIAGNOSIS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the audience should have acquired an increased sensitivity to a range of language and cultural barriers to accurate psychiatric diagnosis.

No. 34A
VALIDATION OF A STRUCTURED INTERVIEW IN EUROPEAN SETTINGS

Yves Lecrubier, M.D., *INSERM U302 Pav Clerambau, Hopital del la Salpetriere, 47 boulevard de l'Hopital, F-75023, Paris, France*

SUMMARY:

Treatments offered to psychiatric patients in Europe refer to ICD-10 or DSM-IV. This increased the necessity for developing the use of diagnostic structured interviews. Since most of them do not check for DSM (or ICD) criteria, the MINI was developed in order to explore 17 core diagnoses plus optional sections. The initial version (French and English) was validated in psychiatric settings against the CIDI.

Due to the heterogeneity of languages and health care systems in Europe, the MINI was proposed to GPs of four different countries in order to evaluate its use in primary care and to compare the diagnosis of GPs with that of an expert in the same patients.

- The validation in psychiatric setting showed an excellent diagnostic performance.
- The comparison between experts and GPs' diagnoses was different from country to country but overall much improved in comparison with the usual figures. The negative predictive values were ≥ .90 for most disorders in all countries, more variability was observed for positive predictive values: these findings will be discussed.
- In GPs settings, results outline the importance of first using the screening questions (5–10) followed by a full assessment of the sections previously identified at the next visit. The positive predictive value of the screening questions was about .68 and the negative predictive value of the screening questions was .85.

No. 34B
RUSSIAN LANGUAGE ASSESSMENT OF MENTAL ILLNESS

Alexander Bystritsky, M.D., *Department of Psychiatry, UCLA, 300 UCLA Medical Plaza, #2200, Los Angeles CA 90095;* Marina Bystritsky, M.A.

SUMMARY:

Assessment of a patient in the Russian language using current DSM classification may present many difficulties. The challenges usually relate to the lack of direct translation possibilities due to differences in vocabulary as well as differences in expressivity and culture. Nevertheless, the translation of English instruments into Russian is possible if the above factors are addressed. The authors present an easy translation of two psychological assessment instruments: the ADIS (Anxiety Disorders Interview Schedule) DSM-III-R and MINI. In addition, the authors will present the results of a pilot survey of recent Russian emigrants in Los Angeles using the translated and adapted ADIS. The difficulties of translation and the results of the survey as compared with the National Comorbidity Study will be discussed.

No. 34C
THE PSYCHIATRIC ASSESSMENT OF ARAB PATIENTS

Ossama T. Osman, M.D., *Department of Psychiatry, Mercer University, 1550 College Street, Macon GA 31207*

SUMMARY:

The Arab culture represents the values, customs, heritage, beliefs, and norms of ethnically varied groups of people (in excess of 250 million), which are united with a poetic common language in the Middle East. Arabic is the official language in *23 countries,* spanning an area that extends from the Arabian peninsula and across all North Africa to the Atlantic Ocean. It has remained essentially unchanged since the 7th century and it is the language of Koran. The origin of each Arabic word is a word root composed of three consonants. The shifting vowels give auxillary meanings. The word root for madness (*Jnon*), mentally ill (*Majnon*) is J-N-N, which conveys several meanings among which is a general meaning of concealment or hiding. A strong cultural stigma against mental illness remains a common attitude. The fear from persons afflicted with mental illness leads to their exclusion from societal activities. Ancient cultural values play a primary role in shaping current practices in individual Arabic speaking societies. Arab culture incorporates gender, education, religion, geographic location, and socioeconomic factors. These cultural views and practices are contradictory to Islamic religious teachings. Islam recognizes people with mental illness or mental retardation as needing continued wrap-around support from society. Under Islamic law, severely impaired persons with mental illness or mental retardation still have their legal rights protected. The following will be outlined in this presentation: (1) conflict between culture and religion, (2) the taboo of sex and addiction, (3) defining the boundaries of normality.

No. 34D
PSYCHIATRIC DIAGNOSIS AND STRUCTURED INTERVIEWS IN HEBREW

Raphael E. Barda, M.D., *495 Frable Road/PO Box 1588, Brodheadsville PA 18322;* Ilan Levinson, M.D.

SUMMARY:

Using an English-based structured interview in the Hebrew language represents a particularly challenging task, as witnessed by the presenter during the translation of a structured diagnostic interview for DSM-IV and ICD-10.

These difficulties result among other reasons from the fundamental differences that exist between the Hebrew and English languages as well as from the political and cultural aspects of Israeli life.

The task was rendered more difficult by the absence of a well accepted Hebrew version of the DSM-IV and the pervasive use of foreign terminology in the Israeli medical community.

Using lay language to describe mood states and psychiatric symptoms while preserving the spirit of questions was a critical element of the translation and took precedent over the desire to obtain an accurate translation of the English questions.

The presentation will focus on the above difficulties and the solutions that were adopted in order to achieve a valid and reliable structured psychiatric diagnostic interview in Hebrew.

No. 34E
DIAGNOSTIC CHALLENGES IN SOUTHERN AFRICAN LANGUAGES

Kerunne Ketlogetswe, *Swarthmore College, 500 College Avenue, Swarthmore PA 19081*

SUMMARY:

Translation into the African languages tends to remain confined among the traditional favorites, such as Swahili or Zulu. In wishing to further understand the challenges posed by a variety of languages in the implementation of global, standardized psychiatric diagnosis, Setswana presents itself as a useful example. A member of the Bantu group of Benue-Congo languages and spoken by an estimated four million people in Botswana and South Africa, Setswana provides a small, yet pertinent gateway into viewing the many facets and nuances of the African language, and the difficulties it can pose for those aiming at translation. In addition, due to the close relation of the language families of Africa, Setswana is a favorable model for providing insight to the cultural barriers that, to some extent, are pan-African.

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SYMPOSIUM 35—PHARMACOLOGY INTERVENTION IN WOMEN AT RISK FOR INFANTICIDE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At completion, the participant should be able to inquire into and recognize infanticidal ideation and symptoms of postpartum psychosis and neonaticide syndrome, and make appropriate diagnosis, and recommendations for treatment.

No. 35A
PREVENTION AND TREATMENT OF POSTPARTUM MOOD DISORDERS

Katherine L. Wisner, M.D., *Department of Psychiatry, Case Western Reserve Univ, 11400 Euclid Avenue, Suite 280, Cleveland OH 44106*

SUMMARY:

Investigators have identified the postpartum period as one of increased risk for the onset of serious mood disorder. Postpartum depression occurs in 10% to 15% of women, and occurs in two to three per 1000 deliveries. Postpartum disorders are associated with both suicide and infanticide.

Rapid identification and provision of effective treatment is imperative. Our research group has investigated the Edinburgh Postnatal Depression Scale, (EPDS), a 10-item, self-report measure to screen women for postpartum disorders. Against a standard of research diagnostic criteria, the EPDS had excellent sensitivity and specificity. Selection of treatment options for postpartum mood disorders is based upon past response to treatment, severity of the episode, presence of breastfeeding, and patient preference. Both antidepressants and mood stabilizers can be judiciously used to treat women who are breastfeeding.

Women who suffer from one episode of postpartum disorder are at risk to develop the illness after subsequent births. Although treatment is effective, prevention is optimal. Randomized clinical trials to prevent postpartum episodes are being conducted by the author and will be described. The minimum standard of care for women who have a history of major depression should be monitoring in the post-birth period for recurrence. Consideration should be given to prophylactic psychotropic treatment in women with highly recurrent forms of mood disorder.

No. 35B
MATERNAL INFANTICIDE

Phillip J. Resnick, M.D., *Department of Psychiatry, University Hospital, 11100 Euclid Avenue, Cleveland OH 44106*

SUMMARY:

This presentation will give an overview of mothers who kill their infants. "Infanticide" is a general term used for child murder. "Filicide" refers to cases in which the murderer is a parent of the victim. "Neonaticide" is the killing of a newborn on the day of its birth.

Mothers who commit filicide after the first day of a child's birth often suffer from psychosis or postpartum depression. Filicides may be "altruistic," done in association with a mother's suicide or to relieve the perceived suffering of the victim. The "accidental" filicide is a fatal "battered child syndrome." "Spouse revenge filicide" is done to deliberately bring suffering to the marital partner.

When mothers who commit neonaticide are compared with mothers who kill older children, they are found to be younger, more often unmarried, and much less frequently psychotic. Whereas the majority of maternal filicides are committed for "altruistic" reasons, most neonaticides are carried out simply because the child is not wanted. Illegitimacy, with its social stigma, is the most common motive. Some teenagers have a particularly difficult time telling their mothers that they are pregnant.

No. 35C
INFANTICIDE: AN EPIDEMIOLOGICAL PERSPECTIVE

Paula M. Bortnichak, M.D., *28 Rose Lane Sparta NJ 07871-3163*

SUMMARY:

Infanticide has existed throughout human history. In biblical times infants were sacrificed to pagan gods and ancient cultures used infanticide for population control by exposing newborns to the elements. Pharaohs prevailed on Hebrew midwives to slay male children, and Chinese culture endorsed the dumping of live infant girls into pits outside the city of Peking. Early legal systems sought to differentiate, at least in terms of punishment, the level of criminality involved in the categories of child murder by a nonparent, a parent (father vs. mother), or by an unwed mother. The law tended to favor fathers over mothers, and married mothers over those who were unwed. The latter were most likely to be viewed in the category of madness, and were in some cultures considered as witches. For example, in the 16th century, the Roman punishment for unmarried women who were thought to have murdered their infant was "sacking," in which the woman, a dog, a cock, and a snake were placed in a leather sack and thrown into the water. Russia, in 1647, was the first country to adopt a more humane position, and several western countries followed suit. The British Infanticide Act of 1938 acknowledged a direct link between the act of infant killing and the mother's intra- or postpartum state of mind. It is this link that is the subject of current controversy in the United States, where approximately 200 cases of neonaticide are reported annually. The actual incidence of neonaticide is not known. The acceptance of a syndrome linking maternal state of mind with the neonaticidal act, i.e., the "neonaticide-dissociative syndrome," may allow for a better defined epidemiology of the condition to emerge over time. Such identification of the syndrome is likely to lead to models for psychological and pharmacological intervention; recognition may pave the way for prevention, which has not been favorably affected by the threat of punishment by the law.

No. 35D
MOTHERS WHO KILL: NEONATICIDE AND THE LAW

Michelle Oberman, J.D., *Law School, DePaul University, 25 East Jackson Boulevard, Chicago IL 60604*

SUMMARY:

Infanticide occurs on a surprisingly routine basis in contemporary American society. And yet, despite its relatively commonplace nature, Americans are loathe to recognize the patterned nature of this crime, and instead tend to perceive each story as isolated, as disconnected from—rather than consisted with—what we know about human society.

This paper explores modern infanticide, in particular, neonaticide, by tracing a collection of cases gleaned from media reports from 1988–1995. The cases depict a distinctly patterned phenomenon, with marked similarities in the lives of the mothers at the time of their infants' deaths. Furthermore, by reviewing the criminal justice resolution of these cases, the author identifies a pattern of inconsistent treatment, wherein the rhetoric of moral outrage expressed against these women by society at large, and by judges and juries in individual cases, is accompanied by an equally strong resistance to equating these homicides with murder.

This paper demonstrates that the tendency to view neonaticide as less heinous than other forms of homicide is consistent with the treatment given this crime in other contemporary societies, as well as historically. Furthermore, by exploring the ways in which neonaticide cases tend to be exceptional, the impulse toward mercy becomes comprehensible. However, the author concludes that the American pattern of over-charging and under-convicting these defendants contributes nothing toward the important task of identifying girls and women at risk of committing neonaticide and reaching them with help prior to the time of childbirth. The paper concludes with cautionary suggestions about preventing neonaticide targeted toward health care professionals and others who work with adolescent populations.

No. 35E
NEONATICIDE IN AMERICA: A SYSTEMATIC INVESTIGATION

Margaret G. Spinelli, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street/Box 14, New York NY 10032;*

Katherine L. Wisner, M.D., Phillip J. Resnick, M.D., Michelle Oberman, J.D., Paula M. Bortnichak, M.D.

SUMMARY:

The act of infanticide, often subject to misrepresentation in the literature, has never been systematically studied. Neonaticide is defined as the murder of a neonate on the day of its birth. In most countries, infanticide and neonaticide are judged to be the result of an altered mental status at the time of delivery. In the United States, neonaticide, like homicide, remains a crime against society. While these acts remain the subject of psychiatric and judicial debate, women in America are incarcerated.

Fourteen women alleged to commit neonaticide, were interviewed in preparation for expert psychiatric witness testimony. These women had similar precipitants and symptoms to include dissociative disorder, denial of pregnancy, antepartum depression, unassisted deliveries, and amnesia for the alleged offense. Some experienced dissociative hallucinations and psychosis. During the trauma of labor and delivery many experience a brief reactive dissociative psychosis.

This paper identifies a complexity of symptoms and precipitants that may establish the existence of a neonaticide dissociative syndrome. Identifying such a syndrome may provide necessary psychiatric evaluation and prevention for women who are otherwise lost to the penal system.

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SYMPOSIUM 36—WORKING IN A FLAWED SYSTEM: THE ETHICAL DILEMMAS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of the symposium, the participant should be able to appreciate the nature of the ethical dilemmas in working in flawed psychiatric systems.

No. 36A
THE ETHICS OF WORKING IN A FLAWED HEALTH CARE SYSTEM

Stephen A. Green, M.D., *Department of Psychiatry, Georgetown University, 5410 Connecticut Avenue NW, Washington DC 20015*

SUMMARY:

Efficiency is open to the criticism that it is indifferent to the unique needs of individual patients in a way that may cause them harm. Practitioners working within such a system of health care bear some responsibility for these consequences, due to personal actions (e.g., withholding services in order to reap financial gains), as well as consequences for which they are not directly responsible (e.g., perpetuating a system whose treatment criteria are discriminatory). In addition, a growing number of clinicians in flawed settings attempt to protect patients by resorting to ethically dubious behaviors (e.g., lying to insurance companies) in an attempt to secure needed services. The author will examine these moral dimensions of the inadequate health care environments, supplementing theoretical observations with case vignettes. A primary goal will be to explore how to establish acceptable ethical responses for clinicians who work within systems they judge as promoting clinical policies harmful to patients.

No. 36B
ETHICAL AND CLINICAL ASPECTS OF PSYCHOTHERAPY SERVICES WITHIN A NATIONAL HEALTH SERVICE FRAMEWORK

Jeremy Holmes, M.D., *North Devon District Hospital, Barnstaple Devon Ex 31 4 5B; United Kingdom*

SUMMARY:

The NHS is a cash-limited service, in which mental health services have been consistently underfunded in comparison with acute services. Current psychiatric priorities have been powerfully influenced by well-publicized instances of failures of community care. On the other hand, unlike a private-practice-based system there is an attempt to meet the health, including mental health, needs of a population. Making the case for psychotherapy within this context presents political and intellectual challenges. How does one balance the needs of people suffering from long-term psychotic illnesses against the pain of depression, eating disorders, or suicidality? Ethical policies must be evidence based, equitable, and effective. The evidence base for psychotherapy in general is powerful, although here analytic therapies lag behind other psychotherapeutic interventions. Where resources are limited, psychotherapy departments must offer the least costly therapy that is likely to achieve change. Careful assessment before allocation is vital, as is an eclectic multidisciplinary psychotherapy department that can offer the full range of therapies. Triage is also essential: some patients are too ill to benefit from intensive therapy; others will recover with minimal interventions. Selecting those whose illness justifies use of resources, and who are also likely to benefit is a key strategy in ethical practice, and will be illustrated in relation to borderline personality disorder. A "flawed" system mirrors the "flaws" we seek to treat. Ethical practice challenges idealization and therefore accepts that there will always be imperfections, while at the same time striving to alleviate human suffering in as equitable way possible.

No. 36C
RATIONING, RESPONSIBILITY AND THE RIGHTS OF THE CHILD

George Halasz, M.B., *Department of Psychiatry, Monash University, C-30 Burke Road, East Malvern Vic 3145, Australia*

SUMMARY:

Almost all members of the United Nations have signed or ratified the 1989 adopted Convention on the Rights of the Child. Governments, like Australia, by ratifying the Convention (President Clinton signed it in 1994, but the U.S. Senate has not ratified it and it therefore has no standing in U.S. domestic law) can make it a relevant instrument to invoke when considering alleged breaches of children's rights. In 1997, The Convention was used to support a central argument advocating for children's rights, to appeal the Australian government's decision to ration rebates for long-term psychiatric treatment. Based on numerous submissions, the Human Rights and Equal Opportunity Commission ruled that aspects of the government's decision to ration services were discriminatory, and as a result, the government partially reversed its decision. The implications of

successful child psychiatry advocacy for the rights of the child will be elaborated; in particular, the ethical obligations that rest on psychiatrists to confront with a clear, strong voice those public decisions that endanger or compromise the "best-interest" standards of care for our patients, children, adolescents, and adults.

No. 36D
PSYCHIATRISTS AS ADVOCATES: DO ETHICS CODES HELP?

Sydney Bloch, M.D., *Department of Psychiatry, University of Melbourne, St. Vincent's Hospital, Fitzroy, Victoria 3065, Australia*

SUMMARY:

Psychiatry, as a branch of medicine, is influenced by its codes of ethics; these include the professional's potential role in a socio-political framework. When socio-political forces exert deleterious effects such that they prevent the proper pursuit of the psychiatrist's clinical task, the question arises as to whether ethical principles contained in codes of ethics can guide moral action. Principles relating to the psychiatrist's position as advocate are noteworthy here since they purport to clarify the type of professional response needed to deal with imposed constraints. More specifically, advocacy-oriented ethics operate on the basis that psychiatrists have a special obligation to represent the interests of a patient group that has been customarily marginalized, and felt vulnerable and lacking in power. I will use the ethical codes of the American Psychiatric Association and the Royal Australian and New Zealand Association of Psychiatrists to discuss the place of society-oriented principles in facing the moral dilemmas of working in a flawed system of care.

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SYMPOSIUM 37—RESOURCE AND CARE MANAGEMENT SYSTEMS: THE LEVEL OF CARE UTILIZATION SYSTEM FOR PSYCHIATRIC AND ADDICTION SERVICES AND A CHILD AND ADOLESCENT VERSION
The American Association of Community Psychiatrists

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to (1) recognize historical, economic, and clinical rationale for development of standardized and reliable utilization systems for behavioral health; (2) understand principles underlying successful and integrated care management systems and recognize barriers to implementation of new systems.

No. 37A
THE LEVEL OF CARE UTILIZATION SYSTEM FOR PSYCHIATRIC AND ADDICTION SERVICES DEVELOPMENT: HISTORICAL BACKGROUND AND STRUCTURAL PRINCIPLES

Wesley E. Sowers, M.D., *Department of Psychiatry, St. Francis Medical Center, 400 45th Street, Pittsburgh PA 15201*

SUMMARY:

This presentation will discuss historical aspects of resource utilization and level of care decision making in behavioral health care in the United States. It will examine how some of the recent changes in mental health and addiction treatment financing have caused radical shifts in how these decisions are made and the types of services that are provided. Some of these changes led the American Association of Community Psychiatrists to begin development of the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS). Approaches that influenced the development of this instrument will be discussed and the principles guiding its structure will be considered. A brief description of the format of the LOCUS will be provided along with an examination of its success in meeting the goals originally set for it by its authors.

No. 37B
IMPLEMENTING THE LEVEL OF CARE UTILIZATION SYSTEM FOR PSYCHIATRIC AND ADDICTION SERVICES: OPPORTUNITIES AND BARRIERS

Kenneth S. Thompson, M.D., *IPHP, Western Psychiatric Institute, 3811 O'Hara Street, Pittsburgh PA 15213;* Wesley E. Sowers, M.D.

SUMMARY:

In 1995, faced with the national movement toward Medicaid managed care, the board of the American Association of Community Psychiatrists (AACP) decided to develop an instrument that would reflect the well-honed clinical knowledge of community psychiatrists and would aggressively stake out this expertise in patient reviews with managed care companies. Once created, this instrument, known as LOCUS, confronted the board with numerous issues regarding how it should be distributed, implemented, and evaluated. Among other things, the AACP, as a nonprofit, noncapitalized professional association and advocacy organization, wanted to ensure the "free" distribution of LOCUS to public sector programs around the country. This paper discusses the phases of the development of LOCUS and traces critical decisions made by the board and its LOCUS subcommittee regarding copywriting, developing an electronic version, and evaluating reliability and validity. Aspects of the market for LOCUS in both the public and private sector and their implications are described.

No. 37C
THE CHILD AND ADOLESCENT LEVEL OF CARE UTILIZATION SYSTEM FOR PSYCHIATRIC AND ADDICTION SERVICES: DEVELOPING A CHILD AND ADOLESCENT VERSION

Andres J. Pumariega, M.D., *Department of Psychiatry, East Tennessee State Univ, 107 Hillrise Hall/PO Box 70567, Jonson City TN 37614*

SUMMARY:

The determination of level of care in the treatment of children and adolescents is an extremely important process, which has long required a more objective and systematic approach. This is a process that has always been fraught with disagreement across clinical team

members given the multiple factors that need to be considered in arriving at its determination, such as dangerousness, stability of the child's holding environment, and level of function. Whereas in years past out-of-home placement predominated in the treatment of seriously emotionally disturbed children, the principles of least restrictive level of care and treatment in the child's natural environment now predominate the field. In the era of managed care, economic factors now play a significant role in level of care determination, with a danger of arbitrary services restrictions. The Work Group on Community-Based Systems of Care of the AACAP and the Child and Adolescent Committee of the AACP have joined forces to create a tool based on the LOCUS, named the Child and Adolescent LOCUS (CALOCUS), for decision support for level of care determination. Modifications from the adult version are reviewed. In the Dimension section, these account for the impact of development on children, the centrality of the child's relationship with his/her family, and both the vulnerability and resiliency found in emotionally disturbed/mentally ill children and adolescents. The Level of Care categories were modified to include an interagency perspective and a wrap-around approach. The scoring for the assessment dimensions and critical cut-offs for mandatory assignment to particular levels of care will be discussed. This presentation also reports the process of development of this tool, its conceptual basis, its potential for application in assisting the individual child and adolescent psychiatrist or mental health professional, and its application in community-based systems of care for children's mental health.

No. 37D
THE LEVEL OF CARE UTILIZATION SYSTEM BY HAND OR PERSONAL COMPUTER: A RELIABILITY AND VALIDITY STUDY

Charles J. George, M.S., *Department of Psychiatry, University of Pittsburgh, 6505 Brighton Road, Pittsburgh PA 15202*

SUMMARY:

The Level of Care Utilization System (LOCUS) for Psychiatric and Addiction Services is designed to provide clinicians with a concise, yet sufficiently sensitive, device to distinguish appropriate needs and services for patients at intake and throughout treatment. A version for adults has been available for two years and a child and adolescent (C&A) version has been recently released.

We report on the current status of reliability studies for this instrument. These include evaluations from ten clinicians rating ten vignettes of adult cases, and from 12 clinicians rating seven C&A cases. Each study group provides ratings on each domain and a recommended level of care (LOC). A recommendation is also determined using the domain ratings as input for a computer scoring method. The adult study group has independent recommendations from an author of LOCUS and from a consensus of seven clinicians unfamiliar with LOCUS. The C&A study group has concurrent measures of several established clinical severity scales.

The current results indicate good initial reliability with some room for further refinement and testing. The observed correlations with independent measures, though favorable, require substantial interpretation. In summary, LOCUS may facilitate consistent placement of patients in psychiatric or addiction services.

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SYMPOSIUM 38—THE BIOLOGY OF TRAUMA

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to (1) recognize the interplay of somatization, medical conditions, and severity of trauma in victims' responses; and (2) understand trauma's effects on sleep architecture, cardiovascular reactivity in children and adults, and on neurodevelopment.

No. 38A
STUDIES OF SOMATIZATION IN THE WAKE OF DISASTER

Carol S. North, M.D., *Department of Psychiatry, Washington Univ School of Med, 4940 Children's Place/Box 8134, St. Louis MO 63110*

SUMMARY:

The phenomenon of somatization after disasters remains a relatively understudied area. A review of the published literature on medically unexplained symptoms in disaster survivors provides little coherent framework and few relevant data on post-disaster somatization. Over the last two decades, the Washington University longitudinal studies of disaster used the Diagnostic Interview Schedule to collect systematic information about somatization symptoms and disorders from more than 1,600 disaster survivors across 11 disaster sites. Expression of full diagnostic criteria for somatization disorder was a rare event. Somatization symptoms, however, were more prevalent, but much less common than PTSD symptoms. This presentation will address both previously published and new data on somatization disorder and somatization symptoms, describing their prevalence and associations after disasters. The finding of significantly higher rates in women necessitated reporting of the data separately by gender. Somatization symptoms were further examined for the timing of their onset in relation to the disasters, to determine lifetime prevalence vs. disaster-related incidence rates. Relatively few of the post-disaster somatization symptoms represented incident occurrence. Part of the reason for the relative lack of attention to somatization after community disasters may lie with the relatively common nature of its occurrence, particularly de novo somatization.

No. 38B
SEVERITY OF TRAUMA AMONG REFUGEE PSYCHIATRIC PATIENTS: DEMOGRAPHIC AND CLINICAL CORRELATES

Joseph J. Westermeyer, M.D., *Department of Psychiatry, University of Minnesota, 1 Veterans Drive, Minneapolis MN 55417;* Eitan D. Schwarz, M.D.

SUMMARY:

This study was undertaken in order to assess the demographic and clinical characteristics of refugee psychiatric patients in relation to the severity of their traumatic experience. The patients were divided into three groups as follows: those who had been deliberately threatened or harmed (i.e., tortured, raped, beaten while being held captive); those who had been threatened or harmed in an impersonal way (during combat or refugee flight); and those who had not been personally threatened or harmed but who nonetheless fled their country due to fear. Type of victimization was found to vary by ethnicity, sex, age, and marital status. With regard to clinical factors, more severe victimization was found to correlate with a greater number of Axis I DSM-III-R diagnoses, more Axis I post-traumatic stress disorder (PTSD), and poorer Axis 5 psychosocial coping. Comorbid Axis III medical conditions were common in all groups. Clinical implications for these findings are reviewed.

No. 38C
SLEEP IN PTSD: FINDINGS FROM CHRONIC, RECENT AND ACUTE STAGES

Thomas A. Mellman, M.D., *Department of Psychiatry, Veterans Affairs Medical Ctr, 1201 NW 16th Street, 116A, Miami FL 33125;* Daniella David, M.D., Bruce Nolan, M.D.

SUMMARY:

Sleep disturbances are prominent features of PTSD and have been proposed to play a role in the genesis and maintenance of the disorder. The DSM-IV criteria refer to nightmares among re-experiencing symptoms, and impairment in initiating and maintaining sleep among symptoms of heightened arousal.

A survey of combat veterans supported the specificity of nightmares regarding combat to chronic PTSD. Our polysomnography (PSG) findings include increased brief awakenings, body movement during sleep, and frequency of eye movements during REM (REM density). Not all studies have found objective sleep disturbance with chronic PTSD, however. In a study completed from six to 10 months after Hurricane Andrew, we found the frequency of brief awakenings to also correlate with symptom severity. We are presently evaluating sleep and PTSD during hospitalization for severe traumatic injuries. To date, nightmares with content related to the traumatic incident have been strongly associated with PTSD severity. Preliminary PSG findings suggest a relationship between entering the wake state out of REM sleep and PTSD.

Inferences regarding memory processing and arousal regulation during sleep during these different stages of PTSD will be discussed along with possible implications for interventions.

No. 38D
PHYSIOLOGICAL AND SUBJECTIVE ASSESSMENT OF FAMILIES BEREAVED AFTER THE OKLAHOMA CITY BOMBING

Phebe M. Tucker, M.D., *Department of Psychiatry, University of Oklahoma, 920 Stanton L Young Blvd, Oklahoma City OK 73104;* Betty Pfefferbaum, M.D., Brian T. Maynard, B.A., Scott M. Rainwater, Shajitha Nawaz, M.S.

SUMMARY:

Comprehensive assessments of 26 individuals from eight bereaved families suffering loss from the 1995 Oklahoma City bombing were performed one and one-half to three years later. Direct losses included parents and grandparents, siblings and half siblings, children and grandchildren, aunts and cousins. The majority of families were African American, with children ranging in age from 8 to 16 years, and adults ranging from 32 to 68 years. Fifteen individual dyads were also examined: seven mother/daughter, three mother/son, three grandparent/grandchild, one aunt/nephew, and one father/adult daughter pairs.

Measures of post-traumatic stress, grief, and depressive symptoms were elevated in bereaved children and adults. Physiological measures were take before, during, and after an interview about participants' salient bombing experiences. Adults showed significant increases of heart rate and systolic and diastolic blood pressures during the interview, and these elevations were greater than in non-bereaved community members. Children increased heart rate and diastolic blood pressure during the interview. Concordance within adult/child dyads was assessed for subjective and physiological measures to explore the relationship within the family of psychopathologic responses to shared traumatic bereavement. The literature pertaining to the biology of traumatic bereavement is discussed, as well as implications for clinicians involved in mental health interventions in affected families.

No. 38E
THE NEUROARCHEOLOGY OF CHILD MALTREATMENT: EVIDENCE FOR ALTERED NEURODEVELOPMENT FOLLOWING TRAUMATIC ABUSE

Bruce D. Perry, M.D., *Department of Psychiatry, Baylor College, One Baylor Plaza, Houston TX 77030*

SUMMARY:

Deprivation of sensory stimuli or abnormal patterns of activation of stress response during neurodevelopment can lead to altered stress response neurobiology. Different brain systems may be impacted at different times during development. Children (n = 524; ages 3 mo.–17 yrs.) experiencing abuse, neglect, or both were evaluated using standard clinical evaluations with the addition of semistructured trauma interviews, psychophysiological measures, and various psychometric instruments (e.g., CBCL, STAIC, STAXI, CPAS, and CDS). Continuous heart rate (CHR) monitoring of maltreated children during various clinical and nonclinical interactions was conducted in a subset (n = 88). Superimposing videotaped interactions of these children (n = 50) with their CHR allows a comparison of "free-play" (FP) vs. structured interviews (SI). In addition, CT or MRI scans conducted for other clinical purposes were reviewed in a sample of these children (n = 32) with total global neglect in infancy and in comparison with age-SE matched.

Cardiovascular: All children demonstrated "trauma-specific" significant changes in mean HR during SI relative to FP. Children (80% female) with predominant dissociative symptoms had mean decreases in HR while those (80% male) with predominant hyperarousal symptoms had increases in HR during SI.

Hematologic: Blood work obtained from this maltreated population in anticipation of adjunctive pharmacotherapy yielded the remarkable finding that 61% of these children were anemic, with hemoglobin with other indices of RBC being normal, and with a mild monocytosis and eosinophilia. In addition, decreased levels of beta-adrenergic receptors on lymphocytes and alpha-2 adrenergic receptors on platelets were seen for males but not females in a subsample of these children, suggesting increased circulating catecholamines in males with hyperarousal symptoms.

Neurodevelopmental: Sixteen of 30 scans demonstrated either "cortical atrophy" or "enlarged ventricles." These findings were out of proportion to physical development or nutritional status. Findings support a "neuro-archeological" conceptual framework for studying brain development and functioning following abuse and neglect.

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SYMPOSIUM 39—NEW VIEWS ON PLAY IN ADULTS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize the importance of adult play; distinguish pathological play from normal; understand the connections between human ritual and play; understand how defense and play work together; and provide examples of adult creativity, good ideas, and physical fitness emerging from adult play.

No. 39A
PLAY IN THE LIVES OF RETIREES: A SIXTY-YEAR STUDY

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

SUMMARY:

This presentation focuses on four facets of play in healthy adults. It is based on the lives of 75- to 80-year-old men and women prospectively followed for 60 years. The men are 268 Harvard graduates selected for health, and the women are 40 members of Terman's Stanford Study of gifted children. The presentation considers four aspects of play that the presenter finds in this group. The first is the association of play with the capacity for nature defenses, especially sublimation. How much is play a part of the work lives of successful individuals? Second, the presenter examines the relationship between play and creativity as assessed in highly gifted individuals over a lifetime. Third, the presenter considers how play correlates with other facets of growing older. Is the sustained capacity for play associated with immaturity or maturity, as assessed by Erikson and Loevinger? Finally, this presentations examines the association between play and relationships. How does play enhance or detract from meaningful personal interaction?

No. 39B
EMILY DICKINSON: PLAY BECOMES POETRY

John F. McDermott, Jr., M.D., *Department of Psychiatry, University of Hawaii, PO Box 6840, Kamuela HI 96743*

SUMMARY:

Emily Dickinson is arguably one of America's greatest poets. The development of her gift as a poet in adult life is traced through three stages:

(1) panic attack symptoms described in letters occurring in the context of
(2) a love relationship with her sister-in-law Susan Gilbert, recounted in letters detailing fantasies of merging, alternating with fears of separation and loss, then
(3) transformed into art form through an exchange "across the hedge" (Dickinson had become agoraphobic) of playful letter/poems to Susan.

Transformation of pain into pleasure is detailed in the Dickinson letter/poems. Verse that emerged from panic symptoms, triggered within a powerful relationship with another woman, constitutes some of her best known death poetry in which she "plays with death." "Gifts" of letter/poems to her beloved Susan represent the essence of the artistic gift—to experience extremes of human emotion, recover, and make the residue available in art form. As T. S. Eliot claimed, great poetry "communicates before it is understood."

The process by which intellectual "play" between two 19th-century women evolved as poetry is examined in light of current feminist and psychiatric thinking about female relationships wherein one person defines herself through her relationship with the other.

No. 39C
RISK-TAKING AS A DANGEROUS OR HEALTHY MECHANISM

Lynn E. Ponton, M.D., *Department of Psychiatry, University of CA at San Fran, 206 Edgewood Avenue, San Francisco CA 94117-3715*

SUMMARY:

This presentation-focuses on the relationship between risk taking and play, from adolescence through adulthood, exploring theoretical, clinical, and research perspectives. Risk taking is one of the major tools that adolescents use to develop and shape their emerging identities. Adolescent risk taking can also be conceptualized as a type of play wherein young people undertake solo and group behaviors that help define their place in the social scheme, illuminating themselves in relation to others, an important aspect of adolescent life. This presentation will address the extension of this process into adulthood. The concept of "deep play," in which the stakes are so high and the outcome so unpredictable that it makes no sense to participate, overlaps with the category of dangerous risk taking, termed "risk behaviors."

Results: The connection between risk taking and play will be outlined through a series of clinical vignettes. This discussion focuses on clinical relevance for psychiatrists, alerting them to dangerous patterns of risk taking, which can be discovered and addressed at least partially through inquiries about play.

No. 39D
BEYOND LOVE AND WORK: WHY ADULTS NEED TO PLAY

Lenore C. Terr, M.D., *Department of Psychiatry, University of CA at San Fran, 450 Sutter Street, Room 2534, San Francisco CA 94108-4204*

SUMMARY:

Adult play derives directly from favorite choices along a developmental ladder. Without fixation or regression, play is retained by adults and can be continued into healthy, mature behaviors. In fact play—"activity done primarily for fun"—may become part of adult work itself, "activity primarily done for financial sustenance, prestige, power, and/or contributions toward mankind." Play is not at all the same as leisure, "time spent not working." And although play can be done either at leisure or at work, it must be active—involving active mentation and/or active physical movement.

Adult animals with enough food, safety, and leisure time play. Then why do so many adult humans give up on the activity? Based on her research, the presenter will compare the tremendous impetus that psychic trauma gives to play—as exemplified by the Chowchilla and Challenger studies—with the more normal individual blockers of these impulses: shame about childishness, gender distinctions, moral and ethical questions, adolescent discouragements, and lack of time, leisure, safety, money, and societal approval.

Play civilizes us. And it aids civilization. The contributions of three Nobel Prize winners in science and the life of one NBA star will be noted as examples.

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SYMPOSIUM 40—UNDERSTANDING AND TREATING PATHOLOGICAL GAMBLING

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize the escalating epidemic of pathological gambling (PG); accurately identify, screen, diagnose, and evaluate patients with PG; understand and be able to employ current behavioral and psychopharmacological strategies; and appreciate neurobiological advances in our understanding of PG.

No. 40A
PATHOLOGICAL GAMBLING: MAJOR PUBLIC HEALTH CONCERN

Marvin A. Steinberg, Ph.D., *CT Council on Problem Gambling, 47 Clapboard Hill Road, Guilford CT 06437*

SUMMARY:

Landmark events in problem gambling:

- 1957: Founding of Gamblers Anonymous
- 1972: Veterans Administration Hospital creates first gambling treatment program
- 1972: Founding of the National Council on Compulsive Gambling
- 1976: First federally funded national study found that .77% of adults are "probable compulsive gamblers"
- 1980: First time pathological gambling included in Diagnostic and Statistical Manual (III). Major revisions in diagnostic criteria in DSM-III-R (1987) and DSM-IV (1994)
- 1997: Harvard metal-analysis of state prevalence studies found that 5.4% of the adult population are problem or pathological gamblers. Increase in problems related to spread of legalization of different forms of gambling, especially lotteries and casinos
- 1997: Congress launches two-year investigation of impact of legalized gambling through the National Impact Gambling Study Commission. Impetus comes from increased concern about regulation of Indian and non-Indian gambling, the specter of uncontrolled Internet gambling, and negative social costs. A commission priority is problem gambling, especially for at-risk groups, i.e., youth, psychiatric patients, substance abusers, certain ethnic groups, women, incarcerated populations. The full report of the commission will be released in June 1999. It is anticipated that the major findings and recommendations will be available for presentation at this conference.

No. 40B
ASSESSING PATHOLOGICAL GAMBLING

Ken C. Winters, Ph.D., *Department of Psychiatry, University of Minnesota, Bx 393 Mayo/420 Delaware St SE, Minneapolis MN 55455*

SUMMARY:

Objective: This presentation will focus on screening, assessment, and diagnosis of pathological gambling. The primary aim will be to provide clinicians with practical and science-based skills for identifying problem gamblers in a clinical setting.

Method: Two broad research literatures will be reviewed: (1) the empirical evidence, albeit limited at this time, pertaining to the validity of the pathological gambling construct, including the issue of whether pathological gambling is a primary disorder or part of a larger spectrum of impulsive behaviors, and (2) the assessment instrumentation literature pertaining to initial screening and diagnosis of adults suspected of having problems associated with excessive gambling. This latter literature will include a review of available self-report screening questionnaires and structured and semi-structured diagnostic interviews.

Results and Conclusion: The pathological gambling assessment field is relatively young compared with more established mental disorders, such as affective disorders and substance use disorders. Moreover, there remains the unresolved debate as to the adequacy of current definitions of pathological gambling. Yet professionals may be observing an increased rate of pathological gambling in their clinical practice. There are several assessment tools available for the clinician when screening and diagnosing excessive gamblers, some of which are associated with favorable psychometric evidence.

No. 40C
MULTIMODAL BEHAVIOR THERAPY FOR PATHOLOGICAL GAMBLERS

Iver E. Hand, M.D., *Department of Psychiatry, Hospital UKE, Martinistrasse 52, Hamburg D 20246, Germany;* Julia V. Schinckel, Ph.D., Brigitte Friedrich, B.N.

SUMMARY:

Pathological gambling often has devastating effects on the private and professional life of the gambler and his family. The comorbidity with other psychiatric and somatic disorders is high—these either being causes for or consequences of the gambling. The few places that offer treatment of this very costly disorder are mostly addiction units. Behavioral and pharmacological treatments have not yet been used to their full potential. This presentation will critically review the mostly symptom-directed behavioral treatments for gamblers. Main emphasis will then be on the presentation of a multimodal, strategic-systemic theoretical and treatment model developed in our unit, and evaluated in three follow-up studies. Main topics will be motivational interviewing (starting with the first phone call) of patient and family members; main risk factors for the progression from social to pathological gambling; intrapsychic and interpersonal functions of gambling; "causal" versus symptomatic interventions for patient, spouse, and family; and outcome and follow-up data. Recommendations for future biobehavioral research will be derived.

No. 40D
PSYCHOPHARMACOLOGY OF PATHOLOGICAL GAMBLING

Marc N. Potenza, M.D., *Department of Psychiatry, Yale University, 34 Park Street, New Haven CT 06508;* Stephanie S. O'Malley, Ph.D.

SUMMARY:

Pathological gambling (PG) represents a serious and increasingly prevalent illness, not infrequently resulting in severe adverse financial, interpersonal, and personal consequences. Despite the relatively high prevalence (often estimated at 2% to 3%) of PG and the often devastating consequences (e.g., bankruptcy and/or suicide) associated with PG, few systematic investigations into safe and effective pharmacological treatments for PG have been performed to date.

Multiple case series and reports exist in the literature suggesting promise of useful psychopharmacological therapies for individuals suffering from PG. Mood stabilizers (lithium and carbemazepine), serotonin/norepinephrine reuptake inhibitors (clomipramine), selective serotonin reuptake inhibitors (fluvoxamine), and opioid antagonists (naltrexone) have been reported in small, often open-label treatment trials to be safe and effective in the short-term treatment of PG. Ongoing, larger, placebo-controlled trials of fluvoxamine and naltrexone are currently being performed to investigate more precisely the role of these drugs in targeting symptoms of PG. Given the availability of drugs (e.g., buproprion and acomprosate) that affect alternate neurotransmitter systems and have been shown to be effective in certain drug-dependent populations, the need for additional studies of pharmacotherapies for PG is warranted, and the hope for finding more effective treatment strategies is promising.

No. 40E
NEUROBIOLOGY OF PATHOLOGICAL GAMBLING

Eric Hollander, M.D., *Department of Psychiatry, Mt. Sinai Medical Center, 1 Gustave Levy Place/Box 1230, New York NY 10029;* Concetta M. DeCaria, Ph.D., Charles Cartwright, M.D., Sherie Novotny, M.D., Jared Finkell, B.A.

SUMMARY:

Pathological gambling (PG) is an emerging public health problem that shares features with other addictive, impulsive, and compulsive disorders. Brain systems involved in reward, arousal, impulsivity, and repetitive behaviors also play a role in PG, may serve as a target for pharmacotherapy, and increase our understanding of other addictive and reward deficiency syndromes.

Genetic variants of D_1, D_2, D_3, and D_4 dopamine receptor genes serve as a risk factor for PG as well as other impulsive-addictive disorders. Deficiency of platelet MAO activity predispose individuals to PG and risk seeking behavior. Pharmacological challenge studies with serotonergic and noradrenergic agonists document involvement of these neurotransmitter systems in specific components of the PG cycle, including arousal, the feeling of "high" associated with the reward of an early big gambling win, and the failure to inhibit or delay acting on the impulse to gamble. Novel gambling provocations during PET help to define regional metabolic activity during gambling in PG patients. Finally, pharmacological treatment studies with SSRIs and lithium help to dissect out specific brain systems involved in the PG cycle and suggest that comorbidity with bipolar spectrum and attention deficit disorders may influence treatment response.

In summary, early evidence suggests that dopaminergic, serotonergic, and brain reward regions modulate the compulsive, impulsive, and addictive nature of pathological gambling.

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SYMPOSIUM 41—FRENCH AND AMERICAN PSYCHIATRY: VIVE LA DIFFERENCE!

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be knowledgeable about several critical differences between French and American psychiatry, especially the problems of special populations, the protection of the rights of the mentally ill, and how two influential psychiatrists (Ey and Meyer) have influenced psychiatry in their respective countries.

No. 41A
SUBURB'S PSYCHOSIS

Thierry Tremine, M.D., *Hopital Robert Ballanger, Aulnay Sous Bois 93802, France;* F. Regis Cousin, M.D.

SUMMARY:

In the suburbs with their extreme poverty, unemployment, and serious emigration, a second generation of immigrant inhabitants have a very special type of psychosis onset. The example of the North African (maghrebin) emigrated population in Paris will enlighten these new standards of schizophrenic pathology. Known as transient psychotic disorders, the English translation of the French concept of "bouffies delirantes," these brief psychoses show particular themes directly linked to family topics. The clinical course of the acute episodes are very different from borderline personality disorder to chronic psychoses. Most of the cases are 20-year-old young boys presenting delusional ideas expressing a specific psychopathology of emigration. They can be considered as a pattern of identity crisis for the new generations even if there is no connection for other cases with emigration. The suburbs then has to be thought of as a country of emigration where one has to deal with acculturation, transculturation, and complex cultural mixtures. All factors are involved specificity in clinical, therapeutic, as well as in forensic practice.

No. 41B
AMERICAN INDIANS IN URBAN AREAS: DEALING WITH CULTURAL DIFFERENCES

James W. Thompson, M.D., *APA, 1400 K Street, NW, Washington DC 20005*

SUMMARY:

France and the U.S. are very different with regard to indigenous populations. The U.S. has a large (over 2 million) American Indian and Alaska Native population. France has no disadvantaged native population, although there are a large number of third-world immigrants, particularly in urban areas. Dealing with cultural difference is an important issue in both countries. Urban psychiatry is also an important area for study in both countries, even with regard to America's native population, since the majority of American Indians in the U.S. live in urban areas. In many cities, Indian people usually come from a great variety of tribal backgrounds and live in loosely-defined communities, contributing greatly to the differences in an already diverse Indian population. This and other factors may result in a different character and distribution of mental disorders than among rural Indians. Services in urban and rural areas are also very different, with rural Indians served by the federal Indian Health Service, and urban Indians served by the same sources as non-Indians. The problems and needs of native peoples throughout the world have great similarities, and international work is called for to better understand and treat their psychiatric problems.

No. 41C
THE PROTECTION OF THE WELL-BEING (RIGHTS) OF THE MENTALLY ILL

Eric Marcel, *Secteur 78 GXV, Institute M Riviere, Route De Montfort, La Verriere 78320, France*

SUMMARY:

Since the first part of the 19th century, French legislation incorporates many texts, which define a juridical system for the mental patient and his civil or penal ability.

The 1838 civil code (1804) had defined, until 1968, the civil rights for people with mental illness.

The new legal status defined by the law enacted January 3, 1968, creates a difference between a majority at the age of 18 years and the possibility that a man can be deprived of his civil rights if "by an impairing of his own mental or physical ability, he can not alone provide for his interest." Also to be protected is the man who, by his "lavishness or his idleness can fall in poverty or cannot follow out his family duty."

Several types of safety devices are defined: the guardianship with a complete loss of civil rights, and the "curatelle," which is only a juridical counsel. It also defined a temporary emergency protection without judgment, the "juridical safe-keeping," in most cases in the expectation of a guardianship or "curatelle." A specialized judge must pronounce these legal protection devices.

The subject himself, his family, and the hospital physician can ask the judge to begin such protections.

Thus, French laws can deprive a man of his civil rights only by medical or ethical reasons. Meanwhile, the legal safety devices and the legal procedures restrict the possibility of misuse. This law is an efficient means for protecting the frailest people, schizophrenic, demented elderly, etc. against abuse. We can, of course, argue about the possibility for people in a democratic nation to accept or not accept a potential loss of liberty.

No. 41D
THE PROTECTION OF THE RIGHTS OF THE MENTALLY ILL IN AMERICA

Carl P. Malmquist, M.D., *University of Minnesota, 909 Social Science Building, Minneapolis MN 55455*

SUMMARY:

In recent dacades the rights of the mentally ill have been protected by a series of controversial measures. The civil rights movement took issue with the dominant model of civil commitment of the mentally ill being based on a mental illness that simply needed treatment. As a result of court cases and legislation, the model shifted from a welfare orientation to one based on dangerousness for involuntary hospitalization. The argument was that this protected the community from the dangerously mentally ill since this was the group to be removed from society. Yet, many also argued that this was a blow to maintaining the freedom of the mentally ill in communities since it made civil commitment more difficult. Similar issues were raised with respect to release from mental hospitals, readmission procedures, etc.

The debate about the rights of the mentally ill has similarly been played out involving issues of their right to treatment, their right to refuse treatment, the types of treatment that could be administered, informed consent issues about their voluntary admissions to hospitals, informed consent about treatment, limitations on their use as research subjects, etc.

The rights of the mentally ill in the criminal process raise issues about the adequacy not only of their legal representation, but of their psychiatric assessment and treatment. The prime areas focused upon have been the adequacy of assessments for competency, the insanity defense, and their status in correctional facilities.

No. 41E
WHAT PLACE FOR HENRI EY (1900–1977) IN A PICTURE OF FRENCH PSYCHIATRY IN 1998?

Suzanne Parizot, M.D., *290 Route de Vienne, Lyon 69373, France;* Jean-Pierre Losson

SUMMARY:

Our presentation will commence with a brief overview of the work of this author (not well known in the United States as not translated into English), followed by a synchronic analysis of his influence. Rather than evoking intellectual "heritage" and the relational evolution in thinking, we will endeavor to provide a "snapshot" of the current practice and debate in the field of psychiatry, so as to reveal the place of Henri Ey's work today.

This picture should help in the understanding of the convergence and divergence between European and American psychiatry, and open a debate comparing the explicit and implicit traces of "fathers" in a discipline where questions and answers are both in constant evolution and in need of a solid background.

No. 41F
ADOLF MEYER AND 20TH CENTURY PSYCHIATRY

Paul R. McHugh, M.D., *Department of Psychiatry, Johns Hopkins Hospital, 600 N Wolfe Street, Baltimore MD 21287*

SUMMARY:

Adolf Meyer, the first director of psychiatry at Johns Hopkins School of Medicine (1913–1941), was the leading American psychiatrist of his era. His contributions to psychiatry and neuroscience were wide-ranging, resting as they did on his background in psychiatry and neurology. In his tenure, he built a model department by emphasizing fundamentals of psychiatry. He forged a core of dependable knowledge by teaching how to examine patients and formulate their conditions. He presented a hierarchical approach to the sources of information that is identical to today's bio-psycho-social approach. He produced leaders from among his students who advanced psychiatry in the years that followed. Alexander Leighton, Paul Lemkau, and Aubrey Lewis in epidemiology; Jerome Frank in clinical investiga-

tion; and Leo Kanner in child psychiatry are examples. His concepts and achievements will be reviewed.

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SYMPOSIUM 42—ARAB CULTURAL PERSPECTIVES ON THE ASSESSMENT AND TREATMENT OF ANXIETY DISORDERS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participants should be able to recognize the influence of ethnicity and culture on the assessment, diagnosis, and treatment of anxiety disorders in Arab patients.

No. 42A
ANXIETY DISORDERS AND TRANSCULTURAL FACTORS IN DIAGNOSIS AND TREATMENT

Ossama T. Osman, M.D., *Department of Psychiatry, Mercer University, 1550 College Street, Macon GA 31207*

SUMMARY:

There is a trend in psychiatry for appreciating the importance of recognizing ethnic and cultural influences on the phenomenological presentation and treatment of psychiatric disorders. The literature suggests the need to broaden the spectrum of symptomatology used in diagnostic classification systems. This may accommodate the varied presentation of psychopathology in non-western cultures. For example, Eastern and Middle Eastern ethnic groups are known to have higher prevalence of somatic complaints with differential increase in complaints relating to specific bodily systems. This is a common representation of psychic distress in those cultures. The concept of stress, its recognition by the individual, and the perception of its levels of severity are also greatly influenced by culture. The multiaxial system used by DSM-IV can therefore be very useful when assessing these important elements of psychosocial stressors. Comparative studies of mental illnesses in different cultures can enrich our understanding of the spectrum of mental illnesses. For that, it is imperative that structured diagnostic instruments be used for collecting data in a systematic and standardized manner. The cultural translation of these instruments needs to be sensitive enough to capture culture-specific symptoms and spectrum of atypical presentations, yet be consistent with widely recognized classification systems (e.g., ICD and DSM) for comparative studying. The author will present the above transcultural concepts with specific reference to anxiety disorders.

No. 42B
THE CULTURAL CONTEXT OF ANXIETY DISORDERS IN EGYPT

Adel Sadek, M.D., *Department of Psychiatry, AIN Shams University, PO Box 22 Deir El Malak, Cairo 11657, Egypt*

SUMMARY:

Whereas anxiety may be a universal emotion, the contexts in which it is experienced, the interpretations of its meaning, and the responses to it are, like those of other emotions, strongly influenced by cultural beliefs and practices.

The cultural determinants of anxiety symptoms and syndromes mean that anxiety must be understood not just in terms of cognitive or physiologic mechanisms, but also in terms of its social meanings and the roles, situations, and cultural practices that may engender anxiety and influence its intrapsychic and interpersonal management.

In this paper, we present what is known about social and ethnocultural variations in the prevalence of anxiety disorders as well as in symptomatology and course in Egypt. We then consider the relationship of specific cultural beliefs and practices. We considered the social embedding and cultural meaning of anxiety disorders in clinical practice with a view to outlining culturally responsive strategies for diagnosis and treatment.

No. 42C
THE STUDY OF PANIC DISORDER IN EGYPT

Afaf H. Khalil, M.D., *AIN Shams University, PO Box 22 Deir El Malak, Cairo 11657, Egypt*

SUMMARY:

At the conclusion of this presentation the attendants should be acquainted with the phenomenology of panic disorder (PD) in Egypt. The most annoying symptoms reported in Egyptian patients are choking, feeling panicky, and heart pounding with tachycardia. The most frequent symptoms are fear of dying and feeling depressed. The mean duration of the attack is 20 minutes and the mean frequency is 9.8 attacks per month. In Egypt, patients with PD differ from patients with major depressive episode in showing more situational, avoidance, and free-floating anxiety. They showed less self-negligence, ideas of guilt, early awakening, and social withdrawal. The way patients describe panic attacks is a reflection of the emotivity in verbal communication in the Arabic language and the cultural pattern of Arab patients' expression of their complaints. Panic attacks are sometimes referred to as an evil eye, magic, possession, or witchcraft. This is why many Egyptian patients with panic attacks may resort to traditional and religious healers before consulting physicians or psychiatrists.

No. 42D
COMORBIDITY OF SOCIAL PHOBIA AMONG SAUDI PATIENTS

Ibrahim Al-Khodair, M.D., *Department of Psychiatry, Armed Forces Hospital, PO Box 60246, Riyadh 11545, Saudi Arabia*

SUMMARY:

Social phobia is reported to be one of the most common mental disorders in western societies. It is well recognized that the distress that results from its lack of recognition may lead to chronicity and complications. This is compounded if there is a complicating comorbid condition. In this presentation, a clinical research study of the comorbidity of social phobia with other psychiatric disorders will be presented in a Saudi Arabian patient group. Seventy-two (72) Saudi patients (52 males, 20 females) who met the DSM-III-R criteria for social phobia were studied. They were all assessed using the semi-structured interview ADIS-R. The mean age for the group was 28 years and the age at onset was 16 years.

The incidence of the different comorbid conditions were as follows: 45.8% reported panic attacks, 13.9% PTSD, 35.7% agoraphobia, 51.3% simple phobia, 31.9% OCD, 9.7% hypochondria, 5.6% somatization disorder, 9.7% substance abuse, 35% using psychotropic medications, and 88.9% reported chronic course. The implications of these data on the assessment and management of Arab patients with social phobia will be highlighted.

No. 42E
THE ISLAMIC LEGAL PESPECTIVE ON MENTAL DISORDER AND IMPEDIMENTS TO COMPETENCY

Abdulrazzak M. Alhamad, M.D., *Psychiatry, King Saud University, PO Box 7805, Riyadh 11472, Saudi Arabia*

SUMMARY:

It is well documented that in some circumstances, the emotional and mental status of individuals can interfere with the ability to perform their duties. Competence in Islamic law is defined as the state of eligibility of persons to be responsible to deserve their rights and to perform their duties. The competence for rights is based on being alive while the competence for duties is based on having sound mind. Accordingly, competency determination according to Islamic law can be affected by several permanent and temporary impediments, namely, insanity, imbecility, oblivion, sleep, faint, inadvertence, or insolence.

Competence, therefore, represents the person's functional capabilities or deficits at the time of evaluation. On the other hand, the concept of criminal responsibility addresses the issue of the offender's mental state at the time of the alleged offense.

The objective of this paper is to discuss the above concepts in relation to impairing mental states. The Islamic legal context in which the psychiatric evaluation for competence is performed will be described. In addition, the relationship of competence to criminal responsibility for mentally disabled offenders will be presented.

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SYMPOSIUM 43—PSYCHOTHERAPY TRAINING: IS IT RELEVANT TODAY?

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize the importance of psychotherapy training.

No. 43A
EDUCATION AND TRAINING IN PSYCHODYNAMICS

Jerald Kay, M.D., *Department of Psychiatry, Wright State University, PO Box 927, Dayton OH 45401*

SUMMARY:

This presentation will review recent efforts to redefine psychiatric training and the impact they would have on psychotherapy education and training, especially regarding psychodynamic psychotherapy. The unique attitudes, skills, and knowledge that are often obtained while studying psychodynamic psychotherapies are described. Current challenges in teaching psychodynamic psychotherapy are elucidated. These include, but are not limited to, diminished curricular time and resources, sparse research on instructional methodology, the underappreciation of acquiring brief psychotherapy skills, the increasing unavailability of mature clinician educators as teachers and supervisors, and the paucity of new technology in teaching. Suggestions for teaching dynamic psychotherapy more effectively will be presented.

No. 43B
THE ROLE OF PSYCHOANALYSIS IN THE DEVELOPMENT OF THE PSYCHIATRIST

Norman A. Clemens, M.D., *Department of Psychiatry, Case Western Reserve Univ, 1611 South Green Road, Ste 301, Cleveland OH 44121-4128*

SUMMARY:

While the intensive, formal training required to become a psychoanalyst generally cannot be combined with the demands of psychiatric residency training, psychoanalytic thinking remains an indispensable part of a resident's introduction to psychotherapy. Psychoanalytic understanding of the psychiatrist-patient relationship facilitates the working alliance and compliance with any form of treatment. The multifaceted knowledge of human development, self, and object relationships derived from psychoanalytic studies of children and adults provides a longitudinal context for knowing the patient as a human being, as well as framing work with personality disorders. Awareness of dynamic intrapsychic conflicts clarifies otherwise inscrutable mental phenomena in patients, regardless of diagnosis. Psychoanalytic knowledge of unconscious mental processes, dreams, and memory now converge with neurobiological discoveries of the plastic, dynamic functions of the brain. All psychiatrists should be well versed in psychoanalytic perspectives; the public expects this and is disappointed when it is lacking.

In the overall career development of psychiatrists, some with a special interest in the field will go on to formal psychoanalytic

training and practice. These may in the future evolve into a new paradigm of integrated psychoanalytic and neurobiological understanding that enhances the treatment process and its benefits to patients.

No. 43C
TEACHING AND SUPERVISING PSYCHOTHERAPY: CURRENT ISSUES

Judith H. Gold, M.D., *Department of Psychiatry, University of Queensland, Princess Alexandra Hospital, Woolloongabba QLD 4102, Australia*

SUMMARY:

The importance of psychodynamics in the treatment of patients has been neglected as training in psychodynamic psychotherapy has decreased in most academic departments in the United States, Canada, and Australia. Residents in psychiatry are thus often ill-prepared to treat patients with psychotherapy, and this provides difficulty in the supervisory process. In this paper, I will discuss the problems encountered in the teaching and supervision of psychodynamic psychotherapy with today's residents. At a time when the number of medical students choosing psychiatry as a speciality is decreasing, it is important to examine the part played in this lack of interest in psychiatry by the diminished emphasis on psychotherapy. Why train in psychiatry if any physician can prescribe psychotropic medications and a variety of other mental health professionals provide psychotherapy?

No. 43D
ETHICAL, GENDER AND CULTURAL ISSUES IN PSYCHOTHERAPY TRAINING

Carol C. Nadelson, M.D., *1493 Cambridge Street, Cambridge MA 02139*

SUMMARY:

There have been few periods in the history of psychiatry when the rapid explosion of knowledge and technology in the midst of major systemic changes have confronted trainees with such bewildering clinical demands, ethical dilemmas, and economic constraints, yet offered such exciting potential. Psychotherapy training has suffered in the midst of this transformation. To meet the challenge of providing relevent psychotherapy education to meet current and future realities, those who train must address areas that had often not been seen as part of psychotherapy training in the past. In addition to imparting new information, understanding, and approaches in ethics, gender, and culture to a diverse group of trainees, educators must be aware of the changing demographics of patients and be able to teach about communicating with those from diverse cultures with differing family and relational systems, ethical codes, and attitudes. Educators must inform themselves and be able to reconsider traditional beliefs and clinical postulates if they are to effectively train future clinicians in a range of psychotherapies. The need to integrate new information and sensitivity about ethics, gender, and culture into the practice of psychotherapy will be the subject of this presentation.

No. 43E
INTEGRATION OF PSYCHOTHERAPY AND BIOLOGICAL TREATMENTS

Glen O. Gabbard, M.D., *Department of Psychiatry, Menninger Clinic, PO Box 829, Topeka KS 66601-0829*

SUMMARY:

The uniqueness of the medical specialty of psychiatry is the integration of the psychosocial and biological. Driven by economic forces, especially managed care pressures, the psychiatrist is increasingly relegated to medication management. Training programs must counteract this trend by positioning the psychiatrist as the mental health professional who is uniquely qualified to integrate psychotherapy and pharmacotherapy. There is largely a false dichotomy between the two treatment approaches. Recent research suggests that psychotherapy affects the brain in similar ways to medication. Most psychiatric disorders benefit from an approach that combines medication and psychotherapy, and one person performing both functions makes clinical and economic sense. This requires the teaching of a particular mindset, not unlike the physicist who must think of both particles and waves. A psychiatrist must be thinking about neurotransmitters and genetics on the one hand, and internal object relations and defenses on the other.

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SYMPOSIUM 44—PRESCRIBING PSYCHOTROPICS FOR DIVERSE POPULATIONS APA Council on National Affairs

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize ethnic, gender, and cultural differences in the response to psychotropic medications and the contribution of pharmacokinetic, pharmacogenetic, and pharmacodynamic factors to these variations.

No. 44A
CLINICAL AND PHARMACOLOGIC CONSIDERATIONS WHEN PRESCRIBING PSYCHOTROPICS FOR CULTURALLY DIVERSE POPULATIONS

Sheldon H. Preskorn, M.D., *Psychiatric Research Institute, 1100 North St. Francis, Ste 200, Wichita KS 67214;* Mujeeb U. Shad, M.D., Annie Harvey, Ph.D., W. Dale Horst, Ph.D.

SUMMARY:

The effect of a drug is a function of three factors: its pharmacodynamics, its pharmacokinetics, and the unique characteristics of the patient being treated. The characteristics include genetics, gender, age, intercurrent disease, and the chemicals the patient consumes (i.e., either concomitant medical treatment or diet). These factors can shift a drug's "usual" dose-response relationships established during the clinical trials needed for drug registration. These trials are in essence population pharmacokinetic studies, which determine the dose of desired mechanism of action to the desired extent. The results of such studies form the basis for the drug's "usual" recom-

mended dose or dose range found in the package insert (i.e., the Physician Desk Reference). However, clinical trials generally endeavor to reduce the biological variance in the population enrolled via their inclusion and exclusion criteria. For these reasons, few patients are enrolled who are older than 65 unless the trial is for Alzheimer's disease. Also excluded are patients with unstable or serious medical conditions. The nature and number of concomitant medications that the patient can be taking is also quite limited. The clinician must extrapolate from such results to the population he/she treats every day. That is particularly true for the clinician whose practice is focused on the elderly, those with serious concomitant medical illnesses, or specific ethnic populations. In terms of the latter, sociocultural factors (e.g., ethnic attitudes about drug taking) may also affect the dose-response curve and/or affect medication compliance. This presentation will use clinical cases to illustrate the above pharmacologic principles with particular emphasis on ethnic populations.

No. 44B
ISSUES IN ETHNIC RESPONSES TO PSYCHOTROPIC MEDICATION

William B. Lawson, M.D., *Department of Psychiatry, Roudebush VAMC, 1481 West 10th Street (116A), Indianapolis IN 46202;* John O. Gaston, M.D.

SUMMARY:

Ethnic differences have been noted in the diagnosis of ethnic minorities. African Americans and Hispanics are more likely to be diagnosed as having schizophrenia while affective and anxiety disorders are under- or misdiagnosed. As a consequence treatment is often inappropriate. Pharmacotherapy in particular may not be optimized for all ethnic populations. Many ethnic minorities are often more likely to receive antipsychotic medication for nonpsychotic disorders. Excessive medication is often given despite evidence that patients of African or Asian ancestry may require the same dosage or less medication. Patients of Asian and African ancestry may be more likely to be slow metabolizers for typical neuroleptics and tricyclic antidepressants in the cytochrome p450 system. Litihum may be metabolized differently in African Americans. The risk for tardive dyskinesia is greater for African Americans on neuroleptics, overdose is greater for all groups on tricylic antidepressants, and lithium side effects are seen more often for African Americans. Newer agents are clearly better tolerated but may not be accessible because of cost, politics, and the way mental health services are provided in this country.

No. 44C
PSYCHOTROPICS AND WOMEN

Freda C. Lewis-Hall, M.D., *Lilly Center for Women's Hlth, Lily Corporate Center DC2128, Indianapolis IN 46285*

SUMMARY:

The role of race and ethnicity has become of increasing importance in the diagnosis and management of psychiatric disorders. The research base as it specifically relates to the ethnopsychopharmacology is steadily growing. Little, however, is reported in the literature related to the "double jeopardy" for women of color: that is, the potential dual impact of race/ethnicity *and* gender. This presentation will review the current published literature and report some yet unpublished data that examine this issue as it pertains to efficacy, adverse events, toxicity, and pharmacokinetics and dynamics.

No. 44D
ETHNICITY AND PSYCHOTROPIC DRUG RESPONSES

Keh-Ming Lin, M.D., *Department of Psychiatry, Harbor-UCLA Medical Center REI, 1124 West Carson Street/B4 S, Torrance CA 90002*

SUMMARY:

Clinical observations and survey findings over the past four decades have repeatedly suggested the existence of dramatic cross-ethnic and cross-national differences in the dose requirement and side-effect profiles of various psychotropic and nonpsychotropic medications. All major classes of psychotropics as well as a variety of other pharmacological agents have been observed to have differential effects in different ethnic groups. Mechanisms responsible for these ethnic differences include pharmacokinetic (including protein binding), pharmacodynamic (receptor-coupled responses), and "non-pharmacological" factors including compliance (adherence), placebo effects, and personality traits. Ethnic differences in pharmacokinetics have further been demonstrated to be caused by genetic factors in some circumstances and environmental factors (such as diet) in others.

This presentation will briefly review these issues as well as their clinical implications, with a special focus on recent research on ethnic variations in the activity of some of the most important drug metabolizing enzymes, genetic mutations responsible for such variations, as well as their relationship with drug responses and toxicity.

No. 44E
OVERCOMING PSYCHOTROPIC DRUG NON-COMPLIANCE: A CULTURAL PERSPECTIVE

Albert C. Gaw, M.D., *Department of Psychiatry, Bedford VA Hospital, 2 Springdale Road, Lexington MA 02173;* John A. Nichols, Psy.D.

SUMMARY:

Psychotropic drug noncompliance is a significant problem in general psychiatry and has specific relevance for various ethnic groups. In addition to biological factors, nonbiological variables strongly influenced by sociocultural beliefs and attitudes, have notable effects on compliance and treatment outcome. To date, this area has not been well studied and is in need of further scientific investigation. The literature cites a number of sociocultural variables that affect noncompliance. They include ethnic attitudes toward diet, combined use of herbs/alternative medicines with psychotropic drugs, culturally determined perceptions pertaining to placebo effects/side effects, and availability of social support systems and families. Also, patients have been found to participate more in treatment and experience better outcome with medications when treatment was culturally responsive. Based on the authors' experience, we recommend the use of a clinician's inquiry that systematically explores some common sociocultural meanings toward taking psychotropic medications. We believe attention to these sociocultural variables fosters better compliance and outcome.

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SYMPOSIUM 45—EATING DISORDERS: ORIGINS, TREATMENTS AND OUTCOMES

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to describe new developments in eating disorders regarding genetics; temperament, substance abuse, and bulimia nervosa; relapse prevention in anorexia nervosa; medication and IPT treatment of bulimia nervosa; and relapse related to treatment in community settings.

No. 45A
THE GENETICS OF ANOREXIA NERVOSA: NEW FINDINGS

Walter H. Kaye, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Room 1086, Pittsburgh PA 15213;* David S. Goldman, M.D., Wade H. Berrettini, M.D., Katherine A. Halmi, M.D., Price Foundation Study Group

SUMMARY:

Eating disorders have not traditionally been viewed as heritable illnesses. However, recent family and twin studies lend credence to the potential role of genetic transmission of a vulnerability to develop an eating disorder. This may be particularly true for restricting type anorexia nervosa (AN) since this disorder has a stereotypic clinical phenotype that has been clearly and consistently defined. Moreover, several lines of evidence suggest that people with AN may have a trait-related disturbance of serotonin (5-HT) that could contribute to restricted eating, behavioral overcontrol, obsessive exactness and perfectionism, and negative affective states.

A polymorphism (−1438G/A) in the promoter region of the gene for the 5-HT_{2A} receptor has been found to be associated with AN (Collier et al., 1997). This finding has been replicated in four of six of the AN cohorts studied (Enoch et al., 1998; Sorbi et al., 1998; Hinney et al., 1997; Campbell et al., 1998). Preliminary data raise the possibility that this polymorphism may be particularly associated with the restricting type of AN and/or obsessive-compulsive disorder, but not bulimia nervosa (BN). The function of this polymorphism is not known but theoretically could alter receptor properties.

A multicenter study funded by the Price Foundation is using a sibling pair type strategy to identify possible genes that may contribute to AN. Genetic analysis is now under way and consists of genome scan for linkage using 400 markers at 20 centimorgan intervals, and assessment of serotonin and other candidate gene polymorphisms. To enter the study, probands must have met criteria for restricting type AN in their lifetime and never have met criteria for BN. Affected relatives must have met lifetime criteria for either AN, BN, or eating disorders not otherwise specified. The collection of assessments and DNA samples from 199 probands and 241 affected relatives and approximately 50% of their biologic parents has been completed. These 241 affected relative pairs provide >95% power to detect a locus that increases risk for an eating disorder by a factor of 3, if the threshold for declaring linkage is lod score >3, in a complete genome scan.

No. 45B
BULIMICS WITH SUBSTANCE USE DISORDERS

Marcia E. Rorty, Ph.D., *Department of Psychology, Azusa Pacific University, Azusa CA 91702;* Joel Yager, M.D., Stephen A. Wonderlich, Ph.D., Elizabeth Rossotto, Ph.D.

SUMMARY:

Purpose: Our study compared bulimic women with and without a lifetime history of alcohol or substance use disorders for possible differences in temperament, Axis II pathology, coping styles, and self-destructive behaviors.

Methods: We administered the SCID-P (Axis I disorders), the SCID II (personality disorders), Tellegen's Multidimensional Personality Questionnaire (temperament), the COPE (coping styles), and a questionnaire regarding self-destructive and impulsive behavior to 80 women with a lifetime history of bulimia nervosa (BN), purging type.

Results: BN subjects with a history of psychoactive substance use disorders (BN + PSUD; abuse or dependence) (n = 36), compared with BN subjects without lifetime PSUD (BN − PSUD) (n = 43), reported greater temperamental qualities of stress reactivity, alienation, impulsivity, and capacity for absorption, as well as a greater likelihood of cluster B personality disorders, especially borderline. BN + PSUD subjects also were more likely to use negative coping strategies when under stress, particularly those suggesting avoiding, denying, and disengaging. Finally, BN + PSUD women displayed greater impulsive and self-destructive behaviors, especially compulsive spending, reckless driving, and unsafe sex.

Conclusions: BN + PSUD subjects, in comparison with BN − PSUD subjects, are prone to greater characterological deficits, poorer coping, and higher levels of self-destructive and impulsive behaviors.

No. 45C
ANOREXIA NERVOSA: PREVENTION OF RELAPSE

Katherine A. Halmi, M.D., *Department of Psychiatry, Cornell Medical College, 21 Bloomingdale Road, White Plains NY 10605-1504;* W. Stewart Agras, M.D., James E. Mitchell, M.D., Scott J. Crow, M.D.

SUMMARY:

One of the major problems in treating anorexia nervosa (AN) is prevention of relapse. Preliminary studies have shown fluoxetine may be effective for preventing weight loss in AN patients who are within 80% of a normal weight (NW). Cognitive-behavioral therapy (CBT) is an established treatment of AN.

In three collaborating centers AN patients within 80% NW are randomly assigned to fluoxetine, CBT, or fluoxetine plus CBT and treated for one year. All three groups receive medical management.

To date 90 AN patients have been randomized for treatment. Lifetime comorbidity is high with major depressive disorder, 70%; obsessive-compulsive disorder, 33%; and alcohol/substance abuse, 30%. The dropout rate is 59% with dropouts being more impulsive (MPQ Impulse Control Scale) and having lower self-esteem (Rosenberg scale) compared with completers. Dropouts were also more likely to be unemployed. A six-month analysis showed patients receiving medication alone to have decreased core AN psychotherapy (YBC-Ed) and general OCD (YBOCS) and have greater self-esteem (Rosenberg scale) compared with the CBT alone group. The latter group is expected to show more of an effect at the one-year analysis.

No. 45D
TREATMENT OF BULIMIA NERVOSA PATIENTS WHO DO NOT RESPOND TO COGNITIVE-BEHAVIOR THERAPY

James E. Mitchell, M.D., *Department of Psychiatry, Neuropsychiatric Research Ins., 700 First Avenue South/Bx 1415, Fargo ND 58107;* Katherine A. Halmi, M.D., W. Stewart Agras, M.D., G. Terrence Wilson, Ph.D., Scott J. Crow, M.D.

SUMMARY:

The authors participated in a multicenter treatment study of individuals with bulima nervosa. Sites included the University of Minnesota, Rutgers University, Cornell University, and Stanford University. At each site, normal weight women with bulimia nervosa were treated with individual cognitive-behavioral psychotherapy. Those who were in remission at the end of treatment were then randomly assigned to follow-up only versus added treatment sessions if they became symptomatic again. Those who failed to achieve remission of symptoms with CBT treatment were randomly assigned to one of two secondary treatments: interpersonal psychotherapy (IPT), a form of psychotherapy that targets interpersonal relationships rather than eating symptoms, and weight and shape concerns; or a series of medication trials beginning with fluoxetine hydrochloride, and if necessary a second trial with desipramine hydrochloride.

The initial CBT treatment and the secondary treatment phase have now been completed. This paper will present the data on the outcome for the secondary treatments and data on the utility of providing additional visits as a relapse prevention technique. The results will be of use to clinicians in choosing the best available secondary treatments for bulimia nervosa in CBT nonresponders.

No. 45E
TREATMENT AND RELAPSE IN EATING DISORDERS

David B. Herzog, M.D., *Eating Disorders, Massachusetts General Hospital, 15 Parkman Street, EDU 725-ACC, Boston MA 02114;* Elizabeth Ekeblad, B.A., Sherrie Selwyn, B.A., Dara Greenwood, B.A., Mark A. Blais, Ph.D., Andrea Flores, M.Ed., David Dorer, Ph.D.

SUMMARY:

Traditionally, anorexia nervosa has been considered a chronic disorder and bulimia nervosa has been characterized as a relapsing disorder. In a recent review of outcome studies on bulimia nervosa, Keel and Mitchell reported a relapse rate of 30%. Rates of relapse in anorexia nervosa are less frequently reported; the few studies that do indicate rates ranging from 4% to 9%.

The MGH Naturalistic Longitudinal Study of Anorexia Nervosa and Bulimia Nervosa, now in its 11th year, tracks the course and outcome of eating disorders in 250 treatment-seeking women followed prospectively at frequent intervals. Our analyses on the rates of full recovery (remaining asymptomatic for at least eight consecutive weeks) over the course of 7.5 years indicate a substantial difference between subjects with bulimia nervosa (74%) and subjects with anorexia nervosa (33%). However, we have found that approximately 32% of both the anorexic and bulimic subjects experience a relapse into full criteria symptoms. We are continuing to gather and analyze data, and we will report on patterns of relapse (i.e., time to relapse) and predictors of relapse such as treatment, comorbid diagnoses, and duration of illness.

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SYMPOSIUM 46—BIPOLAR DISORDER: FROM RESEARCH TO THE COMPLEXITIES OF CLINICAL CARE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: (1) recognize risk factors for poor response to treatment in biopolar illness, and (2) develop a treatment plan for the complexities of bipolar disorder.

No. 46A
RECENT GENETIC FINDINGS IN BIPOLAR DISORDER

John I. Nurnberger Jr., M.D., *Department of Psychiatry, Indiana University, 791 Union Drive, Indianapolis IN 46202;* J. Raymond DePaulo, Jr., M.D., Mary C. Blehar, Ph.D., Elliott S. Gershon, M.D., Tatiana Foroud, Ph.D., Theodore A. Reich, M.D.

SUMMARY:

Bipolar affective disorder (BP) clearly aggregates within families. The genetics of BP is complex, however, and not consistent with single major locus inheritance; no specific genes have yet been located and confirmed. A collaborative study involving four sites was supported as part of the NIMH Genetics Initiative. A structured interview (DIGS) was developed to provide a comprehensive phenotypic assessment of patients and relatives. Families included were required to have at least two affected subjects with bipolar I (BPI) disorder or one with BPI and a second with schizoaffective disorder, bipolar type (SA/BP). Probands and relatives were interviewed and provided a blood sample for transformation and storage at a national data bank. We present results from 540 subjects selected from 97 families. This group included 282 affected sibling pairs, (BP&UP), as well as 412 affected relative pairs. A survey was completed with 319 markers. Analysis was carried out using SIBPAL and Genehunter II. A number of candidate areas are supported, especially areas on chromosomes 6, 10, and 16. New genetic findings may ultimately lead to more specific treatment strategies.

No. 46B
WHAT DO ANIMAL MODELS TELL US ABOUT BIPOLAR DISORDER?

Aimee R. Mayeda, M.D., *Department of Psychiatry, Indiana University VA Med Ctr, 1481 West 10th Street, 116A, Indianapolis IN 46202;* John R. Hofstetter, Ph.D.

SUMMARY:

No single animal model simulates the complex behavior seen in bipolar affective disorder, including cycling, mania, and depression. Nevertheless, animal models have been a rich source for understanding the etiology of the disorder, mechanisms of action of older therapies, and for ideas for novel therapies. Recent studies of circadian rhythms and sleep patterns in animals have identified neurotransmitter pathways important in maintaining normal body rhythms. This has led to new treatments for patients including drugs that affect the circadian system like melatonin, light therapy, and manipulation of sleep cycles. Understanding daily cycles of hormones and neurotransmitters has led to recognition of the importance of timing when medications or light are administered. Genetic studies of bipolar families are identifying chromosomal areas that may predispose a person to bipolar disorder. At the same time studies in animals are showing that genetic differences between strains of mice can lead to a differential response to light and lithium. Studies of kindling and of strains of mice that differ in seizure susceptibility are leading to better understanding of the mood-stabilizing qualities of anticonvulsants. In the future, genetic testing may help to indicate which patients will respond best to a given medication.

No. 46C
SPECTRUM OF MIXED STATES: WITH MANIA AND HYPOMANIA

Hagop S. Akiskal, M.D., *Department of Psychiatry, University of CA at San Diego, 9500 Gilman Drive, La Jolla CA 92093-0603*

SUMMARY:

Bipolar mixed states have commanded considerable attention during the past few years. This presentation reviews collaborative research that the author has conducted with clinical teams in France (n = 104 patients) and Italy (n = 143 patients). The new data show that dysphoric or mixed mania is one of the subtypes within a spectrum of mixed states. At the other extreme are situated mixed states, which consist of hypomanic admixtures with major depression that can be considered depressive mixed states. The first tends to be associated with bipolar I and the second with bipolar II. New research has demonstrated that dysphoric mania does not need to be defined by full syndromal depression, that indeed two or more depressive symptoms (such as depressed mood, hopelessness, suicidal ideation) are sufficient to validate a dysphoric subtype. These are best understood as arising from a dysthymic baseline. Depressive mixed states, on the other hand, are more likely to arise from a cyclothymic or hyperthymic baseline. The emerging data also indicate that patients with mixed states tend to have more psychotic features than nonmixed bipolars. These data have important implications for the treatment of complex bipolar patients with mood stabilizing anticonvulsants and atypical neuroleptics.

No. 46D
ETHNICITY AND TREATMENT OF BIPOLAR DISORDER

William B. Lawson, M.D., *Department of Psychiatry, Roudebush VAMC, 1481 West 10th Street (116A), Indianapolis IN 46202*

SUMMARY:

Bipolar disorder is often underdiagnosed or misdiagnosed as schizophrenia in ethnic minorities. African Americans and Hispanics in particular are more likely to be misdiagnosed or underdiagnosed and often receive inappropriate or no treatment. Three large multisite studies will be reviewed that suggest that African Americans are more likely to report psychotic symptoms or to have more symptoms overall. African Americans are more likely to receive neuroleptics, usually in higher doses, which may contribute to an increased risk for abnormal involuntary movements. Finally, African Americans appear to be less tolerant to lithium. However, we found no racial differences in lithium treatment. Treatment implications and access to care issues will be discussed.

No. 46E
CHALLENGES IN TREATING WOMEN WITH BIPOLAR DISORDER

Katherine L. Wisner, M.D., *Department of Psychiatry, Case Western Reserve Univ, 11400 Euclid Avenue, Suite 280, Cleveland OH 44106*

SUMMARY:

The effects of female reproductive functions on the course and treatment of bipolar illness are receiving increased research attention. Rapid cycling, depressive episodes, and mixed mania are more common among women with bipolar illness than men. Women with bipolar illness who become pregnant face difficult choices with their physicians about pharmacologic management. A model for clinical decision making during pregnancy will be presented, along with a discussion of the author's experience in treating pregnant and lactating women. A contract to study the efficacy of verapamil in childbearing-aged women has been developed by NIMH. The background and methodology will be discussed. The author's case series of women treated with verapamil, which yielded a 47% response rate with doses of 240-300mg/day, will provide a clinical overview of the use of this agent under open conditions.

Women with bipolar illness are at high risk for postpartum episodes. We are conducting a preventive trial of the efficacy of valproate given immediately postpartum to prevent recurrence. Preventively-treated women had a 33% recurrence rate compared with 67% of women who elected no medication. We have studied valproate treatment in breastfeeding women and found their infants developed very low serum levels of valproate without adverse effects.

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SYMPOSIUM 47—NEW INSIGHTS INTO TREATING POSTPARTUM DEPRESSION

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to provide comprehensive treatment for women with postpartum depressions, including safe administration of pharmacological agents during lactation, pharmacological or cognitive behavioral therapy to improve maternal-infant interaction, interventions for fathers, and the use of novel modalities for those mothers refractory to standard management.

No. 47A
POSTPARTUM ANXIETY AND MOOD DISORDERS: EFFECT ON INFANT DEVELOPMENT

Deirde M. Ryan, M.B., *Reproductive Psych Prog, BC Womens Hospital, 4500 Oak Street, Vancouver, BC V6H 3N1, Canada;* Shaila Misri, M.D., Pratibha Reebye, M.D.

SUMMARY:

Mood and anxiety disorders affect up to 15% of postpartum women. In addition to the woman herself, on whom the illness has a devastating effect, the infant's health is greatly compromised. Research on how the emotional, cognitive, and behavioral development of the infant is impacted is relatively nonexistent.

In this prospective sample of 30 mother dyads, maternal interaction will be studied before and after treatment intervention, providing an important insight into identifying risk and protective factors for mothers and infants. Dyadic interaction will be videotaped and coded.

The treatment will be randomized to two modalities: pharmacotherapy and cognitive-behavioral therapy. Comparing the two treatment options will provided information about the efficacy of each treatment in this population.

The study is being conducted at St. Paul's Hospital, Vancouver, British Columbia. The patients will be recruited from the reproductive psychiatry program. Trained infant psychiatrists will be assessing the dyads. The study is expected to be completed in 18 months.

No. 47B
PAROXETINE LEVELS IN MOTHER/INFANT DYAD

Shaila Misri, M.D., *Department of Psychiatry, St. Paul's Hospital, 1081 Burrard Street, Vancouver, BC V6Y 1Y6, Canada;* Diana Carter, M.B., Deirde M. Ryan, M.B.

SUMMARY:

This study is being conducted to determine the amounts of paroxetine in maternal serum, maternal milk, and infant's serum. Thirty mother/infant dyads are being recruited and studied at Women's and Children's Hospital in Vancouver, British Columbia. A team of experts from Pharmaceutical Sciences at U.B.C. are presently conducting the paroxetine assay by using gas chromatography. Postpartum (within 12 months of birth) breastfeeding women with mood anxiety disorders are included in the study. Medically health infants with proper sucking reflex are being recruited. The study is set for completion in one year. The levels of paroxetine in mother's milk is crucial information when advising a breastfeeding mother. Understanding the levels of paroxetine in infants is equally critical. Exposure effects of paroxetine in infants of nursing mothers urgently needs further research.

No. 47C
MEDICATIONS DURING PREGNANCY AND LACTATION: DEFINING EXPOSURE

Zachary N. Stowe, M.D., *Department of Psychiatry, Emory University Med School, 1639 Pierce Drive, Ste 4003, Atlanta GA 30322;* Amy Hostetter, B.S., James C. Ritchie, Ph.D.

SUMMARY:

The treatment of psychiatric illness during pregnancy and lactation represents a complex clinical situation. The increased incidence of mood and anxiety disorders during the childbearing years underscores the high probability that the clinician will encounter such situations. In the absence of enough data to provide scientifically derived guidelines, it is important to appreciate the limitations of the available data and establish a reasonable methodology for comparing treatment options. Pivotal to a comprehensive risk/benefit assessment is being able to compare equally efficacious medications in order to minimize fetal and neonatal exposure. The principles of teratology historically define exposure based on absolute concentrations (ng/ml) and timing rather than "functional exposure" involving molar conversion for comparison. In contrast, behavioral teratology may involve a more complex series of interactions underscoring the potential importance of "functional exposure" based on receptor binding affinities.

Data from the placental passage and breast milk excretion of antidepressants will be presented with an emphasis on comparing medications. The interpretation of laboratory results and how to evaluate an assay (e.g., limits of detection, variability, standard curve) for clinical use will be discussed. In summary, as data are mounting in the arena of treatment during pregnancy and lactation, there is a need to develop a clearer definition of exposure, scientifically derived methods for reducing exposure to both illness and medications, and provide clinically useful interpretation of new research.

No. 47D
MEN CONSTRUCT FATHERHOOD BY TRIAL AND ERROR: A CHILEAN AND CANADIAN STUDY

Susanne I. Steinberg, M.D., *Department of Psychiatry, St. Mary's Hospital, 3830 Lacombe Avenue, Montreal, PQ H3T 1M5, Canada;* Francois Bellavance, Ph.D., Enrique Jadresic, M.D., Daniela Zalaquett, M.D., Daniela Solari, M.A., Eric Belzile, M.Sc.

SUMMARY:

Objectives: To compare Chilean and Canadian fathers with respect to dyadic adjustment, parenting stress, and alliance with (index) and without (controls) partners treated for postpartum depression (PPD), and from different socioeconomic groups. To describe how men construct fatherhood in Canada.

Methods: 64 men have participated to date. Fathers completed self-report scales and a semistructured interview (audiotaped and transcribed). The NUD-IST software was used for coding and theme extraction. Statistical methods involved chi square and ANOVA.

Results: Trends suggest that (1) dyadic adjustment is lower among index fathers ($p = .095$), particularly Chilean fathers with low incomes and less education; (2) Canadians with greater education reported more parenting stress ($p = .051$). Canadians construct fatherhood through sheer necessity. They can not depend upon the extended family (52%) or the health care system (96%), afford day care (88%), or take paternity leave (96%). Double income families are a necessity, although discrimination against mothers in the work place (95%) forces men into the traditional provider roles (96%). Men perceive fatherhood as a rite of passage to manhood, an entry criteria for the corporate ladder, as having no special status. They learn to parent on the job, use male figures as reverse role models, and count upon their wives for guidelines.

Conclusions: (1) Cultural differences were observed for dyadic adjustment. (2) Canadian men require assistance from health care and education systems to invent fatherhood for the millennium.

No. 47E
SLEEP DEPRIVATION IN PREGNANCY AND POSTPARTUM DEPRESSION

Barbara L. Parry, M.D., *Department of Psychiatry, University of California, 9500 Gilman Drive, La Jolla CA 92093;* Megan Curran, B.A., Christine Stuenkel, B.S., Megumi Yokomizo, B.A., Leslie W. Tam, M.D., Katherine A. Powell, J. Christian Gillin, M.D.

SUMMARY:

Objective: Sleep disturbances are common in major depression. Total and partial sleep deprivation can rapidly improve mood in

these patients. The aim of these studies is to test the hypothesis that critically timed sleep deprivation can improve depression and sleep disturbances during pregnancy and postpartum.

Methods: Women meeting DSM-IV criteria for a nonpsychotic major depressive episode with onset during pregnancy or the first year postpartum were randomized to a crossover trial of early (ESD) (sleep 3:00 a.m. - 7:00 a.m.) versus late (LSD) (sleep 9:00 p.m. - 1:00 a.m.) partial sleep deprivation administered at least one week apart.

Results: Of nine patients who completed the study, LSD was more effective than ESD in patients with postpartum depression, although during pregnancy, ESD had beneficial effects according to standardized psychiatric rating scales. Therapeutic responses were noted within one day, although in some women maximum responses occurred after a night of recovery sleep. LSD in particular improved the quality of sleep during recovery nights.

Conclusions: Critically timed sleep deprivation may help to improve the symptoms of pregnancy or postpartum depression. These interventions potentially may offer a novel treatment modality for women with pregnancy or postpartum depressions who are not candidates for pharmacologic treatments.

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2. Stowe Z, Owens M, Landry J, Kilts C, et al: Sertraline and desmethylsertraline in human breast milk and nursing infants. American Journal of Psychiatry 1997;154:1255–1260
3. Stowe ZN, Strader JR, Nemeroff CB: Psychopharmacology during pregnancy and lactation, in APA Textbook of Psychopharmacology. Edited by Schatzberg, Nemeroff. Washington, D.C., APA Press, 1998, pp 979–996
4. Ballard CG, Davies R: Postnatal depression in fathers. International Review of Psychiatry 1996; 8:65–71
5. Gillin JC: The sleep therapies of depression. Prog Neuropsychopharmacol Biol Psychiatry 1983; 7:351–364

SYMPOSIUM 48—PHYSICIAN-ASSISTED SUICIDE: A LOOK TO THE FUTURE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to demonstrate a balanced discussion of the ethical and clinical issues, and possible future developments, and understand new legislation, safeguards, palliative care.

No. 48A
AGGRESSIVE MANAGEMENT OF THE TERMINALLY ILL

Richard Whittington, M.D., *Department of Geriatrics, VA Medical Center, 1601 SW Archer Road, Gainesville FL 32608*

SUMMARY:

The medical, social, ethical, and economic impact of care of the terminally ill is receiving increased attention with the emphasis on improving end of life care. The Center to Improve Care of the Dying, Robert Rood Johnson Foundation (RWJ), Veterans Health Administration (VHA), Health Care Financing Administration (HCFA), Institute for Healthcare Improvement (IHI), and hospices are either initiating, sponsoring, or pursuing studies to accomplish this end. This raises multifaceted problems. Aggressive palliative care requires a change in physician mind set. Traditionally a physician sees himself as "healer" and "protector of the patient" (i.e., prevent substance abuse). This mitigates against recognizing "futility," stopping curative endeavors, increasing opiates, and focusing on the management of problems associated with the last stages of a disease process. These require the recognition and management of shortness of breath; anorexia, nausea, vomiting; nutrition and hydration status; skin care and pressure sores; depression, insomnia, anxiety, nervousness, as well as aggressive pain control. A study of end-of-life care at three cooperating VA facilities and the satisfaction or disatisfaction of surviving next of kin will be reviewed along with other ongoing and proposed studies in this area.

No. 48B
ASSISTED SUICIDE: PHYSICIANS' ATTITUDES

Samuel I. Greenberg, M.D., *Department of Psychiatry, University of Florida, 2715 NW 21st Street, Gainesville FL 32605-2936*

SUMMARY:

The issue of physician-assisted suicide is very much alive. End-of-life care is getting better, but is still not good. Many Americans are afraid that they will die in an ICU, alone, and in pain after days of futile care. All major medical organizations oppose assisted suicide, but many physicians disagree. Doctors, especially psychiatrists, should have a key role to play in this debate, which will severely test their integrity and compassion. The dilemma is how to respect the individual's right of self-determination without weakening the profession's and society's, respect for human life. Attitudes are over-determined, influenced by tradition, ethics, religion, and personal experience. Nothing is harder to change than an attitude. Confusion and lawsuits will continue until there is better definition of standards and procedures. The issues will not be resolved until the various state legislatures and the courts act. The laws have not caught up with the ethical dilemmas created by advances in medical technology. The issues will be discussed and the current literature reviewed.

No. 48C
PSYCHOLOGICAL BENEFITS OF AN ASSISTED DEATH

Faye Girsh, Ed.D., *Hemlock Society USA, PO Box 101810, Denver CO 80250*

SUMMARY:

There are many psychological advantages to knowing that at the end of life there can be a legal end to unbearable suffering in a gentle, quick, and certain way, achieving closure with loved ones. Anxiety about loss of control is relieved, depression is often lifted, control returns to the patient, the bond between the doctor and patient is strengthened, the family can be there to say good-byes, and the patient's integrity is preserved.

In the absence of a legal solution, other anxieties are generated: How will the patient obtain the medication? Will it work? Will the doctor be jeopardized if help is offered? What will happen to the loved ones who are present? Should the patient die alone so as not to put them in legal danger? The process becomes one of subterfuge, secrecy, shame, and guilt. Rather than a peaceful exit with a clear mind, the process of dying becomes anxiety ridden for the patient and the loved ones. While assisted dying is not legal, there will be some residual psychological trauma involved for loved ones who have been asked to help, whether they choose to help or refuse.

No. 48D
LEGAL AND ETHICAL ISSUES

Ross A. McElroy, Jr., M.D., *Department of Psychiatry, University of Florida, PO Box 100256, Gainesville FL 32610-0256*

SUMMARY:

Debate about physician-assisted suicide is one of the most problematic issues facing psychiatry today. While the public endorses the individual's right to physician-assisted suicide, the American Psychiatric Association and American Medical Association remain opposed. Medicine remains polarized by religious, philosophical, and ethical concerns.

The central conflict is between two sets of fundamental beliefs: We wish to respect a patient's wishes to relieve their suffering and to end futile medical care, but we also want to affirm the value of human life. Most ethicists distinguish between active and passive euthanasia. Opponents of physician-assisted suicide maintain that it is never ethically justified, that the taking of a human life is always wrong. Thoughtful arguments can be made for both positions.

As physician-assisted suicide becomes legal in more states, regulations and guidelines will now become the focus of attention. Psychiatrists will need to become more involved in these issues. Hospital ethics committees will now turn to establishing policies and procedures to assure that guidelines are correctly followed.

Medicine will never reach consensus on this issue. However, the lay public has determined that we deal with it. Some physicians will comply with those requests and others will not.

REFERENCES:

1. Brown, et al: Nontreatment and aggressive narcotic Rx among hospitalized pancreatic cancer patients. J Am Geriatric Soc 1998; 46:839–849
2. Back AL, Wallace JL, Starks HE, Pearlman RA: Physician assisted suicide and euthanasia in Washington State: patient requests and physician responses. JAMA 1996; 275:919–925
3. Woolfrey J: Oregon and physician assisted suicide. Hastings Center Report 1998; 28:9–17

SYMPOSIUM 49—CULTURAL ISSUES FOR PSYCHIATRISTS AND PATIENTS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize often overlooked cultural issues of minority and majority groups that affect psychiatrists and other mental health professionals, as well as all patients.

No. 49A
GENDER AS A CULTURAL ISSUE

Leah J. Dickstein, M.D., *Department of Psychiatry, University of Louisville, 323 Chestnut Street, Louisville KY 40202*

SUMMARY:

Gender issues in all majority and minority cultures are important to be understood as cultural issues.

This presentation will highlight the major gender issues across the life cycle for women and men. Furthermore, the audience will be informed of the need to look, listen, ask, and understand gender issues in all subcultures as well as the overriding general issues affecting and too often burdening all women and men.

The importance of mental health professionals understanding gender issues and their roles and effects on their own lives, regardless of when their families arrived in this country, must occur before they can interact appropriately and successfully with patients.

No. 49B
BACK-DROP CULTURE AND LATINOS: CLINICAL IMPACT

Silvia W. Olarte, M.D., *Department of Psychiatry, NY Medical College, 37 East 83rd Street, Apt 1, New York NY 10028*

SUMMARY:

Latino populations are the fastest growing minority in this country. Their cultural heritage is being woven into the backdrop culture provided by the host country, acquiring a novelty of its own. Their acculturation struggle continues to unravel though, influenced among other factors by their command of the new language, their racial markers, and their first and/or second-generation immigrant status.

This presentation will focus on:

(1) Latinos' different levels of acculturation in reference to their first- or second-generation immigrant status, and the relation between generations and its impact on mental health.

(2) Latinos' different levels of proficiency in the host language and its relation to sociocultural, educational, and immigration status.

(3) Impact of such variation on language proficiency on delivery of services, family dynamics, and adaptation to society.

Clinical vignettes from work done with first- and second-generation latino immigrants of different socioeconomic background will be used to illustrate both diagnostic and treatment issues.

No. 49C
GAY MEN AND LESBIANS: CULTURE BASED ON SOCIAL STIGMA

Robert P. Cabaj, M.D., *Mental Health Services, San Mateo City Mental Hlth Ctr, 225 West 37th Avenue, San Mateo CA 94403*

SUMMARY:

Cultural factors and influences have multiple origins. Gay men and lesbians may not appear to be a "culture" in the traditional sense—that is, one based on ethnicity, geography, religion, and so on. The diverse population of gay men and lesbians, however, do have a culture—one created by societal bias and stigma. Growing up in a society that either ignores or outright condemns homosexuality, people who have a sexual orientation different from the majority—homosexual or bisexual—may have emotional problems that develop because of this societal bias. Stigma can shape identity formation and can also influence how gay men and lesbians present for mental health treatment for issues not related to adjustment to their sexual orientation. Psychiatrists need to understand these "cultural" factors in their gay and lesbian patients to provide optimal psychiatric care.

No. 49D
CLINICAL WORK WITH AFRICAN-AMERICAN WOMEN

Marilyn L. Martin, M.D., *Maryland Health, 7172 Columbia Gateway Drive, Columbia MD 21046*

SUMMARY:

Clinicians seeking to work successfully with African-American females over the life continuum should be equipped with skills to address the unique resistances to treatment they may present. Mistrust of mental health providers, the view that mental illness or depression occurs as a result of personal weakness, concerns over "being drugged or experimented on," black homophobia, the Super Black woman front, and the "kick 'em to the curb" adolescent female are only a few examples. Once engaged in treatment, clinicians need to be open to acknowledging and respecting coping mechanisms many African-American women view as tried and true. These include

spirituality, alternative healings, bibliotherapy, journaling, and cultural celebrations such as Kwanza.

The presenter will share the results of interviews with clinicians working with African-American women. Material from African-American female clinicians who have been in their own therapy will be included from the viewpoint of what they found successful. The focus will be on addressing resistance, engagement in therapeutic work, and helping African-American women to more successfully use coping mechanisms they currently have, and those skills obtained during the course of therapy.

No. 49E
PSYCHIATRIC DIAGNOSIS IN AMERICAN INDIANS

Ilena M. Norton, M.D., *Department of Psychiatry, Denver Health Medical Center, Al Center, 777 Bannock Street, Denver CO 80218*

SUMMARY:

Clinicians need to know the cultural factors that determine the patient's presentation of illness in order to effectively assess and treat mental disorder. The aim of this presentation is to describe issues that arise in the psychiatric diagnostic assessment of American Indian patients. Provided are specific clinical examples to illustrate how American Indian cultural values and orientations influence the patient's presentation of illness, using the framework of the cultural formulation in DSM-IV.

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1. Miller JB: Toward a New Psychology of Women, 2nd edition. Boston, Beacon Press, 1983
2. Malgady RG, Rodriguez O (eds): Theoretical and Conceptual Issues in Hispanic Mental Health. Malabar, Fla, Krieger Publishing Co., 1994
3. Cabaj RP, Stern TS (eds.): Textbook of Homosexuality and Mental Health. Washington, D.C., American Psychiatric Press, Inc., 1996
4. Mitchell A, Herring K: What The Blues Is All About. Black Women Overcoming Stress and Depression. Perigee Books, 1998
5. Norton IM: American Indians and mental health: issues in psychiatric assessment and diagnosis, in Cross Cultural Psychiatry. Edited by Herrara JM, Lawson WB, Stamek JJ. West Sussex, England, John Wiley & Sons, in press

SYMPOSIUM 50—THYROID HORMONE: NEUROBIOLOGY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation, the participant should be familiar with general thyroid physiology and its regulation in depression. T3 & T4 will be distinguished from each other by pharmacokinetics, correlations to severity of depression, neurocognition, and clinical applications in the management of depression.

No. 50A
CSF AND SERUM IODOTHYRONINE IN DEPRESSION

Mark A. Frye, M.D., *Department of Psychiatry, UCLA NPI&H, 300 UCLA Medical Plaza, #1544, Los Angeles CA 90095*

SUMMARY:

The central evaluation (i.e., CSF) of iodothyronines, as a measure of pathological severity in depression has not been well studied.

Fifty-two depressed inpatients (26 BP, 26 UP) and 33 controls underwent a medication-free or double-blind placebo lumbar puncture with same day phlebotomy to assess central and peripheral iodothyronines. Serum(s) measurements included: TSH, total T4 (TT4), free T4 (FT4), total T3 (TT3), and total reverse T3 (TRT3). Central (CSF) measurements included: TSH, total T4, total T3, and total reverse T3. Mood was assessed using the Hamilton Rating Scale (Ham-D) for depression.

Each iodothyronine was not significantly different in affective patients vs. controls, except for a reduced patient rT3-S ($p = 0.009$). Severity of depression correlated with s fT4 ($n = 37$, $r = 0.5$, $p < 0.0001$), s TT4 ($r = 0.55$, $p = 0.0001$), CSF TT4 ($r = 0.5$, $p = 0.0001$), and s rT3 ($n = 37$, $r = 0.59$, $p < 0.0001$.

No. 50B
THE USE OF THYROID HORMONES TO DIMINISH THE COGNITIVE SIDE EFFECTS OF PSYCHIATRIC TREATMENTS

Robert A. Stern, Ph.D., *Department of Psychiatry, Brown University, 1110 Lockwood Street, Ste 430, Providence RI 02903*

SUMMARY:

Alterations of the hypothalamic-pituitary-thyroid (HPT) axis have long been known to impair cognitive functioning. In addition to overt forms of thyroid disease, it is now known that subclinical forms of both hypothyroidism and hyperthyroidism can lead to neuropsychological deficits, and that hormone replacement can reverse these impairments. Some psychiatric treatments, most notably lithium and electroconvulsive therapy (ECT), have been shown to affect the HPT axis. These treatments also frequently have cognitive side effects, which can reduce treatment compliance. Recent data have shown that cognitive functioning is significantly related to thyrotropin (TSH) and not to lithium levels in bipolar patients taking lithium. Preliminary results indicate that levothyroxine (T4) treatment can diminish the cognitive side effects of lithium. Other recent preclinical and clinical studies have established that liothyronine (T3) can significantly diminish the cognitive side effects of ECT in euthyroid subjects. These findings suggest that exogenous thyroid hormone may reduce the cognitive side effects of important psychiatric treatments, thus possibly improving treatment compliance and reducing overall morbidity.

No. 50C
T3 ACCELERATION TRIALS IN MAJOR DEPRESSION

Lori L. Altshuler, M.D., *Department of Psychiatry, VA Med Cntr, Bldg. 158, Rm 104, 11301 Wilshire Blvd, B116AA, Los Angeles CA 90073*

SUMMARY:

The author will review the current literature assessing the utility of thyroid hormone (T3) as an augmentation in antidepressant non-responders.

The studies in the literature can be classified into those that use thyroid supplementation early in treatment to accelerate antidepressant response vs. those that use thyroid supplementation late in the trial (6-8 weeks) to augment partial or no antidepressant response. The authors review the efficacy of thyroid supplementation as an adjunctive agent in accelerating antidepressant response. We will review the studies that use thyroid hormones to accelerate the antidepressant response to standard medications or ECT and report our meta-analysis of the pooled eight controlled studies (double- or single-blind). Further, women may be more likely than men to benefit from this addition early in antidepressant response.

No. 50D
ADJUNCTIVE HIGH-DOSE LEVOTHYROXINE IN REFRACTORY MOOD DISORDERS

Michael Bauer, M.D., *Department of Psychiatry, Freie University, Eschenallee 3, 14050 Berlin, Germany*

SUMMARY:

In two open clinical trials we investigated whether adjunctive high-dose levothyroxine (T4) had antidepressant effects in therapy-resistant major depression and long-term bipolar prophylaxis.

Seventeen therapy-resistant euthyroid patients with major depression were studied. Levothyroxine was increased to a mean daily dose of 482 mg. The mean patients' scores on the HRSD declined from 26.6 ± 4.7 prior to the addition of T4 to 11.6 ± 6.8 at the end of week 8. Eight patients fulfilled the criteria for full remission (a 50% reduction in HRSD score and a final score of £9) within eight weeks and two others fully remitted within 12 weeks.

Bipolar patients who were refractory to two or more standard prophylactic treatments were consecutively included in the second study. The mean daily dose of levothyroxine was approximately 400 mg (range 250-600 mg); the mean duration on high-dose T4 treatment was three years (range: 24 to 104 months). Preliminary data show that the overall

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2. Tremont G, Stern RA: Use of thyroid hormone to diminish the cognitive side effects of psychiatric treatment. Psychopharm Bull 1998; 33:273–280
3. Aronson R, Offman HJ, Joffe RT: Triidothyronine augmentation in the treatment of refractory depression—a meta analysis. Arch Gen Psychiatry 1996; 53:842–848
4. Bauer M, Hellweg R, Graf KJ, Baumgartner A: Treatment of refractory depression with high-dose thyroxine. Neuropsychopharmacology 1998; 18:444–455

SYMPOSIUM 51—IMPACT OF PARITY AND MANAGED CARE ON MENTAL HEALTH CARE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, participants should be able to understand the interaction between parity insurance benefits for mental disorders (affecting "demand"), and the economic dynamics of managed behavioral health care, which controls the "supply" of services. Interaction effects on cost, access, and quality of mental health services are illustrated with new research findings.

No. 51A
THE COST OF MENTAL HEALTH INSURANCE PARITY

Darrel A. Regier, M.D., *NIMH, 31 Center Drive, Rm 4A52, Bethesda MD 20892;* Sam Zuvekas, Ph.D., Agnes Rupp, Ph.D., Ellen M. Weissman, M.D., Stuart M. Sotsky, M.D., Edwin Hustead, Ph.D., Anne Rosenfeld

SUMMARY:

Under a predominantly fee-for-service system for delivering mental health services, insurance companies relied heavily on using benefit designs that were more restrictive for mental health than for physical health services—specifically, lower annual and lifetime payment limits, higher copayments, and lower limits on annual outpatient visits and inpatient days. All previous actuarial projections of the cost of increasing mental health insurance benefits to parity levels (with physical health) have assumed no changes in provider (supply-side) management, and have predicted that parity-related cost reductions would produce a "demand" for services that would essentially double the cost of mental health benefits and thereby increase total health benefits by at least 3%.

A new NIMH-supported actuarial model can now account for actual managed behavioral health care experience for cost projections. Empirical data collected from several states and private managed care plans have been integrated with the model to illustrate the market response to parity in a managed care environment. Results show that implementation of parity benefits in fee-for-service settings was always accompanied by managed care, which reduced mental health benefit costs by 30% to 50%. In settings that were already managed, parity resulted in total benefit cost increases of less than 1%.

No. 51B
ACCESS TO MANAGED MENTAL HEALTH SERVICES AND COST: IS THERE A TRADE-OFF?

Ellen M. Weissman, M.D., *NIMH, 31 Center Drive, Rm 4A52, Bethesda MD 20892;* Karen Pettigrew, Ph.D., Stuart M. Sotsky, M.D., Darrel A. Regier, M.D.

SUMMARY:

Managed care has been credited with controlling mental health costs, but evidence of its impact on access to care and quality of care is just now emerging. The proportion of total health benefit costs attributed to behavioral health in private, employment-based health insurance decreased from 6.1% in 1988 to only 3.1% of the total health benefit in 1997. The descriptive study reported here uses empirical data to examine the relationship between payment levels for managed behavioral health services in private insurance programs, and access to specialty MH/SA care. We find that the proportion of specialty mental health service users in managed care plans is directly related to plans' average spending on MH/SA insurance claims on a per member per month (PMPM) basis. For each increment of $0.72 PMPM, an additional 1% of members receive any services during one year. These data highlight the importance of reporting indices of access as well as cost in behavioral health plans.

No. 51C
ASSESSMENT OF QUALITY IN MANAGED MENTAL HEALTH SERVICES

Stuart M. Sotsky, M.D., *NIMH, 31 Center Drive, Rm 4A52, Bethesda MD 20892;* Darrel A. Regier, M.D., Ellen M. Weissman, M.D., Agnes Rupp, Ph.D.

SUMMARY:

Objectives: To understand approaches to assessment of quality in mental health services and the impact of managed care on quality of care.

Method: We will review the methodology and current empirical research results of assessment of quality in managed care based on organizational accreditation, administrative claims datasets, and comprehensive or special clinical outcome information systems.

Results: Within the managed care industry, current incentives generally do not encourage an emphasis on quality of care, its assessment, or the development of comprehensive quality information systems. Considerable variability has been observed in access and

other process measures of quality across managed behavioral health plans, raising concern about the quality and outcome of mental health care in some plans. In some cases in which management has resulted in limited mental health access, decreased work performance, increased absenteeism, and greater use of medical services have been observed. There is some preliminary evidence that access and quality can be maintained or improved after managed care is introduced, at least in higher cost plans, and may be facilitated by application of quality assessment analyses.

Conclusions: Further research is needed to assess treatment outcomes directly, both before and after the introduction of parity benefits.

No. 51D
FINANCIAL INCENTIVES IN MANAGED BEHAVIORAL HEALTH CARE PLANS

Agnes Rupp, Ph.D., *Parklawn Bldg, Rm 10C-06, NIMH, 5600 Fishers Lane, Rockville MD 20857;* Stuart M. Sotsky, M.D., Grayson S. Norquist, M.D., Darrel A. Regier, M.D.

SUMMARY:

The emergence of managed behavioral health care in the mental health care delivery system has many distinctive features in comparison with traditional systems of care, and a complex impact on the cost, access, and quality of care. As background, we review the economic reasons for lack of parity and equity in private health insurance policies for mental health care as they are related to consumer behavior concerning "moral hazard" and "adverse selection." New financial incentives in contracts between providers and purchasers of mental health care influence the benefit design and the interpretation of "medical necessity," which affects access to care. These incentives create differences between mental health benefits included in insurance plans (nominal benefits) based on medical necessity and actual benefits provided under plan management (real benefits) driven by insurance necessity. The interpretation of medical necessity in managed behavioral health care plans depends on four major components: (1) intensity of quality and utilization control mechanisms, (2) financial incentives facing providers, (3) structure of provider network, and (4) features of the nominal benefit package. Finally, the barriers to research in the private and public sectors in this area and the challenges of informing mental health policy formulation are discussed.

No. 51E
NEW PERSPECTIVES ON MENTAL HEALTH TREATMENT NEED

William E. Narrow, M.D., *NIMH, 31 Center Drive, Rm 4A52, Bethesda MD 20892;* Darrel A. Regier, M.D., Agnes Rupp, Ph.D., Donald S. Rae, M.A.

SUMMARY:

With the advent of managed behavioral health care, the ability to monitor changes in treatment rates in comparison with the prevalence of treatment need will be important to evaluate access to and quality of mental health services. One-year mental disorder prevalence rates, a traditional indicator of treatment need, are in the range of 28% to 30%. Pre-managed care treatment rates were 6% for specialists and 11% for any health care provider, with recent evidence indicating the proportion of the population receiving specialty care is declining with the introduction of managed care. Such changes in the health care delivery system have forced a rethinking of the concept of treatment need away from disorder prevalence alone. Recently, attention has turned to using the concepts of symptom severity, functional impairment, and clinical course in addition to diagnosis to arrive at a more informed determination of need. This presentation will describe ongoing NIMH analyses linking disorder prevalence estimates with these other factors to arrive at better estimates of treatment need in the community. Epidemiologic and health services data from the NIMH ECA Program, the National Comorbidity Survey, and other surveys will be presented and future data and research needs will be discussed.

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SYMPOSIUM 52—NEGATIVE SYMPTOMS: BEYOND SCHIZOPHRENIA

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this presentation participants should be able to recognize clinically significant negative symptoms in patients with dementias, strokes, and depression. This symposium will familiarize the participant with the concept of negative symptoms in nonschizophrenic disorders, the underlying neuroanatomy of the syndrome, as well as treatment modalities and treatment strategies.

No. 52A
CHARACTERIZATION AND TREATMENT OF NEGATIVE SYMPTOMS IN NONSCHIZOPHRENIA PATIENTS

Igor I. Galynker, M.D., *Department of Psychiatry, Beth Israel Medical Center, 1st Avenue at 16 St/6 Karpas, New York NY 10003;* Eamon Dutta, M.D., Jun Cai, M.D., Fukiat Ongseng, M.D., D. Howard Finestone, M.D., Alexander Prikhojan, M.D., Richard N. Rosenthal, M.D.

SUMMARY:

Negative syndrome (NS), initially associated with schizophrenia, has recently been described in patients with strokes, dementias, and major depressive disorder (MDD). Patients with diagnoses of dementia of Alzheimer's type (DAT) (n = 27), vascular dementia (VDE) (n = 15), and MDD (n = 23) were evaluated using detailed psychometric assessment and single photon emission computer tomography (SPECT). As in schizophrenia, patients with these disorders demonstrated avolition, amotivation, emotional withdrawal, flat affect, and poverty of speech. In DAT and VDE, but not in MDD, NS intensity was correlated with cognitive impairment. The NS were comorbid with symptoms of depression, anxiety, and psychosis. However, there was no correlation between NS and depressive symptoms or positive psychotic symptoms in these disorders. ^{99m}Tc-HMPAO SPECT studies in patients with dementias (n = 28) and MDD (n =

21) showed decreased cortical-to-cerebellar perfusion ratios in patients with high NS as compared with low NS severity. Decreases in cerebral perfusion were positively correlated with NS severity, particularly in the dorsolateral prefrontal cortex. In patients with strokes and dementias (n = 27), NS and cognition, but not depressive symptoms improved significantly with methylphenidate treatment. Treatment options for patients with NS with and without comorbid MDD will be discussed.

No. 52B
THE RELATIONSHIP OF NEGATIVE SYMPTOMS TO DEPRESSION AND FUNCTION IN DEMENTIA

William E. Reichman, M.D., *Department of Psychiatry, UMDNJ-RWJ Medical School, 667 Hoes Lane, Piscataway NJ 08856*

SUMMARY:

In dementia, the cognitive impairments associated with functional disability are often accompanied by significant behavioral alterations. In Alzheimer's disease (AD) for example, the majority of patients display occasional agitation, restlessness, delusional thinking, anxiety, or depressive symptoms. Notably, emotional withdrawal, impaired initiative, and reduced interest are also important behavioral changes that are very commonly seen in these patients. Widespread clinical experience, as well as our own recent work in this area, have led us to believe that the phenomenological construct of negative symptoms is a useful paradigm for the study of these particular behavioral alterations in dementia. We have demonstrated that in AD subjects, one can reliably distinguish the syndrome of depression from negative symptoms. More recently, evidence has emerged suggesting that negative symptoms in dementia patients may contribute to functional disability independent of cognitive status. As such, these symptoms are of practical as well as theoretical importance. This presentation will specifically focus on the presentation and measurement of negative symptoms in dementia, how these symptoms are distinguished from depression, and how they may be related to functional disability.

No. 52C
NEGATIVE SYMPTOMS IN FRONTOTEMPORAL DEMENTIA

Bruce L. Miller, M.D., *Department of Neurology, UCSF/Mt. Zion, PO Box 792, San Francisco CA 94120;* Kyle Boone, Ph.D.

SUMMARY:

Schizophrenia is a primary psychiatric disturbance, while frontotemporal dementia (FTD) and Alzheimer's disease (AD) are degenerative dementias. Yet, there are many parallels between the behavioral disturbances associated with these differing conditions. Many patients with specific anatomic variants of FTD and AD show blunted affect, apathy, and hypomotility. Such behaviors also characterize the negative symptoms found in patients with schizophrenia. However, unlike schizophrenia, in patients with FTD, these symptoms have a known anatomical substance. Therefore, FTD represents an excellent model for understanding the neuroanatomical and neurochemical bases for negative symptoms.

In this symposium we discuss the relationship between negative symptoms and relative hypoperfusion of frontal regions in 80 patients with FTD contrasted with a cohort of patients with Alzheimer's disease. With imaging a brain-dedicated SPECT camera is used to detect relative cerebral perfusion. Frontal regions are divided between right and left, as well as cingulum, basal, and dorsolateral frontal areas. Apathy and other psychiatric symptoms are quantified with the Neuropsychiatric Inventory and Scales for Assessment of Negative Symptoms (SANS) and the Positive and Negative Symptom Scales (PANSS).

Apathy and negative symptoms are markedly elevated in patients with FTD, particularly patients with severe hypoperfusion of the cingulum. The implications of these findings and the relevance to schizophrenia are discussed.

Following this presentation the audience should have a clear understanding of the clinical symptomatology of FTD, particularly as it relates to positive and negative symptoms. Additionally, the anatomic areas that contribute to these symptoms will be understood, as will potential treatment options.

No. 52D
NEGATIVE SYMPTOMS: PRINCIPAL COMPONENT ANALYSES OF PSYCHOMETRIC SCALES IN NONSCHIZOPHRENIA PATIENTS

Alexander Prikhojan, M.D., *Department of Psychiatry, Beth-Israel Medical Center, 1st Avenue at 16th St/6 Karpas, New York NY 10003;* Igor I. Galynker, M.D., Naomi Vilkas, B.A., Richard N. Rosenthal, M.D.

SUMMARY:

Principal component analysis of two psychometric scales, the Scale for the Assessment of Negative Symptoms (SANS), and the Positive and Negative Symptom Scale (PANSS), was performed in a sample of 75 inpatients with dementia or stroke and no Axis I diagnosis. For PANSS, after Varimax rotation of factors with eigenvalue not less than 1, seven factors emerged. Factor I was interpreted as negative symptom complex, explained 28.5% of variance, and was indistinguishable from negative factor, consistently described for patients with schizophrenia and schizoaffective disorders (S/SA). Factor II, cognition/insight, which was able to explain 19.2% of variance, was also not different from the similar factor, described in S/SA. Factor III with high loadings of poor impulse control and excitement was interpreted as compromised self-regulation. Factor IV with high loadings of guilt feelings, suspiciousness, and disturbance of volition, was considered as a relational attitude/indirect hostility. Anxious/depressive Factor V explained 11.0% of total variance, and except for the absence of guilt feelings item, was similar to the one described in S/SA. Two other factors accounted for less than 10% of variance each. Factor VI, agitation/disinhibition, was close in the content with manic-expansive factor in S/SA. Factor VII, prominent for high loadings of active social avoidance and hostility, constituted a (direct) hostility factor. For SANS, Varimax rotation yielded four factors: Factor I, "personal representation," included eight items and explained more than 50% of the variance. Factor II, "outward interaction," explained 25% of the variance. The content of SANS and PANSS factors will be compared with that in schizophrenia.

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SYMPOSIUM 53—BIOLOGICAL DIMENSIONS OF PSYCHOTHERAPY
APA Commission on Psychotherapy by Psychiatrists

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the biological dimensions of aspects of psychotherapy in its relation to trauma, the immune system, psychopharmacology, and language competence.

No. 53A
IT'S NOT YOU, IT'S YOUR BRAIN: BIOLOGY TALK IN THERAPY

Charles A. Morgan III, M.D., *Department of Psychiatry, Yale University, 950 Campbell Avenue, West Haven CT 06511-3844*

SUMMARY:

Over the century, psychiatrists have confronted the clinical challenge of treating the psychological distress of combat soldiers. In nearly each decade of this century, such physicians have referred to biological factors as a way of explaining, or treating, aspects of patients' distress. However, these biological arguments, and their meanings, have shifted markedly throughout the 20th century. Historical evidence suggests that physicians have used explicit references to biology in their psychotherapeutic encounters with patients for a number of reasons: to help the patient "understand" the true nature of his distress, to "coerce" unwilling patients into following the doctor's treatment recommendations, to facilitate the primarily psychological treatment, or to bolster the professional image of psychiatry by giving it the appearance of "scientific medicine." Contemporary psychiatrists also infuse their psychotherapy encounters with biological rhetoric for multiple, and similar reasons. Clinical case studies from the work of E.E. Southard and L.R. Yealland (WWI), from U.S. Army psychiatric training films (WWII), and from the National Center for PTSD, will illustrate the various ways biology has been used as rhetoric in psychotherapy.

No. 53B
TOWARD A BIOLOGY OF COGNITIVE-BEHAVIOR THERAPY

Michael E. Thase, M.D., *Department of Psychiatry, University of Pittsburgh, 3501 Forbes Avenue, Room 916, Pittsburgh PA 15213;* Jesse H. Wright, M.D.

SUMMARY:

Cognitive and behavioral psychotherapeutic interventions are not ordinarily considered to be neurobiological treatments. Research on the biology of CBT is still at an early stage, but investigators of neuroendocrine functioning, sleep, EEG, and functional brain imaging have provided insights on possible biological effects of psychotherapy. Furthermore, studies comparing cognitive-behavior therapy (CBT) with medication for a variety of mental disorders have most often found these treatments to have equal efficacy. Could these treatments with very different theoretical backgrounds and clinical methods share common psychobiological mechanisms of action? This presentation explores available evidence for neurobiological effects of CBT and suggests ways in which cognitive and behavioral interventions could modulate biological processes. Studies of biological markers of depression have been oriented primarily toward measuring the efficacy of CBT in patients with evidence of possible biological depression. A comprehensive psychobiological treatment model is recommended for the clinical practice of cognitive-behavioral therapy.

No. 53C
POTENTIAL PHYSIOLOGICAL EFFECTS OF THE PSYCHOTHERAPIES

Molyn Leszcz, M.D., *Department of Psychiatry, Mount Sinai Hospital, 600 University Avenue, Toronto ON M5G 1X5, Canada;*

SUMMARY:

Much interest of late has centered in the area of the convergence of mind, brain, and body in efforts at understanding the bidirectional impact exerted from one domain to the other. A particularly important area of focus relates to recent research demonstrating important biological, physiological, and in some regards even survival effects that may be correlated with psychosocial interventions with the medically ill. Interest in the application of psychosocial interventions to patients with cancer and HIV have particularly spurred this area of inquiry.

Psychosocial interventions for the medically ill tend to focus on improvements in coping skills, maintenance of social support, and quality of life. This symposium will review the evidence to date linking psychosocial interventions, particularly group therapeutic interventions with physiological and biological measures. Reviews of work in this area, notably metastatic breast cancer, malignant melanoma, and HIV will be identified. The potential mediators of effect will be outlined as will the overarching, explanatory potential of the new field of psychoneuroimmunology. It is through this area of study that clear, quantitative, and functional alterations of immunocompetence have been demonstrated in response to a range of life stresses. Similarly, immunocompetence has been impacted by social support and by changes in coping mechanisms, underscoring potential responsiveness to psychosocial interventions.

No. 53D
NEUROBIOLOGY OF LANGUAGE IN PSYCHOTHERAPY

William H. Sledge, M.D., *Department of Psychiatry, Yale University, 2039CG, 20 York Street, New Haven CT 06511;*

SUMMARY:

Psychotherapy is intimately related to linguistic competence. Yet there has been remarkably little exploration of the salience of the neurobiological substrate of language competence for endeavors such as psychotherapy. This presentation explores what is understood about the biological dimensions of language skill and acquisition and pathological states in relation to language performance. The author will address the neurobiology of language through a brief summary of what is known from experimental psycholinguistics, imaging studies, and studies of aphasia. Phenomenon important to the psychotherapeutic process such as memory, transference, cognitive style, and psychopathology will then be considered from this neurobiological understanding of language competence and performance. The presentation will conclude with an account of why an understanding of the neurobiology of language is essential to advancing the effectiveness of psychotherapeutic approaches to mental illness and suffering.

No. 53E
GENETICS, TRANSFERENCE AND PSYCHIC REPRESENTATION

David Reiss, M.D., *Ross Hall, Room 613, GW University Medical Center, Washington DC 20037-2336*

SUMMARY:

Transference and psychic representation are closely linked in psychoanalytic thinking. Our behavioral genetics research sheds new light on these concepts. First, heritable characteristics of children elicit very distinctive responses from parents, a phenomenon called active gene-environment correlation. Second, children growing up in the same family are rarely alike on a broad range of attributes unless they share genes, e.g., unrelated step siblings show low or zero correlations for personality, intelligence, or psychopathology. Thus, environmental factors that shape children's development must be unique for each child in the family. This is termed nonshared environment. Active gene-environment correlation points to genetic factors as important in the continuity between what the child may evoke in parents and what that child later, as an adult, evokes in a therapist. It also underscores the wisdom of therapists' attention to their own reactions to patients as a window on the persistent patterns by which patients structure their social world. Evidence on the nonshared environment suggest that children's unique constructions of their family life have more influence on their psychological development than observable characteristics of their parents. Genetic methods provide a secure method for estimating their relative importance in different domains of competence and psychopathology.

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SYMPOSIUM 54—OPTIMIZING THE ADMINISTRATION OF ECT

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be familiar with electroconvulsive therapy research findings and be able to implement this information to improve the efficacy and safety of ECT.

No. 54A
RESOLVING THE CONTROVERSY BETWEEN UNILATERAL AND BILATERAL ECT: OPTIMIZATION OF ECT

Harold A. Sackeim, Ph.D., *Department of Psychiatry, NYS Psychiatric Institute, 722 West 168th Street, Rm 422, New York NY 10032;* Joan Prudic, M.D., Davangere P. Devanand, M.D., Mitchell S. Nobler, M.D., Sarah H. Lisanby, M.D., Shoshana Peyser, C.S.W., Linda Fitzsimons, R.N.

SUMMARY:

Over 40 years, multiple studies have demonstrated that right unilateral (RUL) ECT results in less cognitive impairment than bilateral (BL) ECT. However, because of uncertainty regarding the efficacy of RUL ECT, in clinical practice BL ECT has been the predominant mode of treatment. In recent years, it has been demonstrated that the efficacy of RUL is sensitive to electrical dosage. However, it is uncertain whether RUL ECT at high electrical intensity is comparable in efficacy to bilateral ECT. In this double-blind study, 80 patients with major depression were randomized to three RUL and one BL condition. RUL ECT was administered at an electrical intensity that was 50%, 150%, or 450% above initial threshold, and BL ECT was given at 150% above threshold. The efficacy of RUL ECT improved markedly at the highest electrical intensity. This condition was comparable in all measures of symptomatic improvement to the BL ECT condition. Even at very high stimulus intensity, RUL ECT maintained marked advantages with respect to cognitive side effects. Thus, high intensity RUL ECT may be the treatment of choice.

No. 54B
COMPARISON OF FIXED VERSUS TITRATED DOSE IN RIGHT UNILATERAL ECT

W. Vaughn McCall, M.D., *Department of Psychiatry, Wake Forest University, Medical Center Boulevard, Winston-Salem NC 27157;* David Reboussin, Ph.D., Harold A. Sackeim, Ph.D., Richard D. Weiner, M.D.

SUMMARY:

Objective: The present study compares the antidepressant and global cognitive side effects of two RUL dosing strategies: titrated, moderately supra threshold, and fixed, high dose.

Method: Seventy-two adult patients with major depression were randomized to either titrated RUL ECT at 2.25 times their convulsive threshold, or RUL ECT at a fixed dose of 403 mC. Primary outcome measures were antidepressant response status and global cognitive status one to two days after the course of ECT.

Results: The two treatment groups were comparable in their demographic and clinical characteristics prior to ECT. Both groups received a mean of approximately 5.7 treatments in protocol. Subjects receiving fixed dose ECT were more likely to have an antidepressant response at the end of the protocol (66.7%) compared with the titrated regimen (38.9%). Further, the likelihood of both antidepressant response and global cognitive deficits showed a dose response relationship to stimulus dose relative to the convulsive threshold, up to 12 times the threshold.

Conclusions: The antidepressant efficacy and cognitive side effects of RUL ECT are dependent on the magnitude of the stimulus dose relative to the convulsive threshold, and a dose response relationship extends at least through 12 times the convulsive threshold.

No. 54C
OPTIMIZING ECT IN PATIENTS WITH VERY HIGH SEIZURE THRESHOLDS AND THOSE TAKING BENZODIAZEPINES

Richard D. Weiner, M.D., *Department of Psychiatry, Duke University Medical Center, PO Box 3309, Durham NC 27713;* Andrew D. Krystal, M.D., Margaret D. Dean, M.D., Bradley V. Watts, M.D.

SUMMARY:

There has been growing concern among practitioners regarding management of patients with high seizure threshold, particularly since output of present ECT devices is limited. A new two-year

survey at our facility demonstrated that 18% of 157 index ECT patients required a maximum stimulus and 5% had short or missed seizures at this level. The significantly lower response rate of these 5% (36%) indicates a need for some means to improve efficacy.

One means of managing patients with extremely high threshold is to switch anesthetic agent to ketamine, which is not anticonvulsant. We retrospectively studied 28 such patients, finding that the switch to ketamine was associated with longer ($p < 0.03$) and electrophysiologically more robust ($p < 0.01$) seizures. Ketamine was also well-tolerated.

Other anticonvulsant medications including benzodiazepines may also limit response to ECT. We studied use of flumazenil to reverse anticonvulsant effect in 35 ECT patients concurrently receiving benzodiazepines. We compared them with 49 benzodiazepine/flumazenil-free patients and found no difference in seizure duration or efficacy.

These results suggest that ketamine and flumazenil may be useful to ECT practitioners for optimizing ECT treatment efficacy in patients with high seizure thresholds.

No. 54D
THE ROLE OF ICTAL EEG DATA IN OPTIMIZING ECT TREATMENT

Andrew D. Krystal, M.D., *Department of Psychiatry, Duke Univ Medical Center, Box 3309/Rm 54216/Trent Drive, Durham NC 27710;* Richard D. Weiner, M.D., Bruce Leber, Ph.D., Joan Prudic, M.D., Davangere P. Devanand, M.D., Harold A. Sackeim, Ph.D.

SUMMARY:

Objective: While ECT is a highly effective treatment for a number of neuropsychiatric conditions, some uncertainty remains about how to optimize stimulus dosing. Growing evidence indicates that characteristics of the EEG data recorded during the induced seizures (ictal EEG) are related to treatment therapeutic potency and may be useful for decreasing this uncertainty and improving treatment optimization. We review this literature and present the results of a study intended to test the potential clinical utility of the ictal EEG.

Methods: A multivariate ictal EEG model of treatment therapeutic response was developed in 149 depressed patients at Duke University and tested on data from 30 depressed subjects treated at Columbia University.

Results: EEG evidence of significantly higher seizure intensity was seen in Columbia subjects who were therapeutic responders compared with Columbia nonresponders ($F = 7.6$, $p < 0.01$). The multivariate ictal EEG model accounted for 39% of the variance in therapeutic response of the Columbia subjects.

Conclusions: These results support the potential utility of ictal EEG characteristics for helping clinicians optimize ECT treatment by decreasing some of the uncertainty regarding stimulus dosing. The present clinical application of ictal EEG algorithms will be discussed.

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SYMPOSIUM 55—PEDIATRIC PSYCHOPHARMACOLOGY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to know the major research studies of safety and efficacy of psychotropic medications for children and adolescents with attention deficit hyperactivity disorder, anxiety disorders, major depressive disorder, obsessive compulsive disorder, bipolar disorder, and autism.

No. 55A
EFFECTS OF LONG-TERM TREATMENT WITH STIMULANTS IN CHILDREN WITH ADHD: FINDINGS FROM THREE RANDOMIZED CLINICAL TRIALS

Howard Abikoff, Ph.D., *Department of Psychiatry, NYU Medical Center, 550 First Avenue/NB 21S6, New York NY 10016*

SUMMARY:

There are anecdotal reports of attenuation of stimulant effects over time. However, little is known from controlled studies regarding the clinical effects of sustained long-term stimulant treatment in children with ADHD. Three large-scale randomized clinical trials, which have been completed recently (the NIMH MTA Study, the New York/Montreal Multimodal Treatment Study, and the Swedish study by Gilberg and colleagues), provide a unique oportunity to address this issue. Although the trials differed in their study designs, a common distinguishing feature was a long-term stimulant treatment arm. The duration of stimulant treatment in these trials ranged from one to two years—a time period four to eight times longer than that used in other controlled studies. This presentation will review and compare the studies' findings of the effects of long-term stimulant treatment on multiple domains of functioning and on clinical trajectories. The implications of these findings for clinical practice will be discussed.

No. 55B
A RANDOMIZED CONTROLLED TRIAL OF LITHIUM PROPHYLAXIS IN ADOLESCENT BIPOLAR DISORDER

Neal D. Ryan, M.D., *Department of Psychiatry, Western Psych Institute & Clin, 3811 O'Hara Street, Rm ERC-720, Pittsburgh PA 15213*

SUMMARY:

Adolescent bipolar disorder appears clinically to be very similar to adult bipolar disorder. It is strongly recurrent and associated with significant morbidity and mortality. Open clinical data suggest that mood stabilizers are effective in adolescent bipolar disorder. To date, there have been little controlled study data available to address this question. This is the first report of a double-blind, randomized, discontinuation of mood stabilizers in adolescent bipolar disorder. Subjects were entered at three sites: University of Pittsburgh, (Neal Ryan, M.D., and Boris Birmaher, M.D., PIs), University of UCLA (Michael Strober, Ph.D., PI), and Brown University (Martin Keller, M.D., PI). Subjects were stabilized on lithium or lithium plus other mood stabilizers for a minimum of six months and then either randomly tapered and switched to placebo or continued on the medica-

tion. The blind will be broken in March 1999, and preliminary data will be available for presentation at the annual meeting.

No. 55C
OCD MULTISITE TREATMENT STUDIES

John S. March, M.D., *Department of Psychiatry, Duke University Medical Center, PO Box 3527, Durham NC 27710*

SUMMARY:

This presentation will review the evidence-based treatment of pediatric OCD. First, using a stages of treatment model from the OCD expert consensus guidelines, it will address the integrated treatment of OCD in children and adolescents. Second, it will cover published empirical research supporting medication and cognitive-behavioral treatments as recommended by expert consensus. Third, it will describe the rationale and experimental design for an ongoing two-site (John March/Duke and Edna Foa/AU) comparative treatment outcome study funded by the NIMH that will help answer the clinically relevant question: "Which treatment for which child with what distinguishing characteristics?"

No. 55D
A MULTISITE TREATMENT OF ANXIETY DISORDERS

Laurence L. Greenhill, M.D., *Department of Psychiatry, NYS Psychiatric Institute, 722 W 168th Street, Unit 60, New York NY 10032*

SUMMARY:

The first study undertaken by the Research Units of Pediatric Psychopharmacology (RUPPs) is a parallel-groups comparison of fluvoxamine and placebo in the treatment of children and adolescents, ages 6 to 17 years, with one or more of the following anxiety disorders: separation anxiety disorder, social phobia, and generalized anxiety disorder. The presentation will briefly review past studies of medication treatment of children with anxiety disorders. The design and implementation of the ongoing RUPP study, including development of a new rating instrument, will be discussed.

No. 55E
PSYCHOPHARMACOLOGY OF AUTISM

Christopher J. McDougle, M.D., *Department of Psychiatry, Indiana University, 702 Barnhill Drive, Rm 3701, Indianapolis IN 46202*

SUMMARY:

The group of neuropsychiatric disorders comprising autism-spectrum disorders includes autistic disorder, Asperger's disorder, Rett's disorder, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified. The shared features of autism-spectrum disorders include onset in early childhood, persistence throughout adulthood, abnormalities in communication and social development, and a restricted repertoire of activities and interests. Additionally, aggressive and injurious behavior toward self and others and interfering repetitive thoughts and behaviors are often associated with the core symptoms.

The results of research conducted over the past three to four decades suggest that the etiology of autism-spectrum disorders is multifactorial. Accumulated evidence has implicated disturbances in several neurochemical systems, primarily dopamine and serotonin, as being relevant to the pathophysiology of these disorders. Dopamine antagonists, including haloperidol and pimozide, have been shown in double-blind, placebo-controlled studies to be effective in improving some symptoms of autism (e.g., reducing stereotypies and withdrawal and aggressive behavior, and increasing attention). Preliminary studies of potent serotonin transporter inhibitors, including clomipramine and the selective serotonin reuptake inhibitor fluvoxamine, have also generated evidence for efficacy and relative tolerability, particularly in adults with autism-spectrum disorders. More recently, results from pilot studies of atypical neuroleptics, including risperidone and olanzapine, have appeared that indicate that this group of agents may also provide for symptom reduction for patients with autism with a potentially more benign adverse effects profile than that of typical neuroleptics.

Results from controlled studies of these drugs and data from pilot studies involving more recently developed agents will be presented. Developmental differences in treatment response and tolerability will be highlighted.

No. 55F
TREATMENT OF ADOLESCENTS WITH DEPRESSION: RESEARCH PERSPECTIVES

Benedetto Vitiello, M.D., *DSIR, NIMH, 5600 Fishers Lane, Rm 10C09, Rockville MD 20857*

SUMMARY:

Significant progress has been recently achieved in studying the efficacy of treatments for adolescents suffering from depression. Two large placebo-controlled trials have indicated that fluoxetine and paroxetine significantly decrease depressive symptoms in the short-term (eight weeks). In parallel, cognitive-behavioral therapy has been reported to be more efficacious than nondirective supportive therapy or family therapy. Despite the efficacy of these interventions in reducing depressive symptomatology, a substantial number of patients did not reach full remission in some of these trials. Certain critical questions remain to be addressed by further research in order to arrive at formulating evidence-based treatment guidelines. Among them: What is the long-term effectiveness of pharmacological and psychotherapeutic treatments for adolescents with major depression? What is their impact not only on symptom reduction, but also on disorder remission, level of functioning in various settings, and use of services? How does pharmacotherapy compare with psychotherapy? Do adolescents who are not responsive to one treatment approach respond to the other? Is there a role for combined treatments? What is the cost-effectiveness of these different approaches? Answers to these questions are likely to come from coordinated multiple studies with the contribution of experts in the various aspects of treatment research. Recent initiatives launched by the National Institute of Mental Health in this area of research will be presented and discussed.

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dren and adolescents with depression. Archives of General Psychiatry 1997; 54:1031–37

SYMPOSIUM 56—AGING OF PATIENTS WITH SCHIZOPHRENIA

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the end of the symposium, the audience should be able to recognize late-onset as well as early-onset schizophrenia, understand the nature of cognitive impairment in those patients, learn about the course and quality of life in elderly patients with schizophrenia, and manage them with appropriate pharmacotherapeutic and psychotherapeutic approaches.

No. 56A
SCHIZOPHRENIA AND AGING: MYTHS AND REALITY

Dilip V. Jeste, M.D., *Department of Psychiatry, University of CA at San Diego, 3350 La Jolla Village Drive, San Diego CA 92161;* Thomas L. Patterson, Ph.D., Lisa Eyler Zorrilla, Ph.D., Barton W. Palmer, Ph.D., Laurie Lindamer, Ph.D., Robert K. Heaton, Ph.D.

SUMMARY:

There is a dearth of literature on aging of patients with schizophrenia. Furthermore, a number of the studies that have been published in this area have had methodologic limitations. As a result, there are several misconceptions about this topic. We will discuss the common myths about prevalence, new onset, and course of schizophrenia in older individuals, and present recent data that paint quite a different picture of the disorder. The prevalence of the disorder in the elderly is likely to be much higher than that reported by the ECA study, which had major flaws in design and interpretation. Data from different countries clearly suggest that schizophrenia can and does sometimes manifest for the first time in middle and old age. Finally, the outcome of the disorder in late life is not typically consistent with the Kraepelinian notion of "dementia praecox." Our ongoing longitudinal studies suggest that a large majority of elderly patients with schizophrenia live in the community and do not meet criteria for dementia, although many of them continue to be disabled in their everyday activities by negative symptoms and by relatively stable cognitive impairment. We will discuss clinical and research implications of these findings.

No. 56B
PSYCHOSOCIAL FUNCTIONING OF OLDER PERSONS WITH SCHIZOPHRENIA

Carl I. Cohen, M.D., *Department of Psychiatry, SUNY Health Sciences Center, 450 Clarkson Avenue, Brooklyn NY 11203*

SUMMARY:

Over the next 30 years the number of older persons with schizophrenia will double; however, there is remarkably little research on social adaption and treatment of older persons with schizophrenia. Three-quarters of leaders in community psychiatry surveyed indicated that their local organizations had made few changes to deal with service gaps for this population. In this paper, I review current knowledge about the psychosocial functioning of older schizophrenic persons and its implications for policy planning and treatment. In so doing, I shall show that: (1) Coping strategies appear to evolve with aging, and individuals become more active participants in their recovery; (2) Although social networks of older persons with schizophrenia decrease with age and are smaller than their age peers, with aging there is a reduction in discordant interactions; (3) A "reciprocal socialization" develops in which family members learn to speak the language of the illness; (4) Although quality of life may be lower among older schizophrenic persons than their age peers, a majority report being satisfied with their lives and do not believe that they have more life difficulties than other persons; (5) Life satisfaction is associated with subjective factors—e.g., reliable social contacts, perceived life difficulties—rather than objective measures such as income or physical health; (6) Cognitive deficits, more so than positive or negative symptoms, are related to impaired social functioning; (7) Treatment goals may not be recovery or rehabilitation per se, but how to make life more meaningful and satisfying. Aging for persons with schizophrenia, like aging in general, is a process of adaptation, compensation, and plasticity.

No. 56C
COGNITION IN OLDER PATIENTS WITH SCHIZOPHRENIA

Richard Mohs, Ph.D., *Department of Psychiatry, Mt. Sinai School of Medicine, VA Medical Center 116A, Bronx NY 10468;* Philip D. Harvey, Ph.D., Michael Davidson, M.D.

SUMMARY:

This presentation will review and present new data from studies investigating cognitive differences between schizophrenic patients, normal subjects, and patients with Alzheimer's disease (AD). Over 350 schizophrenic patients were given neuropsychological tests at baseline and annually thereafter. Cross-sectional data are available from schizophrenic patients aged 20 to 90 years of age. They show an age-related decrease in scores on the Mini Mental State Exam (MMSE) averaging approximately two pts/decade. Longitudinal data are derived primarily from schizophrenics over age 65 and these data identify some individuals showing progressive decline over followup of two years. Identical neuropsychological tests were given to schizophrenics, patients with AD, and elderly nondemented persons matched for age, education, and, for the schizophrenics and AD patients, global severity of cognitive dysfunction. Relative to controls, AD patients showed prominent deficits in delayed recall memory, and naming of low frequency items and difficult praxis items. By contrast, older schizophrenics were impaired on many aspects of cognition including memory, language, and praxis, while their impairments on delayed recall and naming of low frequency items were less severe than those of AD patients. Schizophrenics show very slowly progressing cognitive deficits, which affect many aspects of cognition, while AD patients have late onset, more rapidly progressing deficits.

No. 56D
LONG-TERM OUTCOME OF LATE-LIFE SCHIZOPHRENIA

Peter V. Rabins, M.D., *Department of Psychiatry, Johns Hopkins Hospital, 600 N Wolfe Street/Meyer 279, Baltimore MD 21287-7279*

SUMMARY:

A concurrent prospective study of 39 patients meeting DSM-IV criteria for schizophrenia with onset after age 44 was carried out. The likelihood of developing dementia was compared with a similarly constructed cohort of individuals with major depression. Mean followup was 6.0 years. The two groups were similar in age but there were more females in the late-onset schizophrenia group. The likelihood of developing dementia, defined as a decline of more than

three points on the Mini Mental State Examination and the clinical diagnosis of dementia by DSM-IV criteria, did not differ ($p > .05$) using a Cox Proportional Hazard Model ($p > .05$).

These results demonstrate that a condition with symptoms similar to schizophrenia of early-life onset can begin in individuals after age 44 and that this condition does not predispose to the development of dementia. Given other data that demonstrate symptomatic treatment response, and neuropsychological and neuroimaging changes similar to early-onset schizophrenia, the study of the late-onset disorder might provide important leads to understanding the pathogenesis of schizophrenia at all ages.

No. 56E
MANAGEMENT OF LATE-LIFE SCHIZOPHRENIA

Murray A. Raskind, M.D., *Department of Psychiatry, VA Puget Sound Medical Center, 1660 S Columbian Way, 116A, Seattle WA 98108*

SUMMARY:

Most persons with chronic schizophrenia survive into late life despite the increased mortality associated with this disorder. Aging-associated changes in the clinical features of schizophrenia and in the responses of persons with schizophrenia to antipsychotic medication have important implications for management. Delusions and hallucinations usually persist but tend to become less florid with aging. In contrast, sensitivity to the extrapyramidal, anticholinergic, sedative, and hypotensive adverse effects of antipsychotic medications increases with aging. Finally, many elderly schizophrenic patients develop severe oognitive impairment not neuropathologically attributable to either Alzheimer's disease or cerebrovascular disease. Lower doses of antipsychotic medication than used in young patients often maintain elderly patients in remission, although even low doses can produce serious adverse effects. The atypical antipsychotics appear better tolerated than typical agents in the elderly schizophrenic patient, but these newer agents must still be prescribed cautiously. That many elderly schizophrenic patients reside in community settings with minimal access to psychopharmacologic and psychotherapeutic expertise has created a major barrier to optimal management.

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SYMPOSIUM 57—CULTURAL FACTORS IN SEVERE MENTAL DISORDERS
Collaborative Session with the National Institute of Mental Health

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize the relevance and importance of cultural and ethnic factors in severe mental disorders such as depression and schizophrenia in adults and children.

No. 57A
THE MENTAL HEALTH OF IMMIGRANT AND REFUGEE CHILDREN

Peter J. Guarnaccia, Ph.D., *Institute for Health, Rutgers University, 30 College Avenue, New Brunswick NJ 08903*

SUMMARY:

This presentation reviews the literature on the mental health of immigrant and refugee children to highlight what we know about the interaction of culture and mental health among these children and what factors seem to predict both distress and resilience. In looking at the mental health of these children, I focus on three closely related dimensions of mental health: self-esteem, psychosocial distress, and psychiatric disorder. Self-esteem focuses on issues of self-identity and the extent to which the child feels valued in important social contexts such as family, peer group, school, and the broader community. Psychosocial distress is assessed by eliciting a range of symptoms, emotions, and behaviors, and the degree to which they affect the child's ability to function in some important aspects of life. Psychiatric disorder is defined by a constellation of symptoms and behaviors, which cohere in particular ways and severely impair the ability of the child to function. Although child psychiatrists work with the full range of distress, their skills are uniquely suited to working with children who suffer from psychiatric disorder. The overall purpose of this review is to identify the sources of mental suffering in immigrant and refugee children, however that suffering may be identified or measured.

No. 57B
CULTURE, GENDER AND SCHIZOPHRENIA AMONG UNITED STATES LATINAS

Janis H. Jenkins, Ph.D., *Pediatrics & Child Health, 2041 Georgia Avenue, NW, Washington DC 20060*

SUMMARY:

The introduction of DSM-IV diagnostic criteria for schizophrenia marked the centenary of Kraepelin's distinction in 1896 between "dementia praecox" and bipolar disorders. While subsequent reformulations served to elaborate Kraepelin's phenomenological and prognostic formulations, the importance of a specifically "comparative psychiatry" was established long ago by Kraepelin's field observations of symptom differences. Since then, several decades of research conducted largely at the interface of anthropology and cultural psychiatry have empirically established the role of culture in nearly every aspect of schizophrenic illness: identification, definition, and meaning of illness during the prodromal, acute, and residual phases; timing and type of onset; symptom formation in content, form, and constellation; personal and social experience of illness; course and outcome; and utilization of treatment. However, while culture invariably shapes the emotional, cognitive, and behavioral symptoms as-

sessed in the diagnostic encounter, the relevance of culture to schizophrenia for many practicing clinicians has seemed remote at best. The scientific utility of a comparative approach to schizophrenia is illustrated through the author's research program with Latinos in the U.S. (N = 200), with an emphasis on how gender can help to reconfigure the research foundation of schizophrenia studies based on heterogeneity.

No. 57C
CULTURE, ETHNICITY AND THE BIOPSYCHOSOCIAL TRADITION

Keh-Ming Lin, M.D., *Department of Psychiatry, Harbor-UCLA Medical Center REI, 1124 West Carson Street/B4 S, Torrance CA 90002*

SUMMARY:

Contrary to our field's emphasis on biopsychosocial integration, cultural psychiatry has yet to optimally incorporate emerging data showing remarkable biological diversity within and across populations. With new developments coming from fields as divergent as medical anthropology and molecular biology, the bridging of culture/ethnicity and clinical practices may increasingly become a reachable goal. New tools have been or are in the process of being developed, allowing clinicians to systematically assess both cultural diversity and biological diversity in their patients at the level of the individuals, and to design effective strategies for intervention that are individually tailored and culturally/ethnically informed. Regarding cultural diversity, this involves the systematic assessment of the patient's identity, support systems, beliefs, help-seeking preferences, and treatment expectations. In terms of biological diversity, the nature and extent of variations across populations are increasingly clarified regarding the polymorphism of genes coding drug-metabolizing enzymes, brain receptors, neurotransmitter transporters, and other related proteins. This is expected to lead to the development of procedures that are clinically relevant and useful for the formulation of treatment plans congruent with the patient's genetic and ecological backgrounds. Together, these exciting new developments could significantly enrich cultural psychiatry and vastly enhance its clinical relevance.

No. 57D
CULTURE, GENDER AND DIAGNOSIS OF PSYCHIATRIC DISORDER

Delores Parron, Ph.D., *NIMH OD, 5600 Fishers Lane, Rm 17C-14, Rockville MD 20857*

SUMMARY:

The population of the United States and most Western nations includes large numbers of persons, many of whom trace their origins to non-Western societies. This circumstance creates new challenges for clinicians and researchers whose training reflects the Western tradition in biomedical psychiatry as they are called upon to evaluate individuals with different ethnic and cultural backgrounds.

Social science and epidemiologic and clinical research confirm that multiple forces contribute to women's psychological and psychiatric distress. There is compelling evidence regarding important ways in which the varied cultural backgrounds of individuals affect the content and form of normal and abnormal behavior, the expression of specific symptoms associated with particular disorders, the context of evaluation, and the meaning of psychopathology.

This paper will demonstrate how the Outline for Cultural Formulation, developed by the National Institute of Mental Health (NIMH) Culture and Diagnosis Group as part of a broader contribution to DSM-IV, can be used to facilitate clinicians' attention to the cultural framework of the patient's identity, illness experience, and context, as well as issues influencing the clinician-patient relationship. While the Cultural Formulation has importance for patients of both genders, it has special utility for women seeking mental health care.

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SYMPOSIUM 58—GENDER: WHAT'S THE DIFFERENCE?

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, participants will understand the importance of gender differences in mental health at the levels of basic science research, clinical practice, and policymaking.

No. 58A
UNRAVELING THE MYSTERIES: GENDER-BASED RESEARCH

Florence Haseltine, M.D., *Center for Population Research, NIH, 10500 Rockville Pike, Bethesda MD 20852*

SUMMARY:

Gender-based biology is the field of scientific inquiry committed to identifying the basic biological and physiological differences between men and women. Gender differences that are found at the system, tissue, organ, cellular, and sub-cellular level, as well as gender differences in response to pharmaceuticals, are considered gender-based biology. This presentation will introduce psychiatrists to the field of gender-based biology and its implications for the mental health of both genders, the practice of medicine, and health care policy. A number of gender-based biology research findings have occurred with significant implications for our understanding of the gender differences in mental health. For example, research indicates that the rate of serotonin synthesis is 52% higher in men than in women, which may help explain the greater incidence of unipolar depression in women. At the conclusion of this presentation, participants will understand the concept of gender-based biology and its far reaching implications.

No. 58B
CLINICAL IMPLICATIONS OF GENDER-BASED RESEARCH: LESSONS FROM WOMEN VETERANS

Marian I. Butterfield, M.D., *Department of Psychiatry, Durham VAMC & Duke, 508 Fulton Street, Durham NC 27705;* Lauren M. McIntyre, Ph.D., Karen Stechuchak, M.S., Kavita Nanda, M.D., Lori A. Bastian

SUMMARY:

Since the creation of the Army Nurse Corps in 1901, over 1.2 million women have served in the U.S. military. Reports from Operation Desert Storm reveal that military women in that conflict suffer from stress symptoms related to a spectrum of wartime experiences,

including victimization through sexual trauma and battering. Several other recent studies report high rates of sexual harassment and domestic violence in service women and that victimization is a major health problem. Among women veterans using VA primary care services, 68% experienced victimization, and 60% report that this occurred during their military service. We have reported on the association between victimization and mental disorder symptoms in women veterans, as have other clinicians working with them. Until recently, the focus of PTSD research and treatment in veterans was on males who experienced combat. There is strong evidence that sexual trauma, like war trauma, is a powerful contributor to the development of PTSD in women veterans. Responding to the challenge of victimization of service women, the Department of Veterans Affairs established extensive programs on sexual trauma screening and treatment. The clinical implications of gender-based research and implications for treatment in this cohort will be discussed.

Following this presentation, participants will have an understanding of clinical applications of gender-based research.

No. 58C
IMPORTANCE OF GENDER ANALYSIS OF PHARMACEUTICALS

Freda C. Lewis-Hall, M.D., *Lilly Center for Women's Hlth, Lily Corporate Center DC2128, Indianapolis IN 46285*

SUMMARY:

The prohibition on the participation of women in clinical trials ended in 1993 when the FDA reversed its policy and now encourages the inclusion of women in drug trials and gender analysis of new pharmaceuticals. The Lilly Centre for Women's Health is guiding Eli Lilly and Company's commitment to the mental health of women by spearheading the development and analysis of new pharmaceuticals for women. The Lilly Centre's focus is on the top diseases that cause death and illness in women and disproportionately or differentially affect women, making mental health a high priority. A key component of developing effective treatments for any population is understanding the efficacy of the treatment for that population. When looking at women's mental health, we can only provide the best treatments when we include women at all stages of drug research and conduct gender analysis of pharmaceuticals. This presentation will highlight the research that the Lilly Centre is conducting to ensure that women's mental health issues are addressed. At the conclusion of this presentation, participants will understand the research methodologies undertaken at all phases of drug trials to ensure accurate gender analysis of pharmaceuticals.

No. 58D
THE PUBLIC HEALTH SERVICE'S COMMITMENT TO WOMEN'S MENTAL HEALTH

Wanda Jones, Dr.P.H., *Office on Women's Health, PHS, 200 Independence Ave NW, #712E, Washington DC 20201*

SUMMARY:

The Public Health Service's Office on Women's Health (OWH) recognizes that mental and addictive disorders are real, diagnosable, treatable, and sometimes preventable diseases that affect millions of women nationwide. Although women are disproportionately affected by many mental disorders (such as unipolar depression, panic disorder, rapid cycling bipolar disorder, phobias, and eating disorders), historically the research into mental illnesses has focused on male populations. This presentation will summarize how OWH works to improve women's mental health by: (1) coordinating and implementing a comprehensive women's health agenda for research, health care service delivery, and education across the agencies of the Public Health Service and with other government agencies; (2) fostering collaborations to improve women's mental health between government and private sector consumer, scientific, and health care professional organizations; and (3) challenging the scientific and clinical care communities to better understand and better respond to the biological, environmental, and psychosocial factors that contribute to the development of mental and addictive disorders in women. At the conclusions this presentation, participants will understand how the Office on Women's Health provides federal initiatives and public/private partnerships to improve women's mental health.

No. 58E
THE CONGRESSIONAL RESPONSE TO WOMEN'S HEALTH ISSUES

The Honorable Nita Lowey, *US House of Representatives, 2421 Rayburn House Office Bldg. Washington DC 20515*

SUMMARY:

Just as women's health issues have come to the forefront of America's consciousness in the past decade, they have also become key issues on Capitol Hill. Congress addresses women's health issues on a variety of levels, including funding research, requiring health care coverage, prohibiting discrimination, requiring the inclusion of women in clinical research, ensuring patients' rights and confidentiality, funding programs and services, and more. This presentation will highlight the current legislative initiatives for women's health, with a specific focus on legislation relevant to psychiatrists and the practice of psychiatry. In addition, the presentation will focus on the unique role that health care providers can play in influencing health care legislation and advocating for women's health issues. At the conclusion of the presentation, participants will be updated on the current Congressional action on women's health issues and how to influence the lawmaking process.

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SYMPOSIUM 59—THE CLINICAL INTERNET: AMERICAN AND EUROPEAN EXPERIENCES

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this session, participants will be able to discuss how changes in computer technology are impacting the field of psychiatry; understand how Internet use can enhance psychiatric practice; explain how Internet Relay Chat (IRC), USENET Newsgroups, video conferencing, and e-mail can be used to provide psychotherapy; help patients and psychiatrists to choose best opportunities in the Internet.

No. 59A
INTERNET JUNGLE: HUNTING FOR PATIENTS' REAL ADVANTAGES

Sergio De Risio, M.D., *Department of Psychiatry, Catholic University, LF Vito 1, Rome 00168, Italy;* Massimo Di Giannantonio, M.D., Fausta Calvosa, M.D., Benedetto Farina, M.D.

SUMMARY:

The Internet is now revolutionizing access to information and mutual communications for psychiatrists throughout the world. The advancing computer technology has made it possible to convert an enormous quantity of information from paper to digital form, which can be very easily introduced in the Internet. Digital format information available on the Internet can be accessed at increasingly affordable prices, by psychiatrists all over the world from their offices or homes, 24-hours per day, seven days per week. Mental health resources available on the Internet range from information and education about mental disorders to online mutual self-help support groups and professional chat forums. The aim of this presentation is to give a broad overview of the wide range of online resources available and to compare North American and European Internet psychiatrists' experiences. The real problem is to recognize, in this very complicated and wide jungle, what can be really useful for patients or for psychiatrists. The authors will discuss how to identify the real good from the superfluous.

No. 59B
CLINICAL USES OF THE INTERNET: PROMISE, PROBLEMS AND PERILS

Ronald W. Pies, M.D., *Department of Psychiatry, Tufts University, 297 Bedford Street, Lexington MA 02420*

SUMMARY:

The Internet has generated a large number of clinically oriented services, ranging from simple provision of medical information to the actual prescription of medication. While the quality of information on the Internet varies widely, even the most medically sophisticated Web sites must struggle with medico-legal issues and dilemmas. These may range from potentially suicidal or homicidal Web site users, to the risk of inappropriate medical care in the case of "virtual patients" who are not actually seen by the physician. While "telemedicine" provides the opportunity for rudimentary visual assessment of patients, so-called cybermedicine practiced on the Internet does not. The risks and medico-legal perils of this medium have not been sufficiently explored. On the other hand, the Internet does have the potential to serve as a useful instrument for medical education, if used properly.

No. 59C
CLINICAL USE OF THE INTERNET: SOME SUGGESTIONS

Robert C. Hsiung, M.D., *Department of Psychiatry, University of Chicago, 5737 South University Avenue, Chicago IL 60637*

SUMMARY:

Clinical use of the Internet can take many different forms. e-mail can be exchanged with individual patients (and others), public forums can be joined (and created), informational Web sites can be developed, etc. This presents professionals with new opportunities—and new challenges. We must learn not only how to communicate in a new medium, but how to apply clinical, ethical, and legal principles to it.

In conclusion, this paper presents examples of the various online clinical experiences of one Internet psychiatrist and provides some suggestions to guide other clinicians as they explore the clinical use of this new tool themselves.

No. 59D
PSYCHOTHERAPY ON THE INTERNET

Russell F. Lim, M.D., *Northgate Point, 601 W N Market Blvd, Ste 100, Sacramento CA 95834*

SUMMARY:

The Internet is a dynamic, rapidly evolving and enlarging international computer network that enables the exchange of most forms of data, including text, graphics, audio, and video among geographically distant mental health clinicians and their clients. The recent development of graphical interfaces to the Internet has made access to its resources much easier to individual users. In addition, the Internet's explosive growth has given consumers and mental health service providers greater access to its resources and capabilities. In this presentation, the Internet and how it can be used to provide treatment to patients will be described and demonstrated.

In particular, I will discuss the use of electronic support groups on the USENET, the use of Internet Relay Chat (IRC) for real time support groups run by consumers, the use of video conferencing in psychiatry, and the use of specialized software for treatment monitoring and administration, as well as applications for electronic mail for the treatment of specific groups of patients. In addition, consultation and psychotherapy are available on the Internet, and Web sites for both will be demonstrated. Issues of security and confidentiality, liability, and licensure will be discussed.

No. 59E
INTRANET FOR MANAGEMENT AND CLINICAL INFORMATION SYSTEMS

Professor P.M. Furlan, M.D., *Department of Psychiatry, University of Torino, 10043 Orbassano, Torino 10043, Italy;* Manlio Gianmaria, M.D., Stefano Gelati, M.D.

SUMMARY:

The technological developments brought by the diffusion of the Internet propose some interesting possibilities for information systems in psychiatric clinical practice.

The possibility to use in a limited and protected way Web protocols between agencies of a department located in various regions but working on the same patients, allows the resolution of ethical problems of privacy and security together with the exploitation of the typical Internet features: easy access, fast communication, the possibility of developing locally software that is accessible from other points of the net, the possibility of working together on the same document, teleconferences, teleconsultation, and tele-training.

Moreover, it allows interesting searches of clinical records through more and more sophisticated search engines.

There is also the possibility of offering exits from the Intranet to the Web universe, strengthening the information system with notable didactic tools, more readily available online.

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SYMPOSIUM 60—SCIENCE-BASED BEHAVIORAL THERAPIES FOR COCAINE ADDICTION
The National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: (1) identify the role of behavioral therapy in treating cocaine addiction; (2) describe key elements of three types of clinically tested behavioral treatments for cocaine addiction; (3) explain the similarities and differences between these treatment interventions; (4) describe the clinical research base supporting the efficacy of each therapy presented; (5) recognize further sources for improving clinical skills in applying these therapies.

No. 60A
A COGNITIVE-BEHAVIORAL APPROACH TO TREATING COCAINE ADDICTION

Kathleen M. Carroll, Ph.D., *Department of Psychiatry, Yale University, 34 Park Street, Room S-208, New Haven CT 06519*

SUMMARY:

Cognitive-behavioral therapies (CBTs) are among the most frequently evaluated approaches to treating substance abuse disorders. CBTs have been shown to be effective in several clinical trials of cocaine-dependent individuals and other types of drug users. The theoretical background and goals of this approach, the fundamentals of implementing CBT with drug users, and a brief review of the evidence supporting its effectiveness with drug abusers will be presented.

No. 60B
COMMUNITY REINFORCEMENT APPROACH TO TREATMENT

Stephen T. Higgins, Ph.D., *Department of Psychiatry, Univ. of Vt/ Ira Allen School, 38 Fletcher Place, Burlington VT 05401*

SUMMARY:

The community reinforcement approach (CRA) is an intensive behavioral treatment for drug abuse that is based on extensive scientific evidence regarding determinants of drug abuse and effective treatment. Initially demonstrated to be an efficacious intervention for severe alcoholism, CRA was later adapted for and shown to be efficacious in the treatment of cocaine dependence. The basic features of CRA will be outlined, with special attention to its use in outpatient treatment of cocaine dependence. Research findings indicate that CRA can be used with a wide range of drug abusers and is considered an effective treatment if adopted in part or as a whole.

No. 60C
INDIVIDUAL COUNSELING FOR COCAINE ADDICTION

Delinda Mercer, Ph.D., *Department of Psychiatry, University of Pennsylvania, 3600 Market Street, Rm 783, Philadelphia PA 19104*

SUMMARY:

This presentation will describe a model of individual drug counseling that was used in the recently completed Multisite Cocaine Collaborative Study sponsored by the National Institute on Drug Abuse. The training and supervision practices employed and the means by which counselors' adherence and competence were evaluated will be described. The philosophy and methods of this model will be compared and contrasted with other models of addiction counseling and psychotherapy. Modifications that could be made to adapt this treatment for use with alcohol and opiate dependence will be reviewed, with relevant research findings integrated into the discussion. Findings from the multisite study indicate that adequate training and ongoing supervision are as important as the counseling approach itself in providing effective drug treatment. Treatment should be tailored to directly address specific drug dependencies, and adjunctive pharmacotherapy is useful in some cases depending on the particular drug addiction.

No. 60D
RELAPSE PREVENTION AND CONTINGENCY MANAGEMENT OF COCAINE ABUSE

Richard A. Rawson, M.D., *Matrix Center, 10350 Santa Monica Blvd, #330, Los Angeles CA 90025*

SUMMARY:

This presentation will include data from two studies that evaluate two promising approaches—relapse prevention (RP) and contingency management (CM)—for the treatment of cocaine abuse in two populations. Study I will compare RP and CM, alone and in combination, for the treatment of primary cocaine abusers. Cocaine abusers were randomly assigned into one of three groups with either an RP procedure, a CM procedure, or a combination of RP and CM procedure. The RP condition consists of three RP sessions per week for 12 weeks. The CM procedure uses a graduated system of positive reinforcement vouchers delivered to Ss upon achievement of cocaine negative urine samples.

Study 2 compares RP and CM alone and in combination as treatment methods for cocaine abusing methadone patients. The design in this study is a 2 × 2 (RP by CM), with treatment cells consisting of the three conditions described in study 1 and in addition, a condition that involves methadone maintenance treatment as usual, with no specific intervention for cocaine abuse. Cocaine abusing methadone patients were randomly assigned to one of four treatment conditions (n = 30 per condition).

Data on in-treatment performance and program completion will be available on both study populations.

Funding by NIDA Grant: RO1-DA09419.

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SYMPOSIUM 61—PRACTICING EVIDENCE-BASED PSYCHIATRY: BIPOLAR DISORDER

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium the participant should be able to integrate practice guidelines, assessment tools, and clinical data for the treatment of bipolar disorder. At the conclusion of this presentation, participants would be able to apply principles of evidence-based medicine to the treatment of patients with bipolar disorder.

No. 61A
USE OF FORMAL MEASURES IN CLINICAL CARE

Jacqueline Samson, Ph.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont MA 02178*

SUMMARY:

The Handbook of Psychiatric Measures, being developed by the APA, is an evidenced-based guide to educate clinicians in evaluating, interpreting, and using measures. Envisioned as a "toolbox" with instructions for psychiatric measures, it will cover various domains of assessment including symptoms, function, and outcomes. The Handbook's purpose is to provide clinicians in mental health settings with a guide to available measures that are useful in the clinical care of patients or for the interpretation of treatment and services research.

This project responds to challenges and opportunities presented by health care reform, managed care, and patient care needs. Public and private entities are developing new methods for measuring and reviewing psychiatric care that may not reflect good research or the perspective of clinicians. Mental health providers and patients are being held to "criteria" for the determination of access to services or for inclusion in care networks. Many clinical and policy issues are affected by the selection and application of measures: eligibility determinations, outcomes assessment, risk adjustment, quality assurance, utilization review, and practice guideline-related activities.

How to choose, use, and interpret measures for clinical use with bipolar disorder is the presentation's focus. Topics include goals of assessment, implementation issues, interpreting psychometric data, and the selection of measures of severity and screening for BPD.

No. 61B
CLINICAL PRACTICE GUIDELINES FOR TREATMENT

Robert M.A. Hirschfeld, M.D., *Department of Psychiatry, University of TX/Graves Bldg, 301 University Boulevard, Galveston TX 77555*

SUMMARY:

The American Psychiatric Association's practice guideline project is committed to the promotion of evidence-based psychiatry to improve patient care. APA practice guidelines are designed to result in documents that are both scientifically sound and clinically useful to psychiatrists by adhering to a development process that ensures clinical consensus, using standards from the Institute of Medicine and the American Medical Association. Well-constructed guidelines offer a critical review and synthesis of a rapidly expanding treatment literature; a framework for clinical decision making and, within it, recommendations for treating a "typical" patient with a given diagnosis; and consideration, in light of research data, of the implications of specific clinical features for treatment recommendations.

The bipolar disorder practice guideline was published in 1994. The guideline, which will be updated in 1998-1999, covers various treatment principles and alternatives. Pharmacological treatments (e.g., lithium and anticonvulsants) and psychotherapy (e.g., psychosocial and environmental approaches in manic episodes) are reviewed. The revised guideline will update the recommendations made in 1994 based on the current literature available.

No. 61C
WHAT'S REALLY GOING ON IN THE TREATMENT OF BIPOLAR DISORDER?

Deborah A. Zarin, M.D., *Office of Research, American Psychiatric Assoc., 1400 K Street, NW, Washington DC 20005;* Harold Alan Pincus, M.D., Ellen Leibenluft, M.D.

SUMMARY:

Practice-based data collected through the APA's Practice Research Network (PRN) regarding the treatment of bipolar disorder will be presented. The APA PRN consists of 500 psychiatrists nationwide practicing in routine clinical practice settings who collaborate to conduct clinical and services research.

Detailed information regarding the sociodemographic and clinical characteristics (e.g., co-occurring disorders, level of functioning) of patients with bipolar disorder seen by psychiatrists will be presented. Treatment practice patterns including history, services provided, medication usage (dosage and type), and future treatment plans will be highlighted. Factors that may impact the provision of care, such as health care financing issues (e.g., payment source, type of health plan, utilization management techniques) and psychiatrist characteristics, and clinical decision making will be examined. Comparisons of current psychiatric practice patterns for the treatment of bipolar disorder to external measures of quality, such as the APA practice guidelines, will be made.

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SYMPOSIUM 62—BDD: NEW RESEARCH FINDINGS FOR CLINICAL PRACTICE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should (1) be able to recognize and diagnose body dysmorphic disorder, (2) be familiar with recent advances in treatment strategies and be able to use these approaches in a clinical setting, and (3) recognize and treat BDD in special populations, such as depressed patients and children/adolescents.

No. 62A
CLINICAL FEATURES OF BDD: DIAGNOSING AN UNDER-RECOGNIZED DISORDER

Katharine A. Phillips, M.D., *Butler Hospital/Brown Univ, 345 Blackstone Boulevard, Providence RI 02906*

SUMMARY:

Body dysmorphic disorder (BDD) is a distressing and often debilitating preoccupation with an imagined or slight defect in appearance that has been described for over a century. Despite its long historical tradition as well as rapidly advancing research on this disorder, BDD remains underdiagnosed and underrecognized in clinical practice. Available data indicate that BDD is relatively common in patients with depression (in particular, atypical depression), OCD, and social phobia, and in dermatology and cosmetic surgery settings. BDD is a usually chronic disorder that consists of time-consuming and distressing preoccupations with a perceived appearance flaw, as well as associated compulsive behaviors such as mirror checking, excessive grooming, and skin picking. Insight is usually poor, and approximately half of patients are delusional. BDD is associated with notably high levels of perceived stress, unusually poor quality of life, and a high rate of suicide attempts. A majority of patients seek nonpsychiatric treatment (often surgical or dermatologic), with a poor outcome in most cases. This presentation will present recent data on the frequency of BDD in various psychiatric and nonpsychiatric settings as well as the clinical features of BDD. Several classification issues of relevance to clinical practice will be briefly discussed, such as the relationship between the delusional and nondelusional variants of BDD and the relationship between BDD and obsessive-compulsive disorder. This presentation will end with practical guidelines for recognizing and diagnosing BDD in a clinical setting.

No. 62B
PHARMACOLOGICAL TREATMENT OF BDD

Eric Hollander, M.D., *Department of Psychiatry, Mt. Sinai Medical Center, 1 Gustave Levy Place/Box 1230, New York NY 10029;* Andrea Allen, Ph.D., Concetta M. DeCaria, Ph.D., Bonnie A. Aronowitz, Ph.D., Charles Cartwright, M.D., Sherie Novotny, M.D.

SUMMARY:

Body dysmorphic disorder (BDD), the "distress of imagined ugliness," is characterized by an obsessive preoccupation with a perceived body defect, accompanied by behaviors to conceal the defect or obtain cosmetic surgery. Comorbid secondary depression and social phobia are frequent consequences of BDD, and up to half of patients have delusional features or poor insight. The disorder is chronic, and unresponsive to standard tricyclic antidepressant, MAO inhibitor, benzodiazepine, and neuroleptic treatments.

Early studies with serotonin reuptake inhibitors involved retrospective chart reviews, but suggested that these agents were effective in the treatment of BDD. This lack of response to standard TCAs but positive response to SRIs was similar to that previously demonstrated in OCD, supporting an association between the two disorders. Subsequent small and large open clinical trials with SSRIs such as fluvoxamine also suggested efficacy in BDD. A large double-blind, placebo-controlled trial with fluoxetine in BDD is under way.

We describe the results of a double-blind, crossover trial comparing the serotonin reuptake inhibitor clomipramine (CMI) to the norepinephrine reuptake inhibitor desipramine (DMI) in 40 BDD patients. Clomipramine was significantly superior to DMI on all BDD (BDD-YBOCS, BDD-NIMH, BDD-CGI) and social functioning scales, independent of depressive or delusional severity. This confirms the selective efficacy of SRIs in BDD, and has important nosological and clinical treatment implications in this common and disabling disorder.

No. 62C
COGNITIVE-BEHAVIOR THERAPY FOR BDD

David Veale, M.D., *Grovelands Priory Hospital, The Bourne Southgate, London N1A 6RA, United Kingdom*

SUMMARY:

Cognitive behavior therapy (CBT) represents a promising treatment for body dysmorphic disorder (BDD). In a pilot, randomized, controlled trial, 19 patients were allocated to either CBT or a waiting list control. Over 12 weeks, there were significant improvements on the modified YBOCs and on measures of depression in the CBT group. The CBT group had an average decrease of 55% on the modified YBOCS, while the waiting list control had a 14% increase. The key components of CBT in engaging and treating patients will be presented. Work is now in progress to compare CBT against interpersonal psychotherapy to determine if they are of equal efficacy. Further progress in the development of CBT for BDD will depend upon a better understanding of the psychopathology of BDD and the factors that maintain the dysfunctional attitudes and behaviors such as mirror checking. A cognitive behavioral model of BDD will be presented with data on attitudes toward appearance in BDD and what patients do in front of mirrors. Some hypotheses will be discussed for the maintenance of mirror checking behaviors, which may last many hours a day, but invariably make patients feel worse.

No. 62D
BDD IN CHILDREN AND ADOLESCENTS

Ralph S. Albertini, M.D., *Outpatient, Butler Hospital, 345 Blackstone Blvd, Providence RI 02906;* Katharine A. Phillips, M.D.

SUMMARY:

Psychiatry has recently shown an increasing interest in the description, diagnosis, and treatment of disorders that affect children and adolescents. Body dysmorphic disorder (BDD) usually begins during adolescence and often begins during childhood. It is characterized

by painful and time-consuming appearance preoccupations and compulsive behaviors that are associated with significant distress and impairment in functioning. This includes, in children and adolescents, high rates of psychiatric hospitalization, missing or dropping out of school, isolation from peers, and suicide attempts, which could adversely affect psychosocial development. Preliminary data suggest that SRIs are often effective in this age group. This presentation will focus on: (1) demographic and clinical features of BDD in children and adolescents, (2) how to make the diagnosis of BDD in this age group, (3) associated psychopathology, and (4) promising preliminary treatment data for children and adolescents, who appear particularly vulnerable to the development of this distressing, often secret, and underrecognized disorder.

No. 62E
BDD WITH MAJOR DEPRESSION

Andrew A. Nierenberg, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC 812, Boston MA 02114-3117*

SUMMARY:

Within the past decade, body dysmorphic disorder (BDD) has been recognized as a disabling OCD spectrum disorder with major depression as its most common comorbid condition. Conversely, research has shown that up to 15% of those with atypical major depression may have BDD as a condition comorbid to their depression. Patients with BDD and depression tend to have an earlier age of onset of depression, longer episodes of depression, increased rates of social phobia, and avoidant and passive-aggressive personality disorders, along with more social dysfunction compared with those with major depression only. When BDD and depression co-exist and patients present with a chief complaint of depression, BDD usually goes unrecognized by clinicians. Patients collude with clinicians to hide patients' BDD because of shame and embarrassment. The importance of BDD comorbid with depression is that when BDD goes unrecognized and untreated, the BDD continues as a source of distress and may cause not only social phobia but also continued dysphoria. This presentation will focus on data about the implications of BDD in depressed patients.

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SYMPOSIUM 63—SHORT-TERM STABILITY OF PERSONALITY DISORDERS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand which aspects of personality and personalty disorders remain stable during the six months following intake in treatment-seeking patients.

No. 63A
SHORT-TERM STABILITY OF PERSONALITY DISORDER DIAGNOSES

M. Tracie Shea, Ph.D., *Department of Psychiatry, Brown University, 700 Butler Drive, Providence RI 02906;* Robert Stout, Ph.D., Regina Dolan, Ph.D., Andrew E. Skodol II, M.D., Leslie C. Morey, Ph.D., Mary C. Zanarini, Ed.D., Charles A. Sanislow, Ph.D.

SUMMARY:

An important indicator of the validity of personality disorders is their diagnostic stability. The degree to which the personality disorders under study in the CLPS (schizotypal, borderline, avoidant, and obsessive-compulsive) are stable is a central question of the study. Our follow-up assessments include the Diagnostic Interview for Personality Disorders–Follow Along Version, which provides ratings of the presence or absence of individual PD criteria on a monthly basis. Preliminary data from the six-month follow-up assessment of the first 210 subjects in the study has shown only moderate diagnostic stability for the four Pds. Of subjects cell-assigned at baseline to each of the four disorder categories, 68% of 22 schizotypal subjects, 70% of 53 avoidant subjects, 69% of 49 obsessive-compulsive subjects, and 60% of 77 borderline subjects continued to meet full criteria throughout the six months of follow-up. This presentation will report findings on diagnostic stability throughout the first six months of follow-up for the complete PD sample, including 87 schizotypal, 175 borderline, 156 avoidant, and 152 obsessive-compulsive PD subjects. We will compare the diagnostic stability of the PD groups with that of our control sample, 98 subjects with major depression without personality disorder. Factors hypothesized to be associated with the degree of diagnostic persistence will be explored, including course of co-occurring axis I disorders, and different indicators of severity of Pds assessed at baseline.

No. 63B
STABILITY OF FIVE-FACTOR TRAITS IN PERSONALITY DISORDER

Leslie C. Morey, Ph.D., *Department of Psychology, Vanderbilt University, 301 Wilson Hall, NashvilleTN 37240;* John G. Gunderson, M.D., Robert Stout, Ph.D., M. Tracie Shea, Ph.D., Andrew E. Skodol II, M.D., Thomas H. McGlashan, M.D., Regina Dolan, Ph.D.

SUMMARY:

The stability of core personality traits as related to personality disorder was examined in a sample of 209 patients evaluated over an interval of six months. Patients were diagnosed at the time of the baseline evaluation as either borderline (n = 77), obsessive-compulsive (n = 55), avoidant (n = 56), or schizotypal (n = 21), and the NEO-PI-R was administered at baseline and at six-months follow-up to assess the five-factor model of personality variation. For the sample as a whole, personality trait characteristics were highly correlated across the six-month interval, with score correlations ranging

from .785 (neuroticism) to .841 (conscientiousness), with only neuroticism showing a significant change (reduction) across this interval. For the four individual disorders, only the borderline patients demonstrated significant changes as a group across the six-month period, with statistically significant increases in conscientiousness and significant decreases in neuroticism. These results support (1) the general assertion that core personality traits tend to be stable in personality disorder, and (2) the notion that borderline personality tends to manifest the least stable personality constellation over time, although within the six-month evaluation period these changes were relatively circumscribed.

No. 63C
SIX-MONTH STABILITY OF AXIS I WITH PERSONALITY DISORDER COMORBIDITY

Thomas H. McGlashan, M.D., *Yale Psychiatric Institute, PO Box 208038, New Haven CT 06520;* Carlos M. Grilo, Ph.D., Leslie C. Morey, Ph.D., Andrew E. Skodol II, M.D., Charles Sanislaw, Ph.D., M. Tracie Shea, Ph.D., John G. Gunderson, M.D.

SUMMARY:

Objective: It is well known that PD comorbidity renders DSM-IV axis I disorders more chronic and treatment resistant. We hypothesize that in a clinical epidemiologic sample this effect would be seen as more stable axis I diagnoses over time (less remission), especially as the number of comorbid PDs increases. We test this in the CLPS six-month follow along sample (N = 224; N will be 600 plus by Spring 1999).

Method: Axis I and II were ascertained reliably with face-to-face semistructured interviews at baseline (SCID and DIPD, respectively) and six months (LIFE - PS). Remission from axis I disorder is defined as criteria scores below diagnostic threshold for eight consecutive weeks.

Results: Axis I disorders of sufficient sample size have the following rates of remission at six months, from the highest rate to the lowest: OCD: 61%, panic: 58%, GAD: 45%, PTSD: 43%, DYS: 39%, MDD: 36%, social phobia: 33%. The MDD sample (N = 85) was subdivided into MDDs with 0, 1, 2, and 3 plus PDs. Rates of remission were 64%, 58%, 21%, and 19%, respectively. The other axis I disorders were similarly subdivided. While the Ns were too small for significances to emerge, rates of remission went down with increasing PD comorbidity *except* for OCD and GAD where three or more comorbid PDs failed to reduce remission rates from the average.

Conclusions: The expected pattern of truncated axis I remission with increasing PD comorbidity was found, especially for MDD. However, we also found high remission rates in some axis I disorders despite PD comorbidity, especially OCD, panic, and GAD. Analysis of the larger six-month follow-up sample may shed further light on this unusual finding.

No. 63D
STABILITY OF PSYCHOSOCIAL FUNCTIONING IN PERSONALITY DISORDERS

Andrew E. Skodol II, M.D., *Personality, NYS Psychiatric Institute, 722 West 168th Street, New York NY 10032;* Robert Stout, Ph.D., M. Tracie Shea, Ph.D., Thomas H. McGlashan, M.D., John G. Gunderson, M.D., Leslie C. Morey, Ph.D., Martin B. Keller, M.D.

SUMMARY:

Impairment in psychosocial functioning is an essential feature of DSM-IV personality disorders. Even if some traits or behaviors indicative of personality disorders wax and wane over time with the course of axis I disorders or with life crises, impairment in psychosocial functioning should endure if personality disorder diagnoses are valid. Subjects diagnosed at intake with four types of personality disorders—schizotypal (STPD), borderline (BPD), avoidant (AVPD), or obsessive-compulsive (OCPD)—or with major depression (MD) and no personality disorder were reinterviewed six months later and aspects of their social, occupational, and global psychosocial functioning were rated on a monthly basis over the follow-up interval with the Longitudinal Interval Follow-up Evaluation adapted for personality studies (LIFE-PS). Preliminary results (N = 215) indicate that global psychosocial functioning improves minimally across the five groups of patients over six months (mean GAFS at intake = 57.3; mean GAFS at follow-up = 59.6). Subjects with MD improved the most (GAFS = 57.6 to 65.6); subjects with STPD improved the least (GAFS = 53.3 to 53.7). Consistent with findings at intake, subjects with OCPD, AVPD, or MD had better global functioning during each month of the follow-up interval than did subjects with BPD or STPD. These results suggest that impairments in psychosocial functioning associated with personality disorders are indeed stable over the short-term.

No. 63E
CONTINUITY OF TREATMENT FOR PATIENTS WITH PERSONALITY DISORDERS

Donna S. Bender, Ph.D., *Personality, NYS Psychiatric Institute, 722 West 168th Street, Box 8, New York NY 10032;* Andrew E. Skodol II, M.D., Robert Stout, Ph.D., Regina Dolan, Ph.D., John G. Gunderson, M.D., M. Tracie Shea, Ph.D., John M. Oldham, M.D.

SUMMARY:

Objective: The purpose of this study was to compare continuity of outpatient psychiatric treatment for four groups of patients with personality disorders—STPD, BPD, AVPD, and OCPD—and a group diagnosed with major depression and no personality disorder (MDD).

Method: CLPS participants were assessed at intake with the LIFE-Base and at a six-month follow-up interval with the LIFE-PS. Preliminary analyses include 195 subjects, with an anticipated final sample of over 600.

Results: Overall, 74% of patients continued in a treatment begun prior to intake (continuity rates ranged from 67% for AVPD to 82% for BPD), 24% discontinued a treatment, and 35% started a new treatment. Although the AVPD, OCPD, and MDD patients reported greater use of psychiatric medications at intake, significantly higher proportions of the STPD and BPD patients received medication consultations in the following six months. Also, over 90% of the BPD and OCPD patients received individual psychotherapy during the follow-up period.

Conclusions: Over six months, the majority of patients with personality disorders continued in treatment. The rate of beginning new treatments exceeded ending others, implying use of multiple treaters, particularly medication consultations for STPD and BPD patients.

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SYMPOSIUM 64—THE EVOLUTION OF COMMUNITY PSYCHIATRY IN ITALY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the evolution of community psychiatry in Italy by recognizing that 20 years after the "Basaglia Law," Italian psychiatry achieved many objectives, maintaining a style of care focused on community intervention and psychosocial rehabilitation.

No. 64A
STANDARDIZED ASSESSMENT OF PSYCHIATRIC CARE IN ITALY

Carmine Munizza, M.D., *Mental Health Dept of Torino, Piazza Donatoredelsanguz 3, Torino, Italy;* G. Tibaldi, M.D., M. Zuccolin, M.D., C. Palazzi, M.D., E. Scala, M.D., S. Cesano, M.D., R. Dazzi, M.D.

SUMMARY:

Few instruments exist to assess psychiatric services at the international level. To alleviate this situation the European Psychiatric Care Assessment Team (EPCAT) has developed an internationally valid technology for assessing the scope, structure, and content of mental health services available within a catchment area. The resultant instruments, which have been developed and tested by experts from six European countries, are:

1. the Socio-Demographic Schedule-SDS-(J. Beecham and S. Johnson)
2. the European Service Mapping Schedule-ESMS-(S. Johnson and R. Kuhlmann)
3. the International Classification of Mental Health Care-ICMHC-(A. de Jong)

Drawing upon previous research experiences, and with the support of regional and national authorities, the application of this battery of instruments represents the basis of a large field survey, involving various Italian mental health departments and their specific catchment areas.

The field assessment has been preceded by a number of preliminary steps dedicated to training, reliability, and adaptation issues. Presented data refer to a limited number of catchment areas, both in Piedmont and in other Italian regions, with a comparison at two different levels:

- *the catchment area level,* using information from SDS and ESMS
- *the service level,* using information from ESMS and ICMHC

These data allow assessment of the imbalances affecting both the resources available for different populations, and the operational profiles of psychiatric facilities of the same type, but their presentation will permit an evaluation of the descriptive and comparative capabilities of the methodology proposed by the EPCAT group.

No. 64B
THE ORGANIZATION OF COMMUNITY PSYCHIATRY: OTHER THAN REHABILITATION

Bruno Commodari, M.D., *Mental Health Dept of Catania, Via Malta 3, Catania 95127, Italy;* C. Zaffora, M.D., F. Spadaro, M.D., R. Ortoleva, M.D., A. Fallica, M.D., B. Salmeri, M.D.

SUMMARY:

Italian psychiatry, after Law 180 of 1978, began community practice in cases of severe psychosis and experimented in the field with many interventions without long-term inpatient care. The more advanced community mental health centers adopted models of intervention focused on "global and continuous care" of the patient. This kind of care consists of an in-depth approach to the person affected by severe mental illness rather than only a clinical approach to the disorder. This global and continuous care permits the community management of grave forms of psychosis and focuses the psychiatrist's attention on social and human relationship problems. It also favors the development of psychosocial rehabilitation strategies, effective with both old and recent chronic patients. In some mental health services, with the support of the local institutions, they have experimented with original ideas that have increased re-entry of patients into the social and work environments. The innovation, introduced in 1992 by the new legislation, transformed the local health authorities in public health companies. It imposed new rules of conduct and placed special attention, other than the clinical aspects, to the company aspects—employee resources, evaluation of the results of treatments and their outcomes, research of the most effective welfare combinations—areas usually neglected. The introduction in the clinical practice of new antipsychotic drugs has given new enthusiasm to community management of the most severe patients and generated new expectations with regard to the recovery and re-entry into the social and work environments. First cloazapine, followed by risperidone and most recently other effective new drugs, have revolutionalized the course of psychosis and made psychosocial intervention possible in the cases of a major number of patients.

No. 64C
THERAPEUTIC PROGRAM INTEGRATED WITH THE COMMUNITY PSYCHIATRY FACILITIES AND THE FUNCTIONS OF THE MENTAL HEALTH DEPARTMENT

Vincenzo Gatti, M.D., *Mental Health Dept of Avellino, Viadegli Imbimbo, Avellino, Italy*

SUMMARY:

The author examines the concept of community psychiatry as a cultural process historically determined by the evolution of major psychosis treatment. The mental health departments, in their various facilities, face the diversification of structures and functions to reach their intermediate goals (prevention, diagnosis, care, and psychosocial rehabilitation). The inpatient ward in the general hospital, the half-day facilities, the supported houses, and the community mental health centers, of course, cannot be secluded from one another. They must respect the professional autonomy and at the same time integrate among themselves. All of this can be obtained through gradual interventions. These interventions often have the same goals, notwithstanding the facility, but they are focused on the individual needs of the patient. The psychiatrist does not ever have to consider intervention as a total solution, but as a step toward a better long-term relationship between the patient and the staff. In the Italian model of community psychiatry the therapeutic program is the integration between the patient's needs, the professional knowledge of the psychiatrist, and the resources of the community.

No. 64D
RESIDENCY IN A COMMUNITY PSYCHIATRY PROGRAM WITHOUT A MENTAL HOSPITAL

Luigi Ferrannini, M.D., *Mental Health Dept of Genova, Via Giovanni Maggiog, Genova 16147, Italy*

SUMMARY:

The completion of the Italian Mental Hospital's overwhelming process was actually put into effect by a renewed legislative push.

One side brought about reform of psychiatric care, such as modernization of the structure, while the other side dealt with problems of psychiatric services, especially in the field of residential structure. The criticism and the long decline of the mental hospitals, is not always tied to a deepening of the thematic connection to the residentiality, which is characterized by an uncertain definition, not only in terminology but also in the objectives, standards, treatments, and intervention techniques. Due to the effects of the closing of the mental hospitals and because of social pressure to be consistent, the psychiatric residentiality is emphasized as a central point of the entire community psychiatry system. It is necessary to incorporate the experiences realized in these past 20 years, as well as from the experiences of other countries. In this process, one may encounter the following problems: (1) need for a clearly defined concept of psychiatric residentiality, for each psychiatric patient in which intervention is carried out, that request each model and specific technique; (2) it would be better to clearly define each of these moments and in particular those connected to specific interventions and structures, directions, standards, treatment guidelines, evaluation systems; (3) it is extremely difficult to find criteria for "the best" residential facilities; (4) the sustainability of a residential system, in relation to the times of treatment, the costs, and the outcomes; (5) the characteristics of the supply and the role of public service in a scenario in Italy that sees the end of a monopolistic system and the beginning of various relationships with social, entrepreneurial, and technical characteristics; (6) the typology, the professionalism, the education and training of the mental health workers, and the development of intervention models in combination with other disciplines.

No. 64E
THE LONG-TERM TREATMENT OF SCHIZOPHRENIA: THE OPINIONS OF THE ITALIAN PSYCHIATRISTS

Mariano Bassi, M.D., *Strada Maggiore 82, Bologna 40125, Italy*

SUMMARY:

Despite accumulated evidence that available pharmacological treatments for schizophrenia are effective, adherence to treatment regimes by patients is notoriously poor. The reported incidence of noncompliance with antipsychotic medication ranges from 11% to 80%. Forty-eight percent of patients are estimated to be noncompliant within the first year of treatment, and 74% within the first two years. For schizophrenic patients who are treated in the community psychiatry setting, as in the Italian mental health system, continuing benefit from antipsychotic drugs depends on compliance with community care and maintenance pharmacotherapy. However, in studies of schizophrenic patients referred for outpatients services, only 34% to 46% actually completed the referral. Moreover, between 25% and 94% of patients who attend outpatient medication clinics do not take their medication as prescribed. This problem is particularly noted in Italy, because our psychiatric system is based on community mental health centers that treat the majority of schizophrenic cases as outpatients. Even the patterns of antipsychotic prescriptions demonstrate that the psychiatrists do not have concurring opinions on the dosage of medication, on the minimal effective dose or on the duration of treatment. After the studies conducted in Germany by Kissling and other colleagues, the attention of psychiatrists has focused more on the difference between the results of studies and the everyday practice. This study is an overview of the psychiatrists' opinions on the long-term treatment of schizophrenia in an outpatient setting as that in Italy.

No. 64F
FROM INFORMED CONSENT TO CONTRACT IN THE PRACTICE OF ITALIAN COMMUNITY PSYCHIATRY

Claudio Mencacci, M.D., *Mental Health Dept of Milan, Via c Matteucci 4, Milano 20129, Italy*

SUMMARY:

In psychiatry, unlike any other science, the progressive consciousness of human rights on the part of patients and their families has greatly changed the field. The consciousness movement fused the achievements of human rights with the new acquisitions of neurobiology and psychosocial rehabilitation. The same movement reinforced the perspectives of care and recovery for mentally ill patients. The law on "La Carta dei Servizi" is introducing to Italy the concepts of control and the verification of quality of public health services. This law constitutes a very important step in the favor of the patient who passes from being the user to being the evaluator of the results. In this way, we have a new therapeutic alliance between the mental health staff and the patient. The patients become protagonists, users of the complete and transparent information, with the guarantee of equal access and use of health resources. The application of "La Carta dei Servizi" in community psychiatry brings into evidence more critical areas with respect to other sectors in the health system. These critical areas are informed consent, confidentiality, free choice of psychiatrist, management of complaints, and indicators of client satisfaction. These problems are a starting point for a stronger transformation, growth, and improvement for all community psychiatry.

SYMPOSIUM 65—RELAPSE IN CO-OCCURRING DISORDERS
The Substance Abuse and Mental Health Services Administration, DHHS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize the precursors and indicators of relapse in patients with co-occurring psychiatric and substance use disorders and develop a treatment and service strategy.

No. 65A
EPIDEMIOLOGY OF DUAL DISORDERS

Bert Pepper, M.D., *The Information Exchange, 120 North Main Street, #109, New York NY 10956–3717*

SUMMARY:

During the past 15 years the NIMH has funded two groundbreaking epidemiologic studies that have provided a broad and intensive data set on mental disorders, substance abuse disorders, and co-occurring disorders in the United States. The Epidemiologic Catchment Area (ECA) study was conducted in the 1980s by five university teams, coordinated at the NIMH. The second study, the National Co-Morbidity Survey (NCS), was conducted in the early 1990s by the University of Michigan. Although the ECA and the NCS were conducted in different ways, a combined set of data from the two has tended to validate each, and has provided valuable incidence, prevalence, and other data about co-occurring disorders. A profile of the estimated 9 to 11 million individuals currently affected by at least one mental health and one substance abuse disorder will be presented. Emphasis will be placed on the relationship between number of disorders,

impairment of function, and disability. Implications for both prevention and treatment will be noted.

No. 65B
SYSTEMS APPROACH IN CO-OCCURRING DISORDERS

Michael English, Ph.D., *KDSC, CMHS SAMHSA, 5600 Fishers Lane, Rockville MD 20857*

SUMMARY:

As research findings accumulate in support of models that integrate and coordinate mental health and substance abuse treatment within a single agency for individuals with co-occurring disorders, there is increased demand for publicly supported systems to be responsive to this emerging standard of care. At the state and local levels, mental health and substance abuse treatment services have developed within different historical contexts, have separate nomenclatures, different diagnostic and eligibility criteria, and have unique interpretations of such issues as relapse. The Center for Mental Health Services is facilitating efforts by the National Association of State Mental Health Program Directors and the National Association of State Alcohol and Drug Abuse Directors to establish cooperation and collaboration between state mental health and substance abuse treatment authorities in addressing co-occurring disorders in a comprehensive manner. This presentation will describe a conceptual model that will facilitate integrated services through publicly funded treatment systems.

No. 65C
RELAPSE TO FORENSIC SETTINGS

Raymond F. Patterson, M.D., *Human Services, Commission on Mental Hlth Serv, 2700 Martin L King Avenue, SE, Washington DC 20032;*

SUMMARY:

The impact of increasing numbers of individuals with serious and persistent mental illness and/or co-occurring mental illness and substance abuse on the criminal justice system will be discussed. The differing missions of jails, prisons, and mental health and substance abuse treatment systems will be reviewed.

The provisions of in-house, referral, and aftercare services for persons with these disorders will be discussed.

No. 65D
RELAPSE TO HOMELESSNESS

Walter Leginski, Ph.D., *CMHS SAMHSA, 5600 Fishers Lane, Rm 11C-05, Rockville MD 20857*

SUMMARY:

Individuals with co-occurring psychiatric and substance use disorders are at high risk for becoming homeless. Based on research sponsored by the Center for Mental Health Services (CMHS) and other federal agencies, it has been estimated that approximately 25% of homeless persons have co-occurring disorders. From the psychiatric perspective, 51% of persons with mental illnesses report a lifetime history of one or more addictive disorders; for persons with addictive disorders, 41% to 66% report a lifetime history of one or more psychiatric disorders. To address the high incidence and prevalence of co-occurring disorders, CMHS has initiated a variety of study and programmatic responses to address the treatment and service needs of this population. This presentation will focus on the descriptive, treatment, systems linkage, and systems integration initiatives supported by the agency and their implications for clinical practice.

No. 65E
RELAPSE INTO INSTITUTIONAL AND EMERGENCY CARE SETTINGS

Roger Peele, M.D., *Nova Mental Health Institute, 8002 Lion's Crest Way, Gaithersburg MD 20879*

SUMMARY:

The majority, sometimes the vast majority, of psychiatric patients in public psychiatric hospitals were admitted because they relapsed—or they have remained in the hospital because of continuing relapses. Thus, public hospital psychiatry is largely the management of these patients. Caring for and treating these patients is primarily what many a public psychiatric hospital is about. Key to addressing the needs of these patients is comprehensiveness and continuity. In this presentation, we will review how to achieve the comprehensiveness and continuity that these patients need.

REFERENCES:

1. Randolph F, Blasinsky M, Leginski W, Parker LB, Goldman HH: Creating integrated service systems for homeless persons with mental illness: the Access Program. Psychiatric Services, March '97
2. Drake RR, Osher FC, Wallach MA: Homeless with dual diagnosis. Am Psychologist 46: 1149–1158, 1991
3. Osher FC, Kofoed LL: Treatment of patients with psychiatric and psychoactive substance abuse disorders. Hospital & Community Psychiatry 40: 1025–1030, 1989
4. Ryglewicz H, Pepper B: Lives at Risk: Understanding and Treating Young People with Dual Disorders. New York, The Free Press, 1996
5. Patterson RF: Treatment of offenders with mental disorders, in Administration in Forensics. Edited by Wettstein R. Gilford Press, 1998
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7. Hertz MI, Lamberti JS: Prodromal systems and relapse prevention in schizophrenia. Schizophrenia Bulletin 1995; 21:541–551

SYMPOSIUM 66—SEXUAL BEHAVIOR AND SUBSTANCE USE RESEARCH WITH THE MENTALLY ILL

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium the participant should be able to demonstrate the following, three objectives: (1) present data on high risk sexual behavior and substance use associated with transmitting HIV/STDs; (2) examine the role of psychiatrists and psychiatric research in providing guidance in clinical practice and public policy on the extremely complex issue of treatment of underserved populations with potent drugs; and (3) present potential research opportunities that exist in mental disorders, behavioral research, and AIDS at NIMH.

No. 66A
HIV RISK BEHAVIOR AMONG OUTPATIENTS AT A STATE PSYCHIATRIC HOSPITAL

Michael P. Carey, Ph.D., *Department of Psychology, Syracuse University, 430 Huntington Hall, Syracuse NY 13244*

SUMMARY:

This presentation is based on a study to determine the prevalence and correlates of HIV-related risk behavior among adults with a severe and persistent mental illness (SPMI). New admissions and ongoing outpatients at a large public psychiatric hospital were screened for sexual behavior and substance use during routine care. Of 1,214 eligible patients, 889 (73%) were screened. During the past year, 49% were sexually active, 52% used alcohol, and 18% used street drugs. Eleven percent could be classified as at risk for HIV infection; 7% reported having three or more sexual partners, 3% had traded sex, and fewer than 1% had shared injection equipment. HIV risk status was modeled with logistic regression using diagnostic status, type of residence, drug and alcohol use, and demographic variables; five- and six-predictor models were derived for two HIV risk indicators. A bootstrap simulation confirmed the reliability of each regression model. Many persons living with a SPMI are sexually active, and a significant minority engage in behaviors that increase risk of HIV infection. Routine screening for HIV risk in psychiatric settings can identity those patients who may benefit most from risk reduction programs.

No. 66B
OUTCOMES OF HIV PREVENTION INTERVENTIONS INTEGRATED IN COMMUNITY CLINICS THAT SERVE PERSONS WITH SEVERE MENTAL ILLNESS

Jeffrey A. Kelly, Ph.D., *Department of Psychiatry, Medical College of Wisconsin, 1201 North Prospect Avenue, Milwaukee WI 53202*

SUMMARY:

Men and women with severe and persistent mental illness constitute a population at high risk for contracting HIV infection. Both HIV seroprevalence and risk behavior epidemiology studies indicate that a substantial proportion of severely mentally ill adults are at risk for the disease or, in some areas, are already infected. This presentation will begin by summarizing data on the sexual and substance use risk characteristics found in samples of severely mentally ill men and women interviewed in outpatient mental health programs. These data show that, especially among young patients and those with greater severity of illness, rates of unprotected sexual activity with multiple or high-risk partners are high and are often associated with substance use. Among males, patterns of sexual risk behavior were particular associated with high levels of drug use. Among females, high-risk sexual behavior was especially linked with fatalism, low self-esteem, and being in a relationship with a steady but risky male partners.

The presentation then will describe the results of two recent randomized outcome trials of HIV prevention interventions undertaken by our research group for severely mentally ill men and women who receive services in inner-city community-based clinics. Each study evaluated the effects of small-group HIV risk reduction programs tailored to address the risk circumstances of this population. In each study, patients attended interventions that provided risk education; skills training exercises in such areas as condom use, sexual assertiveness, and risk self-management; and reinforcement and support for making sexual risk behavior change. In both studies, follow-up assessments conducted three to 12 months postintervention demonstrated reductions in high-risk sexual behavior practices and increase in condom use. The presentation will conclude by discussing how HIV prevention interventions can be incorporated in community settings that provide services to severely mentally ill persons.

No. 66C
CLINICAL TRIALS OF ETHNOGRAPHICALLY-BASED INTERVENTIONS

Ezra S. Susser, M.D., *Columbia University, 1216 Fifth Avenue, Room 556, New York NY 10029*

SUMMARY:

Over the past six years, our team has conducted two randomized clinical trials of ethnographically-based sexual risk reduction interventions for homeless men with severe mental illness (SMI). This presentation will provide important lessons about HIV/STD prevention that can be learned from these studies: *Feasibility of trials:* It is possible to conduct a randomized clinical trial of sexual risk reduction in a population of men with SMI and have excellent long-term follow-up. *Safety:* Sexually explicit interventions did not stimulate sexual risk behavior by sexually inactive men. *Efficacy:* Theory-based sexual risk reduction can significantly increase condom use during penetrative anal and vaginal sex in the initial six months of follow-up. The longer (15 session) intervention was more efficacious than a briefer (7 session) intervention. *Specificity:* The interventions were effective only with non-steady partners. *Maintenance:* There may have been a diminution of effect after six months. Modifications to promote maintenance are needed. An additional lesson that can be drawn from this work is the need to develop strategies that complement behavioral change in this vulnerable population. The role of testing and treatment of STDs among men attending psychiatric outpatient clinics will be explored in future work.

No. 66D
ADHERENCE TO TB AND HIV DRUG REGIMENS AMONG MARGINALIZED PEOPLE

Andrew Moss, Ph.D., *Epidemiology/Biostatistic, San Francisco Hospital, 995 Potrero Avenue, San Francisco CA 94143*

SUMMARY:

Data will be presented from a program of research that focuses on adherence to TB and HIV drug regimens among marginalized people, many of whom are mentally ill and substance abusers. Lack of adherence is a major concern because a drug-resistant strain of TB and HIV have been identified. Surveillance of pharmacotherapy for TB has shown that this population is at high risk for poor adherence. Data will be presented on a three-arm randomized controlled trial of methods to give six-months of INH therapy to TB-infected homeless persons. Peer health advisors, money, and usual care were compared for efficacy. Because TB is an infectious disease that is spread with minimal or no social contact, and problems with poor adherence to protease inhibitor therapy in terms of developing drug-resistant virus, this population is often not prescribed these complex therapies. Data are available on a survey on the adherence to single and combined antiretroviral therapy among homeless or marginally housed people. A study on adherence has demonstrated that it is possible to achieve approximately 80% adherence in this group, which is comparable to other less marginalized populations. This presentation will review the multimethods used to elicit information on missed doses and problems encountered in taking protease inhibitors. Predictors of drug adherence will be explored using subject characteristics such as demographics, medical insurance status, risk behaviors, coping strategies, beliefs about the effectiveness of therapy, substance use, mental illness, CD4 count, and frequency of medical visits. Guidelines for adherence will be suggested.

REFERENCES:

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3. Pilote L, Tulsky JR, Zolopa AR, Hahn JA, Schecter GG, Moss AR: Tuberculosis in the homeless: a trial to improve adherence to referral. Archives of Internal Medicine 1996; 156:161–165

SYMPOSIUM 67—PSYCHIATRIC DISORDERS IN A SPECIAL POPULATION: THE ATHLETE
The International Society for Sport Psychiatry

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should have an appreciation of anorexia athletica, body dysmorphic disorder, and certain axis I and axis II disorders as they manifest themselves in the athletic arena. The participant should be more aware of the growing tide of steroid abuse among our youth, have an understanding of how athletes can be positive or negative role models for our young people, and have a better appreciation of how the psychiatrist can interface most productively with the athletic world.

No. 67A
PATHOLOGICAL BODY IMAGE IN THE ATHLETIC ARENA

Antonia L. Baum, M.D., *Department of Psychiatry, George Washington University, 2150 Pennsylvania Avenue NW, Washington DC 20037*

SUMMARY:

The human form is the instrument of the athletic pursuit; it must be finely tuned for peak performance. Preoccupation with body image is expected in athletes, but the intensity of this focus can transform into a pathological obsession.

While compulsive overexercise may be one manifestation of eating disorders, certain sports predispose to the development of eating disorders. Preoccupation with body image is seen in sports where aesthetics are central, where minimal body fat generates winners, or in sports requiring the athlete to "make weight" for competition.

Bulking up may be a priority in still other sports. This may lead to a pathologic drive to increase muscularity, as described in the phenomenon of muscle dysmorphia. Athletes with this psychopathology are prone to the abuse of anabolic steroids, a growing problem characterized by physical and psychological dependence. This has raised complex ethical issues at all levels of competition.

The sport psychiatrist must work with coach and athlete to negotiate the delicate balance between pathology and perfection. It is necessary to establish safe guidelines for equitable competition. These goals can be achieved through psychoeducation, case identification, and treatment where necessary.

No. 67B
ANOREXIA ATHLETICA AND OTHER ATYPICAL EATING DISORDERS

Robert W. Burton, M.D., *Department of Psychiatry, Northwestern University, 405 North Wabash Avenue, #4605, Chicago IL 60611*

SUMMARY:

A range of disordered eating behaviors affect athletes. Certain syndromes, like anorexia athletica, can be classified as an eating disorder, not otherwise specified, using the DSM-IV. Other conditions may be subclinical, or preclinical, but pathological nonetheless. As such they, too, pose significant health risks, the extent of which has not been fully appreciated. With the recent deaths of the wrestlers in Michigan, it is important that the underlying causes for such extreme weight control behavior be examined.

The morbidity and mortality associated with the eating disorders anorexia nervosa and bulimia nervosa have been well documented. While certain symptoms and behavioral features of these illnesses have been identified as placing individuals at risk for developing the full syndromes, clearly the behaviors themselves can pose health risks.

Athletes have added incentive to engage in these pathological and risky behaviors, and are therefore at greater risk for developing eating disorders of all types. Believing that their performance will be enhanced by achieving some idealized body state, they can lose perspective and resort to extreme measures in hopes of attaining it. The range and types of behaviors commonly used by athletes as well as their specific health risks will be reviewed. In addition, diagnostic and therapeutic approaches will be discussed.

No. 67C
TREATMENT TO KEEP ATHLETES FUNCTIONING

Ira D. Glick, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Suite 2122, Stanford CA 94305-5490;* Jessica L. Horsfall, M.A.

SUMMARY:

This presentation focuses on how psychiatric intervention can help keep professional athletes functioning at peak levels.

Material was derived from a review of the literature and from the author's clinical practice of sports psychiatry.

There are three kinds of problems: (1) psychiatric illnesses, including mood and anxiety disorders, which sometime lead to personality change (for example, former basketball player Eddie Johnson's behavior was partially due to bipolar disorder); (2) nonpsychiatric disorder, the so-called problems of living. These include not only an athlete's individual issues, such as (lifelong) character traits of selfishness, moodiness, and dysfunctional aggressiveness, but also family problems such as marital disorders and/or spousal abuse; (3) problems relating to the team—including coaches, other players, and management (owners), as well as agents.

Diagnostic treatment strategies for each of these types of problems will be described, including use of medication, couples and family therapy, individual therapy, and team meetings.

Summary: Sports psychiatry's message to professional sports is that it is not (just) the "talent," but how to find ways to maximize the expression of that talent, and how to meld many unique, individual talents into a "team" that works together.

Panel of Athletes: Gerald A. Cooney, former heavyweight boxer; Herb McCauley, professional thoroughbred jockey, and John R. Park, olympic swimmer, body builder and professional trainer.

REFERENCES:

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2. Pope HG Jr, Gruber AJ, Choi P, et al: Muscle dysmorphia: an underrecognized form of body dysmorphic disorder. Psychosom 38:548–557. 1997
3. Brower KJ, Eliopulos GA, Blow FC, et al: Evidence for physical and psychological dependence on anabolic steroids in eight weight lifters. Am J Psychiatry 1990; 147:510–512

4. Sundgot-Borgen J: Risk and trigger factors for the development of eating disorders in female elite athletes. Medicine and Science in Sports and Exercise 1994; 26:414–419
5. Begel D: An overview of sport psychiatry. Am J Psychiatry 1992; 149:606–614

SYMPOSIUM 68—EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR)

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be familiar with the basics of EMDR: method, clinical applications, and existing outcome research.

No. 68A
EMDR: INFORMATION PROCESSING THERAPY FOR TRAUMA

Francine Shapiro, Ph.D., *Mental Research Institute, 165 LaGrande, Moss Beach CA 94038*

SUMMARY:

It is crucial that all new psychotherapeutic methods be objectively and rigorously tested. Controlled research with EMDR demonstrates that 84% to 100% of single trauma victims no longer have post-traumatic stress disorder after approximately four hours of treatment. Therefore, the EMDR research will be reviewed in the context of other trauma treatments currently used in the field. In addition, component analyses will be reviewed to address the contribution of exposure, cognitive restructuring, and bilateral stimulation. Potential areas of improvement will be examined.

The presenter will then review the eight-phase treatment approach and the paradigm used to guide EMDR clinical practice. It may be argued that EMDR catalyzes a change that allows the client's brain to heal at the same rate as the rest of the body. For example, after a rape, with appropriate medical care, the body is expected to heal in days or weeks. Put simply, EMDR appears to allow an equally rapid mental recovery to occur. The current generic EMDR protocol will be delineated, along with an evaluation of the implications for clinical application and practice. The integrative nature of this complex methodology will be explored.

No. 68B
EMDR TREATMENT FOR CHILDREN WITH DISASTER-RELATED PTSD

Claude M. Chemtob, Ph.D., *National Center for PTSD, 1132 Bishop Street, Suite 307, Honolulu HI 96813;* Joanne Nakashima, M.A., Roger Hamada, P.A.D. John Carlson, P.A.D.

SUMMARY:

Effective psychological intervention is needed to help children recover from disaster-related distress and to prevent the development of chronic psychopathology. This study evaluated the effectiveness of brief intervention for disaster-related PTSD. During the one-year follow-up of a large post-disaster treatment intervention, it became apparent that some of the previously treated children were still suffering significant post-disaster distress. Using a randomized lagged-groups design, we provided three sessions of Eye Movement Desensitization and Reprocessing (EMDR) treatment to 32 of these children who were (1) treatment nonresponders and (2) met clinical criteria for PTSD. The Children's Reaction Inventory (CRI) was the primary measure of the treatment's effect on PTSD symptoms. Associated symptoms were measured using the Revised Children's Manifest Anxiety Scale (RCMAS) and the Children's Depression Inventory (CDI). There were substantial reductions in both groups' CRI scores following treatment. There were also significant, though more modest, reductions in RCMAS and CDI total scores. Treatment gains were maintained at six-months follow-up. Health visits to the school nurse were significantly reduced the school year following treatment. Videotapes of the treatment of these children will be presented to illustrate working with children suffering with disaster-related PTSD using EMDR.

No. 68C
NEUROBIOLOGICAL DIMENSIONS OF EMDR: PHYSIOLOGY AND NEUROIMAGING

Bessel A. van der Kolk, M.D., *Department of Psychiatry, Boston University, 227 Babcock Street, Brookline MA 02146;* Elizabeth Matthew, M.D., James Hopper, Ph.D., Jennifer Burbridge, M.A., William Simpson, Ph.D.

SUMMARY:

This study reports pre/post EMDR psychophysiological outcome data as well as the first neuroimaging study of PTSD treatment outcome, utilizing EMDR. Twelve subjects with PTSD had an initial CAPS Score >50. They were given three EMDR sessions, using the standard protocol for trauma (Shapiro, 1995). Outcomes of EMDR sessions are shown in Table 1.

SPECT neuroimaging scans were done, using scriptdriven imagery, before and after treatment. ROI analyses of the scans suggest increased activation of the cingulate cortex and increased frontal activation, bilaterally, after effective treatment. These findings suggest that improvement of PTSD symptoms may be mediated by increased activation of these regions, which promote the capacity to distinguish between real threats and traumatic reminders that are no longer relevant to current experience. The activation of the prefrontal cortex may indicate the assignment of meaning to the emotions associated with traumatic memory via the elaboration of cognitive strategies. These results are preliminary, not necessarily the specific result of EMDR (as opposed to any effective treatment) and do not clarify the mode of action of EMDR.

No. 68D
USING EMDR IN COMPLEX PTSD AND ADULT ATTACHMENT DISORDERS

Andrew M. Leeds, Ph.D., *405 Chinn Street, Santa Rosa CA 95404*

SUMMARY:

Attention has focused increasingly in recent years on addressing the traumatic memories of patients with post-traumatic stress and related disorders for whom EMDR has been shown in controlled studies to be effective and efficient. However, patients with complex PTSD and adult attachment-related disorders often do not meet readiness criteria for EMDR treatment. Indeed, they generally make extremely slow progress in any form of treatment due to severe problems including mood instability, poor impulse control, self-injurious behavior, maladaptive schemas, impaired self-capacities, and limited affect tolerance.

This presentation will review research on attachment theory, affect theory, and the developmental neurobiology of affect regulation and will propose an alternative approach to using EMDR for these patients called Resource Installation.

Treatment planning and intervention strategies will be offered for addressing specific developmental deficits related to failures of early

attachment. A basic protocol and case illustrations will be presented for facilitating movement through all stages of treatment and for dealing with specific recovery tasks including developing self-soothing capacities; clarifying responsibility; establishing safety and new choices; processing grief, anger, and guilt; reconnection with others; and development of self-identity.

REFERENCES:

1. Shapiro F: Eye movement desensitization and reprocessing: Basic principles, protocols & procedures. Guilford Press, 1995
2. Carlson JG, Chemtob CM, Rusnak K, Hedlund, NL, Muraoka, M: A controlled study of eye movement desensitization and reprocessing (EMDR) for combat related PTSD. Journal of Traumatic Stress 1998; 11:3–24
3. van der Kolk BA: The psychobiology of traumatic memory: clinical implications of neuroimaging studies. Ann NY Acad Sciences 1997; 99–113
4. Schore AN: The experience-dependent maturation of a regulatory system the orbital prefrontal cortex and the origin of developmental psychopathology. Development and Psychopathology 1996; 8:59–87

SYMPOSIUM 69—MUSIC THERAPY IN PSYCHOSOCIAL CARE AND PAIN MANAGEMENT

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: (1) describe the development of music therapy in the United States, (2) understand the use of music therapy in psychosocial care and pain management across a spectrum of medical diagnoses, (3) understand the role of creativity in healing, and (4) describe the range of music therapy interventions in geriatric populations.

No. 69A
MUSIC THERAPY: AN OVERVIEW

John S. McIntyre, M.D., *919 Westfall Road, Suite 210, Rochester NY 14618*

SUMMARY:

Music therapy is an efficacious treatment for a wide spectrum of medical diagnoses. Programs in music therapy can be divided into the following 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 music in psychotherapy. Different levels of music psychotherapeutic intervention will be explored including listening, recreating, improvising, and composing. Descriptions of specific clinical programs will be included.

No. 69B
MUSIC THERAPY AND PAIN MANAGEMENT

Joanne V. Loewy, D.A., *Music Therapy, Beth Israel Medical Center, 317 East 17th Street/4 Fierman, New York NY 10003*

SUMMARY:

The International Association for the Study of Pain defines pain as the sensory and emotional experience associated with actual or potential tissue damage. What's significant about pain is that unlike most other medical symptoms, pain includes not only the perception of the stimulus that can cause discomfort, but the response to that perception as well. Thus, pain is a factor that directly affects how a patient perceives his/her own ability to heal. Music therapy serves as an important diagnostic tool in the assessment of pain that enables the evaluation of intensity, source, function, and degree of absorption or denial of pain within the body. This presentation will examine several models of pain and the medical and biopsychosocial aspects of its effects in treatment. A review of the literature will focus on the growing use of music therapy in medical institutions. Current study and practice in conscious sedation, procedural, acute, and chronic pain management will be presented. The music therapy techniques of vibration, entrainment, integration, and psychoacoustics will be viewed as the sensory, emotional, and cognitive components are considered.

No. 69C
MUSIC THERAPY, ASSISTED LABOR AND DELIVERY

Bryan C. Hunter, Ph.D., *Music Department, Nazareth College, 4245 East Avenue, Rochester NY 14618*

SUMMARY:

Music therapy has been effectively used in providing psychosocial support and pain management strategies for women during labor and delivery. This presentation will review the research literature that has identified specific functions that music can fulfill during labor and delivery, along with specific benefits documented in patient self-reports. In addition, topics such as music selection, preparatory sessions, and equipment will be covered. A case study will be presented via videotape illustrating the use of music therapy during an actual labor and delivery, along with a statistical analysis of behavioral observations of pain management.

No. 69D
CREATIVE MUSIC THERAPY: ACCESSING THE HEALTHY CARE

Kenneth S. Aigen, D.A., *Music, New York University, 82 Washington Sq East, 4th Flr, New York NY 10003*

SUMMARY:

This presentation will illustrate the variety of ways in which creative expression through clinically directed improvisational music therapy allows for the transcending of limitations imposed by disability. Disabled individuals demonstrate cognitive, motoric, and affective skills in the context of improvisational music therapy that are not discernible through other means. The nature of interactive music making can reveal the presence of sensitivities and capacities for social exchange not possible through verbal forms of relating. Moreover, the existence of these expressive and communicative improvisational musical skills can suggest the presence of underlying cognitive processes characteristic of a capacity for abstraction not thought to be possible for severely disabled individuals. Through the use of videotape excerpts from actual music therapy sessions, this presentation will illustrate the spectrum of aesthetic, expressive, and communicative skills seen in a variety of different musical idioms utilized in improvisational music therapy.

No. 69E
BEYOND THE SING-ALONG: CURRENT TRENDS IN MUSIC THERAPY RESEARCH AND PRACTICE WITH OLDER ADULTS

Anne W. Lipe, Ph.D., *24724 Nickelby Drive, Damascus MD 20872*

SUMMARY:

An increasing number of music therapy practitioners are working with older adult populations. This includes not only those in nursing

homes, but those living in retirement communities or attending senior centers and adult day care programs. Given the growing diversity of this population and the services available to it, it is important for music therapists to adapt their strategies and techniques to a wide variety of clients. The purpose of this presentation is to provide a summary of music therapy research and current trends in clinical practice with this population. While research indicates that music therapy may be of significant value in improving the quality of life of people with dementia, little research has been done to demonstrate its efficacy with healthy older adults (Prickett, 1996). The presentation will focus on the use of music performance tasks in assessing cognitive functional levels among older adults with dementia, and highlight the effectiveness of preferred music in decreasing aggressive behaviors during bathing. The implications of this research for clinical practice with older adult populations in general will be discussed.

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4. Aigen K: Cognitive and affective processes activated in music therapy: a model for contemporary Nordoff-Robbins practice. Music Therapy 1995; 13(1):13–46
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SYMPOSIUM 70—NEW WORLD PSYCHIATRIC ASSOCIATION INITIATIVES ON EDUCATION

The World Psychiatric Association

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to acknowledge the importance of the WPA Educational Center in the dissemination of educational material, so that even psychiatrists in the remotest regions can have access to some form of CME.

No. 70A
EDUCATIONAL STRUCTURES OF THE WORLD PSYCHIATRIC ASSOCIATION

Roger M. Montenegro, M.D., *World Psychiatric Association, Juncal 2425 8B, Buenos Aires 1425, Argentina*

SUMMARY:

Colleagues all over the world are constantly demanding educational support. The WPA has answered by creating the WPA Education Center, which spins around the axis WPA member societies, WPA zonal representatives, WPA educational networks, WPA educational programs, WPA educational activities. The center is conducted by the WPA Secretary for Education, who is assisted by the WPA Standing Committee on Education. The WPA Educational Liaisons Network was created to facilitate the contact among colleagues who are interested in psychiatric education all over the world. Its members play a key role in the distribution, implementation, and evaluation of WPA educational programs. A presentation of such programs is always made at WPA meetings to achieve wider information and distribution among WPA member societies. Moreover, new educational programs are being developed to make our educational offerings much more varied and interesting. CME activities are encouraged at WPA meetings and member societies are invited to grant credits for such activities.

Another key area is the WPA Web site, which enables us to satisfy the expectations of these vast groups at a low cost. The WPA network of consultants to the SCE is also very helpful in achieving this goal.

No. 70B
INTERNATIONAL GUIDELINES FOR DIAGNOSTIC ASSESSMENT

Juan E. Mezzich, M.D., *Department of Psychiatry, Mt. Sinai School of Medicine, Fifth Avenue & 100th Street, New York NY 10029*

SUMMARY:

This is a WPA educational program under development aimed at offering international recommendations for comprehensive and practical diagnostic evaluations. It covers the following components: (1) conceptual and historical bases, (2) interviewing the patient, (3) extended sources of information, (4) organizing the clinical chart, (5) symptom and mental status evaluation, (6) supplementary assessment instrument, (7) standardized multiaxial formulation, (8) idiographic or personalized formulation (which includes consideration of cultural framework), and (9) linking diagnosis to treatment and prognosis.

One of its innovative features is the articulation of a comprehensive diagnostic model. This encompasses a standardized, multiaxial diagnosis aimed at facilitating international communication on clinical patterns and therapeutic approaches as well as an ideograph formulation that pays attention to the uniqueness of each patient and thus engaging him or her in the process of clinical care.

No. 70C
CORE CURRICULUM IN PSYCHIATRY FOR MEDICAL STUDENTS

Ahmed M.F. Okasha, M.D., *Neuropsychiatry, Ain Shams University, 3 Shawarby Street, Kasr Elain Cairo 00094, Egypt*

SUMMARY:

The WPA program on the core curriculum in psychiatry for undergraduates was started by a survey conducted among 500 medical schools to determine the present status of undergraduate's education in psychiatry. The steering committee had several meetings, discussions, and reviews prior to the production of the program in 1996. The emphasis in the curriculum with the general recommendations of the World Federation of Medical Education, was that education in psychiatry should not deal only with curative aspects, but that prevention and promotion of mental health should take the upper hand. The curriculum discusses the requirements of the undergraduates for knowledge, skills, and attitudes. The details of these aspects and how to evaluate and assess them are described in the text. Examples of the knowledge and the diagnosis according to the primary care health version of ICD-10 and many other appendices are included.

No. 70D
TEACHING ABOUT PUBLIC HEALTH ASPECTS OF PSYCHIATRY

Norman Sartorius, M.D., *Department of Psychiatry, University of Geneva, 16–18 Blvd de St. Georges, Geneva CH1205, Switzerland*

SUMMARY:

The fact that psychiatry was developing apart from medicine rather than as a part of it was one factor reflected in the separation of psychiatry from public health. As a consequence, psychiatry has created subdisciplines that deal with epidemiology of mental disorders, with the administration of mental health services, with the prevention of mental disorders, and with matters that are for all other disciplines of medicine are dealt with by the discipline of public health.

Aware of the harmful consequences of this arrangement, the World Psychiatric Association has undertaken to develop an educational program that can be used in the training of postgraduate students in psychiatry—who have to learn about public health aspects of their discipline if they are to perform well in all the tasks that are expected them—and of postgraduate students of public health who often complete their training with scant knowledge of facts about psychiatry relevant to their work.

The presentation will refer to these matters and provide a brief description of the training program that is currently being developed in seven centers and in four languages.

REFERENCES:

1. Minutes of WPA Executive Committee Meetings in 1998; WPA Educational Programs
2. Reports of the WPA Secretary for Education (Minutes of the WPA Executive Committee meetings in Beirut-Lebanon in April 1998, Johannesburg-South Africa in September 1998, Guadalajara-Mexico in October 1998); WPA General Survey Report
3. Mezzich JE: International perspective on psychiatry diagnosis, in Comprehensive Textbook of Psychiatry, VI Edition. Edited by Kaplan HI, Saddock BJ. William & Wilkins, Baltimore, 1995

SYMPOSIUM 71—STRATEGIES FOR SELECTING AN ANTIDEPRESSANT MEDICATION

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the range of mechanisms of action of current antidepressant medications, and recognize several different strategies for selecting among available medications.

No. 71A
CLINICAL SYMPTOMS AND ANTIDEPRESSANT MECHANISM OF ACTION: ANY RELATION?

Robert M.A. Hirschfeld, M.D., *Department of Psychiatry, University of Texas Medical Branch, 301 University Blvd., Graves Bldg., Galveston, TX 77555*

SUMMARY:

There is a panoply of antidepressants with a variety of mechanisms of action in several different neurotransmitter systems at several different sites on the neuron. Most antidepressants involve actions on the serotonergic or noradrenergic transmission system, but some involve both. In addition, dopaminergic and other neurotransmitter systems have some involvement. Site of action includes presynaptic reuptake pumps, postsynaptic receptor sites, as well as other sites. Does knowledge of neurotransmitter mechanism of action affect clinical decision making? For example, are certain clinical symptoms predictive of response to particular medications of a specific mechanism of action? This presentation will review our current state of knowledge on this theoretically intriguing and clinically important question.

No. 71B
AGE-RELATED DIFFERENCES IN MEDICATION RESPONSE

Ian A. Cook, M.D., *Department of Psychiatry, Neuropsychiatric Institute, 760 Westwood Plaza, Rm 37-443, Los Angeles CA 90024-1759;* William F. Stubbeman, M.D., Elise Witte, Ph.D., Andrew F. Leuchter, M.D.

SUMMARY:

Studies suggest that response to antidepressant medications is not constant over the life span, and that treatment for late life depression is not consistently as successful as for younger adults. Causes may include whole-body changes with normal aging, comorbid illnesses and medications, specific changes within the brain, and differences in response at different points in the course of the disorder.

Physiologic changes with normal aging that may affect response include alterations in body composition; changes in hepatic metabolism, and decreases in renal clearance. Comorbid medical illnesses are more common in late life, and can impact the metabolism of medications or produce changes within the CNS (e.g., Parkinson's, stroke). Medications to treat comorbid conditions may alter the bioavailability of antidepressants and cause drug-drug interactions. Reports also indicate altered sensitivity to psychotropics at sites within the brain. Additionally, treatment of a recurrent depression may be intrinsically different from treatment of a first episode in late life. Finally, side effects limit the response attainable in clinical practice: physiologic changes make some elderly more susceptible to side effects from psychotropic medications, with an adverse impact on compliance and thus outcome.

This presentation will review how considerations of age can be incorporated into effective pharmacotherapy.

No. 71C
IMPROVEMENTS IN SOCIAL FUNCTIONING WITH ANTIDEPRESSANT TREATMENT

Martha L. Bruce, Ph.D., *Department of Psychiatry, Cornell Medical School, 21 Bloomingdale Road, White Plains NY 10605*

SUMMARY:

Old age brings with it increased vulnerability to compromised social and physical functioning, including disability, social isolation, and residential dependency. These problems have profound impact on the quality of life of older adults. They are important to the study of late-life depression, not only because depression often occurs in the context of functional problems, but also because both epidemiologic and clinical trials suggest that depression and poor functioning contribute to the risk of each. Traditionally, randomized clinical trials purposefully excluded older subjects with such disabilities so that little was learned about the impact of antidepressant treatment on social and physical function. More recently, some trials have broadened their target populations and their measures, allowing for investigation of the effect of antidepressant treatment on social and functional outcomes. This presentation reviews these data. The presentation also suggests additional strategies for further specifying the effect of antidepressant treatment on functional outcomes as a step toward the twin goals of improving the lives of patients with geriatric depression and of understanding the underlying relationships between depression and function.

No. 71D
BRAIN FUNCTION AND SELECTION OF ANTIDEPRESSANT MEDICATION

Andrew F. Leuchter, M.D., *Department of Psychiatry Neuropsychiatric Institute, 760 Westwood Plaza, Rm 37-452, Los Angeles CA 90024-8300;* Ian A. Cook, M.D., Elise Witte, Ph.D., William F. Stubbeman, M.D., Michelle Abrams, R.N., Sandy Venneman, Ph.D., Jennifer Dunkin, Ph.D.

SUMMARY:

There is considerable heterogeneity in clinical response to antidepressants. Although most patients respond to the first antidepressant administered, up to 45% require treatment with a second or third agent. Pretreatment clinical characteristics of patients, such as age or types of symptoms, are weak predictors of which patients will benefit from a specific medication. There is an emerging consensus that measures of brain function such as positron emission tomography (PET) can detect subgroups of patients who are at risk for poor outcome. Several studies show that low metabolism or perfusion in limbic structures predicts poor response to medication. In studies of 43 subjects with major depression, we evaluated quantitative electroencephalographic (QEEG) cordance as a predictor of differential responsiveness to antidepressant medication. Subjects with pretreatment concordance were most likely to benefit from a selective serotonergic antidepressant, while those with discordance were most likely to benefit from an antidepressant with a mixed/noradrenergic neurochemical profile. The proportion of subjects with low cordance increased with age: 34% of subjects under the age of 60 showed discordance, while 63% of subjects over the age 60 showed discordance. These findings lend further support to the concept that brain function prior to antidepressant treatment may identify subgroups of subjects with differential responses to medications.

No. 71E
MECHANISM OF ACTION OF ANTIDEPRESSANTS

Alan Frazer, Ph.D., *Pharmacology, Univ of TX Health Sciences, 7703 Floyd Curl Drive, San Antonio TX 78284*

SUMMARY:

There is considerable evidence that many, but not all, drugs acting to enhance either central noradrenergic or serotonergic neurotransmission can be effective antidepressants. Interestingly, different types of antidepressants have comparable efficacy in treating heterogeneous groups of depressed patients. Drugs that selectively block the uptake of serotonin (e.g., SSRIs such as fluoxetine or sertraline) or norepinephrine (desipramine, the investigational compound reboxetine) or both monoamines (imipramine, venlafaxine) cause a similar extent of improvement in nonselected depressed patients. Whether this holds true for subgroups of depressed patients is currently under investigation. Such data will be reviewed together with studies examining whether or not SSRIs are effective in nonresponders to "noradrenergic" drugs or vice versa. Also, data will be presented showing the complex effects produced over time by antidepressants on both noradrenergic and serotonergic neurons, in particular receptors and transporters for these monoamines.

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SYMPOSIUM 72—SEXUAL MEDICINE: THE HIGHLIGHTS OF THE DECADE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participants should be able to have a working knowledge of the most recent pharmacologic and nonpharmacologic advances for the treatment of sexual disorders. They will better understand the potential for different antidepressants to cause sexual dysfunction and the need for increased research on sexuality, particularly with respect to women.

No. 72A
ADVANCES IN THE SEX THERAPEUTIC TREATMENT OF WOMEN

Barbara D. Bartlik, M.D., *Department of Psychiatry, Cornell University Medical Col, 865 West End Avenue #7E, New York NY 10025*

SUMMARY:

Traditionally women's sexuality has been neglected by the medical community. In the past decade, tremendous progress has been made in pharmacologic remedies for male sexual dysfunction, yet there have not been comparable gains with regard to women. This presentation will both highlight the advances that have been made in women's sexuality and underscore areas in need of further research.

Despite considerable speculation about new medications believed to alleviate sexual dysfunction in women, well-funded, rigorous studies assessing both efficacy and safety remain to be done. Potentially sex positive medications for women that will be described during this presentation include testosterone, sildenafil, oxytocin, psychostimulants, deprenyl, bupropion, trazodone, apomorphine, progesterone, ginseng, ginkgo biloba, prostaglandins and topical vasodilators.

There is also a new awareness of the magnitude of sexual dysfunction in depressed patients, both before and after the initiation of antidepressant medication. Management techniques, gender differences and new, less intrusive methods of avaluating sexual functioning will be covered.

Increasingly, clinicians are recommending the use of the improved sexual aids to their patients with sexual dysfunction. The presentation will guide participants through the range of products available including erotic video, literature, lubricants and vibrators.

No. 72B
ADVANCES IN THE TREATMENT OF MALE SEXUAL DISORDERS

Peter M. Kaplan, M.D., *50 East 78th Street, New York NY 10021*

SUMMARY:

There are several categories of pharmacological treatment of male sexual disorders. The following is a brief overview of these disorders and their treatments.

- *Vasodilators:* There are a number of various vasodilators currently being marketed in the U.S. for the treatment of both psychogenic and organic impotence. Their delivery systems appear to be the greatest difference in their clinical utility. These include sildenifil, caverject, and Muse. All these agents are approved for use in organic, mixed, or psychogenic impotence.
- *Ejaculatory delay compounds:* In the treatment of premature ejaculation, the most commonly used and safest agents are the SSRIs in adjunctive therapy. Their effect appears to be dependent on dosage and rate of titration.
- *Hormonal replacement therapy:* In a significant group of men hypo or relatively low testosterone has been found useful in the treatment of diminished libido and impotence. There are a number of different delivery systems available.
- *Associated physical and mental conditions leading to sexual dysfunctions:* In any complete work-up of a man suffering from a sexual dysfunction, primary organicity and psychopathology must be initially ruled out and treated. There are numerous physical and psychological etiologies and treatments for these disorders.

No. 72C
TESTOSTERONE: THE FOUNDATION FOR FEMALE SEXUAL FUNCTION

Susan Rako, M.D., *83 Walker Street, Newtonville MA 02160-1519*

SUMMARY:

Each woman has her own particular adjustment to the sexual aspect of life, with her familiar rhythms of sexual feelings, fantasies, dreams, and activities. Life circumstances can disrupt sexual rhythms, but the bottoming out of sexual desire that results from a critical reduction in testosterone is different from the fluctuations experienced with the various ups and downs of life and relationships.

In the introduction to "The Hormone of Desire: The Truth About Sexuality, Menopause, and Testosterone" (S. Rako, 1996), Dr. Helen Singer Kaplan and Dr. Barbara Bartlik stated that "No matter how hard a women might try to assemble the building blocks of healthy sexual functioning—the required amounts of other hormones, a loving partner, adequate stimulation, possibly a good sexual fantasy—it cannot work if she does not have the basic foundation of enough testosterone."

Testosterone has some biological activity on virtually every tissue in the body. Recent publications are pointing to cardiovascular-protective effects, and bone-protective effects are undisputed. My presentation in this symposium will focus primarily on the aspects of testosterone essential for female sexual function—with attention both to the differential diagnosis of testosterone deficiency and to up-to-date methods of physiological supplementation for women.

No. 72D
USING NATURAL PRODUCTS TO TREAT SEXUAL DYSFUNCTION

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

SUMMARY:

Botanical extracts and their derivatives have been used for centuries as remedies throughout the world. Sexual dysfunction is known to have been treated since early pharmacopiae was developed in ancient China. In this symposium, I will describe the use of a number of plant-derived therapies for sexual dysfunction. Relevant studies will be reviewed and critiqued. In addition, side effects, pharmacological interactions with other substances, purported uses for specific conditions, as well as new research findings relating to these botanical products will be covered. Proposed mechanisms of action for selected treatments will be explored, with special focus on : Ginseng, Ginkgo biloba, Ehedra, Damiana, and Cordyceps sinensis, Avena sative, and Yohimbine.

The risks and benefits of these botanical substances will be detailed, particularly in regards to their efficacy.

New research developments will be described including double-blind placebo controlled trials of plant extracts currently active.

The participants will learn about the variety of herbal treatments being used in the community, and how to approach the "prescribing" of ethnobotanicals to their patients. In addition, the participants will gain greater familiarity with the regulatory factors influencing the production and control of these substances.

No. 72E
THE THERAPEUTIC USE OF EROTIC VIDEO AND SEXUAL AIDS

Nina Hartley, M.D., *1442-A Walnut Street, #242, Berkeley CA 94709*

SUMMARY:

If a picture is worth a thousand words, and a moving picture is worth 10,000 words, then the worth of a carefully selected, sexually explicit image in conjunction with a course of professional sex therapy is incalculable. The power of an image of "something never before imagined" can cut through a client's defenses in a way most useful to the therapist.

Combining her life-long feminism, nursing degree, and over 15 years of experience as a sexual advocate/entertainer, Nina Hartley continues to break new and exciting ground by creating explicit videos designed to be more than "mere" entertainment, exemplified by her trend-setting series of Sex Education Guides, now in its 10th volume. Topics covered include open relationships, basic anatomy/physiology, and specific sexual skills.

Sexual illiteracy is endemic to our culture. Words alone rarely are sufficient to affect change in an individual. Using video to role model healthy behavior as well as impart basic information fosters an intimacy and creates a common reference point that renders therapy more effective.

No. 72F
The Age of Cybersex and its Impact on Patient Population

Sharna L. Striar, Ph.D., *4 Park Ave., Suite 20E New York, N.Y. 10016*

SUMMARY:

The advance of technology has brought forth a new global form of communication—e-mails and chatrooms on the internet. This new form of communication includes everything from basic information gathering to the most erotic sexual exchanges. In particular, it provides computer sex forums organized according to various sexual interests and preferences. These meeting places are designed so that people can "listen in," get free sex advice, chat with others, have steamy sexual exchanges, or fire up long-term relationships. This has also been known to lead to phone sex and actual face-to-face relationships.

This presentation will discuss the variety of sex information and chatrooms available on the Internet and its impact on the patient population. With the catapulting of anonymity to new levels on the Net, people around the world, particularly the introverts, are asking sex questions, and even exploring sexual fantasies and clandestine love in the relative safety and obscurity of cyberspace. Shame and embarrassment are nonexistent because the individual can hide behind a digital veil. Anything goes to anyone at anytime. Case studies will be presented here which highlight the impact of cybersex on people's lives and the powerful force it is having on our society today.

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2. Kaplan PM: The use of serotenergic reuptake inhibitors in the treatment of premature ejaculation. J Sex and Marital Therapy, 1994; 20:4
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SYMPOSIUM 73—UPDATE ON TREATMENT OF STIMULANT ABUSE

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: recognize stimulant abuse in patients, diagnose its common psychiatric comorbidities, and treat it effectively using both psychosocial and pharmacological modalities

No. 73A
BEHAVIORAL AND COMMUNITY-BASED TREATMENT APPROACHES

Douglas M. Ziedonis, M.D., *Department of Psychiatry, RW Johnson Medical School, 675 Hoes Lane, Room D349, Piscataway NJ 08854*

SUMMARY:

Behavioral and community-based (including self-help) approaches can be important components of overall treatment of individuals with stimulant abuse. Such approaches include motivational enhancement therapy, relapse prevention, psychoeducation, 12-step facilitation, and community reinforcement, all of which have shown efficacy in psychotherapy research. Specific clinical strategies and treatment-matching techniques can improve the efficacy of these approaches, such as strategies to better engage low-motivation patients in treatment. The progressive stages of recovery will be reviewed, including various models such as the neurobehavioral model, developmental model of recovery, and the pavillon stages of recovery. The recommended psychotherapeutic approach varies according to the stage of recovery. Polysubstance abuse, psychiatric comorbidity, and other compulsive activities are often complicating factors that require adaptations in the treatment.

No. 73B
PSYCHOTHERAPY AND COUNSELING APPROACHES FOR COCAINE ABUSERS

David R. Gastfriend, M.D., *Addiction Services, Mass General Hospital, 15 Parkman Street/WACC-812, Boston MA 02114*

SUMMARY:

Psychotherapy and counseling approaches for stimulant abuse may be considered in two domains: therapy modality and level of care. Several therapy modalities have been formally studied in rigorous, manual-driven, multisite designs. The leading study of this type is the NIDA Cocaine Collaborative Treatment Study, which compared cognitive therapy, supportive-expressive therapy, individual drug counseling (all delivered along with group drug counseling) and group drug counseling by itself. Optimal approaches are indicated by this study and others. Early results from the leading study of placement criteria, the MGH/Harvard ASAM Criteria Validity Study, suggest that level of care matching may also offer benefits. Together, these findings suggest that patients with stimulant dependence require psychosocial treatments with a coherent recovery-oriented message, adequate treatment intensity, and consideration of motivational, relapse prevention, and environmental support needs.

No. 73C
PHARMACOLOGICAL TREATMENT OF STIMULANT ABUSE

David A. Gorelick, M.D., *Treatment, NIDA IRP, 5500 Nathan Shock Drive, Baltimore MD 21224-0180*

SUMMARY:

Stimulant abuse remains a significant public health problem in the U.S. for which no broadly effective treatment is yet available. Numerous pharmacological treatments acting through a variety of neuropharmacological mechanisms have been evaluated, but none has been consistently effective in controlled clinical trials. Some medications showing promise but not yet rigorously evaluated, include selegiline, a selective MAO inhibitior; phenytoin, an anticonvulsant; and the combination of bupropion plus bromocriptine. Some promising new approaches undergoing preclinical evaluation include compounds (e.g., GBR 12909) that bind to the presynaptic dopamine transporter, a major site of action for cocaine; antibody that binds cocaine peripherally, thus preventing it from entering the brain (cocaine vaccine); and enhancement of cocaine metabolism with the naturally occurring enzyme butyrylcholinesterase. A particularly difficult group of patients to treat are those abusing other drugs in addition to stimulants (e.g., "speedballers"). Buprenorphine, a part mu-opiate agonist, has shown some promise in the treatment of such patients.

No. 73D
PSYCHIATRIC COMORBIDITY IN STIMULANT ABUSERS

Richard N. Rosenthal, M.D., *Department of Psychiatry, Beth Israel Medical Center, First Avenue at 16th St, 9F, New York NY 10003*

SUMMARY:

Epidemiologic and treatment-survey data consistently indicate that psychiatric comorbidity is very common among stimulant abusers and alters the course and recommended treatment of the substance use disorder. This presentation will focus on treatment issues of the dually diagnosed after reviewing important epidemiologic and diagnostic issues specific to this population. Stimulant abusers often present for treatment with complaints of psychiatric symptoms, especially depression and anxiety. In addition, stimulants are known to

directly cause psychotic symptoms as well as a variety of mood and anxiety symptoms, and as such, diagnosis of non-substance-related (NSR) mental disorders in this group is not straightforward. Yet, it is important to accurately elucidate the present diagnoses in order to provide the most specific and effective treatments. New approaches to behavioral treatment of stimulant abusers with differing NSR psychiatric diagnoses such as schizophrenia, mood disorders, and PTSD and will be presented, with information on how traditional addiction approaches have been effectively modified for the mentally ill. In addition, novel pharmacotherapeutic strategies that have been developed for stimulant abusers with differing comorbidity will be reviewed.

No. 73E
NEW DEVELOPMENTS IN TREATING METHAMPHETAMINE ABUSE

Steven L. Batki, M.D., *Department of Psychiatry, University of CA at San Fran, 1001 Potrero Avenue, San Francisco CA 94110*

SUMMARY:

Methamphetamine abuse is a serious and growing problem in the United States. Deaths involving methamphetamine use have increased in recent years, and the spread of methamphetamine is particularly extensive in the western states including the Pacific Northwest, Arizona, Hawaii, and especially California. Methamphetamine is prominently associated with severe forms of psychiatric and medical morbidity. Psychiatric effects include psychosis and depression with suicidal behavior (Baberg 1996). Among the most serious medical consequences may be an increase in HIV risk. Methamphetamine use has been closely linked to high-risk HIV behaviors, and methamphetamine users have some of the highest HIV seroprevalence rates among drug users. Relatively little work to date has been done to find medical treatments of methamphetamine abuse, and there are no established, effective pharmacotherapies, although a number of medications are theoretically plausible to utilize. Treatment remains primarily psychosocial, focusing on motivational counseling and relapse prevention in a group setting. This presentation will review the medical and nonmedical treatment of methamphetamine abuse and dependence and its sequelae.

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SYMPOSIUM 74—DISABILITY COSTS: REHABILITATION OPPORTUNITY? The World Psychiatric Association's Section on Rehabilitation, The World Association for Psychosocial Rehabilitation

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium the participant should be able to a) describe disability costs and factors influencing them, b) demonstrate awareness of rehabilitation efforts in various countries to offset disability costs and, c) promote rehabilitation efforts over cost capping.

No. 74A
DISABILITY AND MENTAL HEALTH

Norman Sartorius, M.D., *Department of Psychiatry, University of Geneva, 16-18 Blvd de St. Georges, Geneva CH1205, Switzerland*

SUMMARY:

Disability is increasing in the world's population, of whom it is reckoned that 10% are functionally disabled, 40% of which is due to mental and neurological problems. There are increasing demands (at work). There is an increase in chronic illness as well as 25 major new illnesses, e.g. AIDS (which afflicts 50,000 each month). The changing social fabric left us with nuclear rather than extended families and more old people. At the same time we find comorbidity (60% have more than one disease) with concomitant codisability. We find gaps between disciplines. Why talk of social psychiatry when all psychiatry has a social component. But in practice, people are ping-ponged from health to social to educational programs. We need better understanding of the process disease > impairment > disability > handicap. We must understand that impairment, disability, handicapped can be separate axes. Psychological factors are among the determinants of severity and duration of disability. Disability can determine the outcome of mental illness. Disability and mental illness can coexist, precede, follow one another, or appear independently. Costs are enormous and growing worldwide. There are tremendous opportunities for improvement in general health achievable by redirecting existing funds.

No. 74B
REHABILITATION AND DISABILITY IN JAPAN

Naotaka Shinfuku, M.D., *International Health, Kobe University School of Med, Kusinoki-cho, 7 Chome, Chuo-Ku, Kobe 650, Japan*

SUMMARY:

Japan provides a study in disability contrasts in that it has perhaps the highest rate of psychiatric hospitalization in the world and high employment. Its disability rate is low, and there are few controversies about disability. Determinations are made by physicians without written guidelines and generally are accepted without appeal. The explanation for these contrasting phenomena could be called stigma or part of Japanese national culture. It is not acceptable to be partially disabled. It is acceptable to be totally disabled for a time and to be hospitalized. However, national policy is directed at reducing psychiatric hospitalization and providing for more treatment in the community, which will enhance the use and role of psychiatric rehabilitation.

No. 74C
GERMANY: RECONCILING POLICIES

Michael Stark, M.D., *Department of Psychiatry, U Hamburg Medical School, Martinstr 52, Hamburg D20246, Germany*

SUMMARY:

German health costs are borne by the states and an array of sickness funds. Employers provide contributions, but are not unduly burdened by disability costs, which are mostly in the public sector and very high. Unemployment is also high, which leads to programs that reduce unemployment by promoting determinations of varying levels of employability, i.e., disability. All who receive unemployment benefits are required to report for counseling on how to find a job. A person may be partially disabled, but not receive benefits unless more than 50% disabled. The result is considerable pressure on clinicians to pronounce a person more disabled than not. Written guidelines are being prepared and it is likely that, as in Norway, definitions will be narrowed and applied with a higher degrees of interrater reliability.

No. 74D
FRANCE, CANADA, THE EUROPEAN COMMUNITY, AND THE INTERNATIONAL LABOR ORGANIZATION

Gaston P. Harnois, M.D., *Who Center, Douglas Hospital, 6875 La Salle Boulevard, Montreal, PQ H4H 1R3, Canada;* Jacques Dubuis, M.D.

SUMMARY:

The total cost of illness in Canada in 1993 was estimated at $156.9 billion: $71.7 billion in direct costs and $84.1 billion in indirect costs. By 1996 direct costs had risen to $75.2 billion 9.5% of GDP) with an additional $11 billion in direct disability costs. While health care costs are predominantly a public sector responsibility, disability costs are borne by the private sector and now are estimated at 8% of payroll costs. It is clear that many physically disabled workers have developed depression, a sense of inferiority, and anxiety about returning to work, but developing incentives for them to do so is problematic. The situation in France is more tumultuous, with strikes marking the end of "La Medicine Liberale" as managed care methodology is increasingly adopted. France's problems are aggravated by high general overall unemployment and the use of disability in part to reduce the numbers of people competing for work. We work with the European Community on employing the handicapped and can point to significant affirmative action programs as well as an overall decrease in stigma. The International Labor Organization has emphasized the importance of work for all despite handicaps. We describe the importance of international liaisons in promoting psychiatric rehabilitation.

No. 74E
UNITED STATES: MANAGED DISABILITY CARE?

Zebulon C. Taintor, M.D., *Department of Psychiatry, NYU School of Medicine, 19 East 93rd Street, New York NY 10128*

SUMMARY:

The United States presents an increasingly well-differentiated view of disability, in that accommodation is separated from cost. The Americans With Disabilities Act could include up to 46 million citizens as disabled in the sense that a) they should not be discriminated against on the basis of their disability, and b) a reasonable workplace accommodation may be made for them. Cost, however, is the subject of concerted attacks even while it has grown faster than anywhere else in the world. Workmen's compensation laws have been reformed state by state. Disability fraud is a burgeoning area of investigation. With welfare reform has come the sense that many people receiving financial assistance from the state are able to work. Massive reductions in what were thought to be chronic welfare situations have led to suggestions that all receiving disability should be re-evaluated. Benefits have become time-limited for those with a primary diagnosis of substance abuse. A Watson Wyeth Worldwide survey of employers found disability costs at the top of their health priorities, especially improving return-to-work results. The effect of treatment can be seen by integrating disability costs with other health costs and programs, reducing direct costs from 5.4% of payroll to 2.7%.

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SYMPOSIUM 75—ALTERNATIVE THERAPIES IN DEPRESSION AND ANXIETY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be familiar with usage patterns and patient concerns regarding alternative therapies among psychiatric outpatients. In addition, the participant will demonstrate an understanding of specific alternatives to treat depression and anxiety and the evidence for their efficacy.

No. 75A
ALTERNATIVE THERAPIES IN PSYCHIATRIC OUTPATIENTS

Kathryn M. Connor, M.D., *Department of Psychiatry, Duke University, Box 3812/DUMC, Durham NC 27710;* Jonathan R.T. Davidson, M.D., L. Erik Churchill, M.S.

SUMMARY:

The burgeoning U.S. alternative therapy (AT) market demonstrates patients' willingness to seek treatment outside of conventional medicine. This study characterizes usage of and attitudes toward AT among psychiatric outpatients. A 40-item survey was completed, assessing the following: ATs used for psychological, medical, and general health problems over the last year; frequency and effectiveness of AT; concomitant prescribed medications; perceived physician attitudes towards AT; and individual attitudes, particularly advantages, disadvantages, and the importance of AT information availability. Of 217 respondents, over 1/3 used AT to treat psychological and/or medical problems in the previous year, with 89%–97% noting at least some improvement. ATs were reportedly at least as effective as and helped in ways different from conventional medicine. While subjects perceived physicians as generally supportive, only 60% informed their doctors of their AT use. The "natural" quality of

ATs was the primary advantage, while their unproven effects were the main disadvantage. AT information availability was very important, and nearly all who had not tried AT expressed willingness to consider it (97%). These findings reinforce the importance of physician recognition of patient usage patterns and appreciation of attitudes about AT and underscore the need for further understanding the efficacy and safety of alternative treatments.

No. 75B
BOTANICAL EXTRACTS AS ANXIOLYTIC TREATMENTS OR ADJUNCTS

Jerry M. Cott, Ph.D., *NIMH, 5600 Fishers Lane, Room 1075, Rockville MD 20857*

SUMMARY:

Despite considerable efforts to develop new psychotherapeutic drugs, novel agents with unique mechanisms are extremely rare. A significant scientific constraint is placed on drug development that is limited to molecules interacting with known biological substrates in predetermined ways, e.g. serotonin uptake inhibition. On the other hand, many plant extracts have complex, possibly synergistic, effects on neurotransmitters and second messenger systems. The traditional herbalist view is that these mixtures of compounds act in concert to bring about a more gentle and holistic therapeutic effect. Botanical formulations are routinely used in most other countries for a host of indications. Those approved in Germany for the treatment of anxiety include hypericum perforatum (St. John's wort), humulus lupulus (hops), and piper methysticum (kava). In this country, the primary botanical treatments for anxiety include kava, valeriana officinalis (valerian), passiflora incarnata (passion flower), and scutellaria laterifolia (skullcap). In this context, a major new category of consumers must be acknowledged. They include people with subclinical symptoms who are not yet ready for mainstream psychotherapeutic agents. Since these putative herbal anxiolytics are sold as food supplements, massive amounts are being sold in retail stores around the country. The evidence for their efficacy will be discussed.

No. 75C
CENTELLA ASIATICA DECREASES THE ACOUSTIC STARTLE RESPONSE

Jacques Bradwejn, M.D., *Department of Psychiatry, University of Ottawa, 1145 Carling Avenue, Ottawa ON K17 7K4, Canada;* Yueping Zhou, M.D., Diana Koszycki, Ph.D., Jakov Shlik, M.D., Martin A. Katzman, M.D., Franco J. Vaccarino, Ph.D.

SUMMARY:

The present study in healthy volunteers examined the effects of acute administration of the Ayruvedic herb gotu-kola (centella asiatica) on acoustic startle response (ASR), a well-known model of anxiety in humans. Recent experiments have demonstrated that CCK-B agonists enhance ASR in humans and rats, whereas CCK antagonists decrease ASR in rats. Gotu-kola has also been reported to decrease ASR in rats. Forty healthy subjects participated in this double-blind, placebo-controlled study. Subjects arrived at the laboratory after an overnight fast and were randomly assigned to treatment with gotu-kola (12 g) or placebo. ASR was measured at baseline and 30, 60, 90, 120 minutes post-dose by recording eye-blink response to a series of acoustic stimuli (110 dB). Compared with placebo, gotu-kola significantly attenuated the peak amplitude of ASR 30 ($p < 0.05$) and 60 ($p < 0.001$) minutes post-dose. Gotu-kola had no significant effect on heart rate, blood pressure, or mood ratings. The only notable exception was that subjects were less energetic following pretreatment with gotu-kola. The present study demonstrates that a single dose of gotu-kola significantly decreased ASR in humans, suggesting that this herb may have anxiolytic properties. While the mechanism of action of gotu-kola is unknown, preliminary data suggest involvement of CCK receptors.

No. 75D
HYPERICUM PERFORATUM: ITS RELEVANCE TO PSYCHIATRIC PRACTICE

Jonathan R.T. Davidson, M.D., *Department of Psychiatry, Duke University Medical Center, Box 3812, Durham NC 27710*

SUMMARY:

Extracts of hypericum perforatum (St. John's wort) have been shown to possess antidepressant activity in outpatients with mild to moderate depression. Comparators have included placebo and tricyclic antidepressants, but no studies have simultaneously compared hypericum with placebo and an active drug. Doses of active comparators have generally been inadequate, and no trials have included a new-generation antidepressant (e.g. SSRIs, bupropion). Furthermore, length of treatment had tended to be short, doses of hypericum may also have been suboptimal, more severe types of depression have remain unstudied, and designated subtypes (e.g., atypical depression) have not been delineated. There is also the possibility that in some trials, the characteristic odor of hypericum may have compromised blinding, although this issue was not assessed.

Hypericum is mechanistically an interesting compound, which could alleviate depression in any number of ways (e.g., via noradrenaline, dopamine, serotonin, NMDA, interleukins). Quite possibly, its inherent balance of synergistic effects on numerous CNS neurotransmitters accounts for its psychoactive effects. Its effects in animal models of depression certainly support its antidepressant properties in humans.

Current knowledge about hypericum will be summarized in this presentation along with a discussion of its relevance to psychiatric practice.

No. 75E
THE EFFICACY OF ACUPUNCTURE IN THE TREATMENT OF DEPRESSION

John J.B. Allen, Ph.D., *Department of Psychology, University of Arizona, PO Box 210068, Tuscon AZ 85721;* Rosa N. Schnyer, Dipl.Ac., Sabrina K. Hitt, M.A., Rachel Manber, Ph.D.

SUMMARY:

We present the results of a small but controlled study of the effectiveness of acupuncture in the treatment of major depression. Thirty-three women with major depression were randomly assigned to one of three treatment groups. Those in the specific treatment group received acupuncture treatments individually tailored to their symptoms of depression; those in the nonspecific group first received acupuncture treatments tailored to address symptoms that were not clearly part of the depressive episode (e.g., back pain), and later received the acupuncture treatments specifically tailored to their symptoms of depression; those in the wait list group waited without treatment for eight weeks before receiving the acupuncture treatments tailored for their symptoms of depression.

Following treatments specifically designed to address symptoms of depression, 64% of women experienced remission. Comparing the immediate effect of these three eight-week treatment conditions, subjects receiving specific acupuncture treatments demonstrated greater improvement than those receiving nonspecific acupuncture treatments and showed marginally more improvement that wait-list controls. Based on this outpatient sample of women with major depression, it appears that acupuncture can provide significant symp-

tom relief at rates comparable to standard treatments such as psychotherapy or pharmacotherapy. Acupuncture may hold sufficient promise to warrant a larger-scale clinical trial.

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SYMPOSIUM 76—MODEL RESIDENCY PROGRAMS ON RELIGION/SPIRITUALITY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the importance of religious/spiritual issues in clinical training of psychiatric residents, and to understand how seven model residency programs have implemented curricula on religious/spiritual issues.

No. 76A
THE BAYLOR CURRICULUM ON RELIGION/ SPIRITUALITY AND PSYCHIATRY

James W. Lomax II, M.D., *Department of Psychiatry, Baylor University, One Baylor Plaza, Ste 619D, Houston TX 77030*

SUMMARY:

This presentation describes a carefully sequenced, four-year curriculum in spirituality and psychiatry. The PGY-I year involves a basic instruction and demonstration of patient interviews. In PGY-II, there is a clinical experience with a spirituality group at a private hospital. In PGY-III, there is an extensive didactic course providing a cognitive perspective on spirituality and the way in which it influences the experience of health, illness, and specifically, psychiatric treatments. There is a PGY-IV option for a research track experience. Dr. Lomax will also preview videotape material on psychiatry and spirituality developed in part through support of the Templeton Foundation.

No. 76B
PSYCHIATRY RESIDENCY AWARD PROGRAM AT BRONX-LEBANON HOSPITAL

Nalini V. Juthani, M.D., *Department of Psychiatry, Bronx-Lebanon Hospital, 1276 Fulton Avenue, Bronx NY 10456*

SUMMARY:

The curriculum at Bronx-Lebanon Hospital consists of four-month modules. Module 1 involved PGY-1 residents who were introduced to history taking with emphasis on patients' religious and spiritual belief system and the role it takes in patients' lives. Residents learn how to assess religious biography and identify healthy vs. unhealthy religiosity. Module II involved PGY-2 an PGY-3, where religious/spiritual issues were presented and discussed in clinical case conferences. This discussion then became part of each patient's record. Module III involved PGY-1,2,3,4, and 5 in a seven-week course where topics ranging from religions of the world; how to involve the religious elder in patient care; role of faith in medical practice, transference, countertransference and God images; role of religion/spirituality in depression; synchronicity in spirituality and psychiatry; and role of meditation in psychiatric treatment were presented. Module IV involved PGY-4 residents who visited the house of worship of major religions practiced in our community. Faculty mentors accompanied the residents, and presentation of their experience was made to all trainees. Spiritual group therapy and research projects evolved out of this curriculum.

No. 76C
THE JEFFERSON MEDICAL COLLEGE CURRICULUM ON RELIGION/SPIRITUALITY AND PSYCHIATRY

Shimon Waldfogel, M.D., *Personal Health Network, 100 West Avenue, Suite W965, Jenkintown PA 19046*

SUMMARY:

In order to explore the interface of religion, spirituality, and psychiatric practice, didactic instruction has been part of the Jefferson Medical College curriculum for the past six years. Objective of the curriculum is to train the psychiatrist to become competent in addressing the spiritual/religious dimension of the person. More specifically, the goals of the didactic program include the following:

- To educate the resident about the importance of the religious and spiritual aspects of existence in an individual's life.
- To develop competence to work with individuals with religious/spiritual commitments in the psychiatric setting.
- To provide the residents a forum to discuss their own religious/spiritual commitments in the psychiatric setting.
- To learn to work in collaboration with clergy.
- To learn about different religious/spiritual belief systems as they relate to psychiatric practice and increase the residents' tolerance and comfort with other points of view.
- To establish a dialogue of science and religion as it presents in the medical setting.
- To become familiar with the research literature in the area of religion and spirituality in medicine.

No. 76D
RESIDENCY TRAINING ON RELIGION/ SPIRITUALITY AT LOMA LINDA UNIVERSITY SCHOOL OF MEDICINE

Donald L. Anderson, M.D., *Department of Psychiatry, Loma Linda University, 11314 Mt. View Avenue, Loma Linda CA 92354;* Khushro B. Unwalla, M.D.

SUMMARY:

The department of psychiatry at Loma Linda University School of Medicine has attempted to integrate the spiritual dimension into the biopsychosocial model as part of its mission "To Make Man Whole." This effort has received new impetus as a recepient of the John Templeton Spirituality and Medicine Award for Psychiatry Residency Training Program. Our curriculum, while maintaining respect for diversity, seeks to address spiritual issues in the care of emotional and behavioral problems. The program consists of the following:

I. Didactic Module
   A. Grand rounds: This is a formal academic presentation by faculty from Loma Linda University and outside guests and is devoted to the spiritual aspects of psychiatric care every other month.
   B. Psychiatry and religion seminar: This seminar meets weekly for six sessions and covers topics such as practices of the world's major religions.

II. Clinical Training Module: Clinical rotations on inpatient services, chemical dependency, outpatient services, and consultation-liaison with a spiritual history and discussion with the pastoral care department.

III. Experiential Module: This module will consist of spiritually sensitive individual supervision, case conferences, and experiential process groups.

No. 76E
FUNCTIONS OF FAITH: A FRAMEWORK FOR THERAPY AT THE UNIVERSITY OF PITTSBURGH

Carl A. Jensen, D.M.N., *Pittsburgh Pastorial Institute, 6324 Marchand Street, Pittsburgh PA 15206*

SUMMARY:

This presentation outlines how psychiatric residents are being taught ways to use patient resources in assessment and treatment. It discusses the basic curriculum and principles of the cooperative program between Pittsburgh Pastoral Institute and the University of Pittsburgh Medical School.

This education effort builds on the research that indicates a positive correlation between lived out, intrinsic religious faith and physical and emotional health and healing. Residents are invited to observe for themselves how the various expressions of religious faith relate to this research.

The key concept has to do with examining the functions of faith in the various contexts of therapy: patients' making of meaning, family system, religious community, encounters with therapists, etc. The role of faith and religious community in binding anxiety is seen as central.

Attention is given to the role of therapists, who explore the processes of faith, as distinguished from the content. This distinction provides a basis for therapists to explore emotional functions of beliefs and practices respectfully, without making value judgments about the content of a particular religious belief. It also provides a basis for a collaboration with religious professionals, which maintains clarity of roles.

No. 76F
TRAINING PROGRAMS ON SPIRITUALITY AT CALIFORNIA PACIFIC MEDICAL CENTER AND THE UNIVERSITY OF CALIFORNIA AT SAN FRANCISCO

Elizabeth F. Targ, M.D., *CPMC, 2300 California Street, Ste 204, San Francisco CA 94115*

SUMMARY:

The psychiatry departments of the California Pacific Medical Center and the University of California, San Francisco, have collaborated to offer a multifaceted training program introducing psychiatry residents to concepts and issues relating to spirituality. The program consists of 12 lectures offered as a required series of 50-minute lecture presentation, in the CPMC curriculum and offered as an elective series of two-hour seminar-style evening discussions for all residents. In addition, residents can choose from two clinical electives—a year-long rotation in a breast cancer support program offering patients meditation, yoga, imagery, and exploration of spiritual issues, or a four-week elective in the health and healing clinic. Both programs offer residents the opportunity to learn to take a spiritual history and to work with patients in an environment that supports spiritual exploration.

The course begins with the question of what is spirituality? Lecture topics include, psychospiritual development, working with clergy, spiritual emergence syndrome, crises of faith and conversion, spirituality and addiction, cults, gurus, death and dying, meditation, and interviews with patients and community members for whom spiritual issues are important.

This presentation will include discussion about the impact of the course on residents' clinical practice and attitudes about spirituality.

No. 76G
SPIRITUALITY AND RELIGION IN THE HARVARD LONGWOOD RESIDENCY

John R. Peteet, M.D., *Department of Psychiatry, Brigham and Women's Hospital, 75 Francis Street, Boston MA 02115-6195;* Mary K. McCarthy, M.D.

SUMMARY:

With the support of the Templeton award, we have expanded the teaching of spirituality and religion in years PGY-II through PGY-IV. In the PGY-II, residents learn how to take a spiritual/religious history and in the PGY-III, while on the C/L service, learn the relevance of spiritual and religious factors at the bedside.

In the PGY-IV, all residents participate in a 10-session seminar, "Religion, Mental Health, and Culture". Each session consists of a brief didactic orientation, handouts with relevant references, and the opportunity for residents to discuss how they deal with these issues in their own clinical work. Topics include: the relevance of religious/spiritual issues in clinical work; the psychology of religion (developmental, psychodynamic, and psychopathological aspects); studies of faith and medical outcomes; the use of spiritual practices in healing (a panel discussion with representatives from different faiths); approaching religious or spiritual problems in psychotherapy; transference, countertransference, boundary, and informed consent issues; the role of the psychiatrist in the patient's moral life; and special topics of the residents' choosing. We continue to modify this course based on our experience and resident feedback.

REFERENCES:

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SYMPOSIUM 77—MANAGED CARE VERSUS FEE-FOR-SERVICE MEDICAID FOR ADULTS WITH SEVERE MENTAL ILLNESS

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of the symposium, the participant should recognize risks and possible benefits associated with managed care Medicaid for adults with severe mental illness.

No. 77A
MEDICAID MANAGED MENTAL HEALTH CARE: OVERVIEW

A. Michael Wylie, Ph.D., *Department of Psychology, University of Hawaii, Honolulu HI 96822*

SUMMARY:

A nationwide study examining the use, cost, and outcomes of managed care for potentially vulnerable Medicaid clients is being supported by the Substance Abuse and Mental Health Services Administration. Since 1996, some 20 study sites in 12 states have been evaluating the impact of managed care on Medicaid programs for adults with severe mental illness, children with serious emotional disorders, adults with substance use disorders, and youth with substance use disorders. This symposium focuses on research in Florida, Hawaii, Oregon, Pennsylvania, and Virginia examining managed care versus fee-for-service financing of treatment for adults with severe mental illness. Research methods include: (1) analysis of managed care contracting arrangements through surveys of Medicaid and mental health agencies and providers as well as analyses of managed care contracts; (2) retrospective examination of service utilization and cost of treatment based on Medicaid claims and other administrative records; and (3) prospective evaluation of utilization, cost, and outcomes through interviews with clients (at baseline and at six-month follow-up) as well as by interviews of family members. Questions to be answered include: (1) Has access to services changed with the implementation of managed care?; (2) Do consumer outcomes differ between fee-for-service and managed care?; and (3) What is the relationship between type of financing and consumer outcomes?

No. 77B
MANAGED CARE SYSTEMS IN ADULT MEDICAID CLIENTS WITH SEVERE MENTAL ILLNESS IN FIVE STATES

David L. Shern, Ph.D., *Mental Health, University of South Florida, 13301 Bruce Downs Boulevard, Tampa FL 33612;* M. Susan Ridgely, J.D., Sara A. Steber, M.S.S., Trevor Hadley, Ph.D.

SUMMARY:

Background: Behavioral health managed care for Medicaid clients with severe mental illness takes several forms. These systems may involve private sector health maintenance organizations, managed mental health "carveout" companies, community mental health centers, and other entities. Financial arrangements can include discounted fees, risk sharing, and full risk capitation. It is unknown whether the type of managed care relates to consumer outcomes.

Methods: Five study sites (Florida, Hawaii, Oregon, Pennsylvania, and Virginia) are collecting data from multiple archival sources and key informants using a structured, descriptive protocol that measures enrollee demographics, managed care organization characteristics, benefit design (including "medical necessity" definitions and utilization review procedures), composition of provider networks, payment and risk arrangements, and accountability structures.

Results: There is considerable variation in the managed care arrangements across and within the five states. Each managed care arrangement will be briefly described and variations within and between states will be identified. Relationships among managed care arrangements, service utilization, and consumer outcomes will be addressed.

Discussion: Essential to implementing Medicaid managed behavioral health care is an understanding of relationships among managed care plan characteristics, access to care, and treatment outcomes.

No. 77C
SERVICE USE BY MENTALLY ILL PERSONS IN MANAGED CARE

Aileen Rothbard, Sc.D., *Department of Psychiatry, University of Pennsylvania, 3600 Market Street, Room 713, Philadelphia PA 19104;* Hanteng Dai, M.D.

SUMMARY:

Background: Policymakers need to know how behavioral health managed care (MC) compared with fee for service (FFS) changes access to and utilization of services for Medicaid-eligible adults with severe mental illness.

Methods: Projects in the five study states all employ a pre- versus post-analysis of the MC intervention(s) as well as comparison with site(s) using FFS provider(s). Each state provides an analysis of utilization and cost over a two-year period prior to the intervention and one year following. Data sources include Medicaid administrative claims and managed care organization encounters as well as Medicaid eligibility records. Measures include the mix of service types, service substitution, and continuity of care. Analyses of variance and multiple regression analyses are being used to test differences from pre- to post-managed care as well as between MC and FFS concurrently.

Results: Preliminary data suggest that (at least in some states) access to Medicaid behavioral health services may have increased following the implementation of managed care. Inpatient, residential, and outpatient psychiatric services in FFS will be compared with those in the MC systems.

Discussion: These analyses may help policy makers ensure that vulnerable individuals are adequately served.

No. 77D
OUTCOMES FOR MEDICAID BENEFICIARIES IN MANAGED CARE VERSUS FEE FOR SERVICE

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

SUMMARY:

Background: The Substance Abuse and Mental Health Services Administration's nationwide study on Medicaid managed behavioral health care is designed to compare managed care with fee-for-service programs on outcomes such as consumer satisfaction, symptoms, and health status.

Methods: Client interviews are conducted at baseline and at six-month follow-up in Florida, Hawaii, Oregon, Pennsylvania, and Virginia. Family member opinions are also being obtained. Instruments include measures of symptoms and health status plus consumer-designed measures of satisfaction and empowerment. The satisfaction measure includes a five-point scale with 1 being the most satisfied.

Results: Preliminary analyses from baseline interviews with 1,310 subjects show variation in consumer satisfaction. Oregon consumers reported greater satisfaction with mental health services in managed care than fee for service (1.9 versus 2.4, $p < .001$) as did Virginia consumers (1.8 in managed care versus 2.1 in fee for service, $p < .001$). Conversely, in Florida (2.3 in managed care versus 2.3 in fee for service, p = NS) and Hawaii (2.1 in managed care versus 2.0 in fee for service, p = NS), consumers had similar satisfaction in managed care and fee for service.

Discussion: Preliminary results suggest that managed care may not have an adverse impact on consumer outcomes. More detailed analyses will be presented.

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2. Shern DL, Donahue SA, Felton C, et al: Partial capitation versus fee-for-service in mental health care. Health Affairs 1995; 14:208–219
3. Rothbard AB, Schinnar AP, Hadley TP, et al: Cost comparison of state hospital and community-based care for seriously mentally ill adults. Am J Psychiatry 1998; 155:523–529
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SYMPOSIUM 78—NEW INSIGHTS INTO DEMENTIA

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the end of the symposium, the audience should be able to recognize and treat severe behavioral disturbances in patients with dementia, especially psychotic symptoms and depression; know the appropriate use of genetic testing in Alzheimer's disease patients; and understand the usefulness and limitations of behavioral interventions as well as cognitive enhancers in the management of patients with dementia.

No. 78A
GENETICS OF ALZHEIMER'S DISEASE

Gary W. Small, M.D., *Department of Psychiatry, UCLA Neuropsychiatric Institute, 760 Westwood Plaza, Los Angeles CA 90024-8300*

SUMMARY:

Thanks to developments in genetic epidemiology and molecular biology, investigators have identified several genetic loci that cause or influence risk of Alzheimer disease (AD). For the rare forms of familial AD beginning before age 60, genetic mutations on chromosomes 1, 14, and 21 are the cause. More commonly, AD begins late in life; for such late-onset cases, the apolipoprotein E (APOE) gene on chromosome 19 influences risk. The APOE gene has three alleles, APOE-2, APOE-3, and APOE-4. Everyone inherits one allele from each parent so that five common genotypes are possible (2/3, 3/3, 2/4, 3/4, and 4/4). The APOE-4 allele increases risk and decreases dementia onset age in a dose-related fashion, while the APOE-2 allele may have a protective effect. Using APOE genotyping as a prognostic test for asymptomatic persons is not recommended until results from further studies are available. Instead, APOE genotyping may be useful in increasing the likelihood of a diagnosis of AD. Other genetic risk factors are likely since familial aggregation is present in families without APOE-4. This presentation will review our current understanding of the genetics of AD, practical clinical applications, and intriguing areas of current and future research.

No. 78B
PSYCHOSIS AND AGITATION IN DEMENTIA

Dilip V. Jeste, M.D., *Department of Psychiatry, University of CA at San Diego, 3350 La Jolla Village Drive, San Diego CA 92161;* Enid Rockwell, M.D., Daniel D. Sewell, M.D., Hoang A. Nguyen, M.D., Jonathan P. Lacro, Pharm.D., M. Jackuelyn Harris, M.D.

SUMMARY:

Numerous studies have shown that 30% to 40% of patients with Alzheimer's disease and other dementias have psychotic symptoms such as paranoid delusions and visual or auditory hallucinations. These symptoms are most frequent in the middle stages of dementia and are particularly common in the Lewy body variant of Alzheimer's disease. The incidence of agitation varies according to the stage of dementia, and may be over 80% in later stages. Psychosis and agitation often cause severe stress in the caregivers and may result in institutionalization of the patients. A number of pharmacologic and nonpharmacologic strategies are available for treating these symptoms. The newer atypical antipsychotics, including risperidone, olanzapine, and quetiapine, represent a marked advance over typical neuroleptics in having a significantly lower risk of extrapyramidal symptoms and probably of tardive dyskinesia. Other psychotropic agents of some value in this population include sodium valproate, carbamazepine, trazodone, buspirone, benzodiazepines, and beta blockers. Nonetheless, all of the antipsychotics as well as other drugs do have side effects and must be used cautiously.

We will present data from recently completed and ongoing studies of various agents and make therapeutic recommendations for their use in patients with dementia. Nonpharmacologic management approaches deserve special consideration in these patients.

No. 78C
MECHANISMS OF DEPRESSION IN DEMENTIA

George S. Alexopoulos, M.D., *Department of Psychiatry, Cornell University Med College, 21 Bloomingdale Road, White Plains NY 10605*

SUMMARY:

Depressive symptomatology can be identified in almost half of demented patients, and major depression has been reported in 10%–30%. Epidemiological studies suggest that depression is a risk factor for subsequent cognitive deterioration as well as a frequent early manifestation of dementing disorders. Follow-up studies suggest that the depression of demented patients is persistent and recurrent and not simply a transient state during the early phases of dementia.

Depression of demented patients appears to be linked to the pathophysiology of the underlying dementing disorder rather than being a randomly occurring comorbid state. Severe depression is most frequent in disorders affecting the basal ganglia, including vascular dementias, Parkinson's disease, and the diffuse Lewy body variant of Alzheimer's disease, while frontotemporal dementia is rarely complicated by depression. These clinical observations suggest that damage of frontal cortico-striato-pallido-thalamo-cortical pathways (CSPTC) is associated with development of depression in demented patients. However, lesions alone may not be sufficient to cause depression. Depression is most frequent in demented patients with family history of mood disorders. Moreover, the APO 3/4 genotype has been found to be associated with depression in Alzheimer's patients. These observations suggests that a lesion-genetic vulnerability interaction may best explain the development of depression in demented patients.

The association of depression of demented patients to CSPTC impairment may have treatment implications. Executive impairment has been found to be associated with chronicity and early relapse of geriatric depression. Treatment studies need to investigate the efficacy of acute, continuation, and maintenance treatments in depressed demented patients with evidence of CSPTC impairment.

No. 78D
COGNITIVE ENHANCERS

Lon S. Schneider, M.D., *Department of Psychiatry, University of Southern CA, 1975 Zonal Avenue, KAM-400, Los Angeles CA 90033*

SUMMARY:

Therapeutic approaches to treat cognitive impairment in dementia and to slow decline are making their way into clinical practice. Cholinergic agents are currently the most promising. Soon 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), (3) irreversible inhibitors (e.g., metrifonate). In addition, these medications vary with respect to other pharmacodynamic and pharmacokinetic effects. As physicians learn more about dosing, side effects, and mechanisms, they will be able to prescribe these drugs more efficiently. It is likely that patients may respond differentially as well. Concurrently there are several potential therapeutic options that may affect the progression of neuronal degeneration or slowing of 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 both as food supplements and for other medical indications. Although these medications were developed with the dementia of Alzheimer's disease in mind, they may be potentially useful in other cognitive impairment syndromes including mild cognitive impairment or dementia and in attention deficit disorder. Therefore, physicians are faced with new and complex challenges and opportunities with respect to enhancing cognition through pharmacotherapy.

No. 78E
BEHAVIORAL INTERVENTIONS IN DEMENTIA CARE

Soo Borson, M.D., *Department of Psychiatry, University of WA Sch of Med, 1959 NE Pacific St/Box 356560, Seattle WA 98195;* Jim C. Chen, M.D.

SUMMARY:

This presentation highlights the key role of behavioral interventions in effective management of patients with Alzheimer's disease and other neurodegenerative dementias. Effective strategies are of four mutually complementary types. 1) *Individualized patient management plans* are based on training of caregivers to understand, anticipate, and intervene in specific target symptoms such as agitation, anxiety, depression, and catastrophic reactions. 2) *Clinical care for caregivers themselves* focuses on alleviating depression, anxiety, and anger; teaches methods for controlling sources of burden, resolving conflicts about caregiving, minimizing caregivers' contributions to patients' symptoms and behavioral problems; and promotes use of appropriate supportive services. 3) *Environmental interventions* structure patients' time, offer pleasurable activities and nonthreatening social stimulation, limit occasions for heightened confusion and fear, and provide relief for caregivers. 4) *Becoming an expert resource for information and referral* creates an opportunity for clinicians to provide comprehensive management of patients and families over the long term as their needs change.

Clinical vignettes will illustrate the use of each approach, and data from empirical studies will be synthesized to construct a working model of behavioral care that can be adopted by psychiatrists in a variety of clinical settings and adapted to individual needs. A range of resources for continuing education for clinicians and assistance to families and professional caregivers will be provided for permanent reference.

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SYMPOSIUM 79—SUICIDALITY: DIAGNOSIS AND TREATMENT

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

Participants will appreciate the challenge of diagnosing and treating suicidality. They will have more tools and information with which to make clinical judgments about hospitalization and other modalities.

No. 79A
EVALUATION OF SUICIDE RISK IN A TIME OF MANAGED CARE

Richard C. W. Hall, M.D., *100 East Sybelia Ave, Ste 210, Maitland FL 32751-4757*

SUMMARY:

Physicians must assess patients for suicide risk and need for hospitalization while recognizing that third party payors (HMOs, PPOs, PROs, etc.) use admission protocols—of sometimes "proprietary" criteria unknown to the clinician—to determine their willingness to pay for psychiatric hospital stays.

A study was conducted at a large tertiary metropolitan hospital of 100 patients who made serious but nonfatal suicide attempts. Each required medical treatment for self-inflicted injuries prior to psychiatric admission. Particular attention was paid to the presence or absence of previously defined suicide prediction criteria. Our results confirmed much from previous reports as to predictors of suicide attempts. They pointed out serious flaws in some managed care protocols employed in our city. We noted several unexpected but significant differences from national data.

Patients who made serious suicide attempts but survived tended to be younger (17–35) and to display classic depressive symptoms. Other predictive indicators were recent severe interpersonal conflict, important relationship loss, inability to maintain job and/or attend school, alcohol and/or substance abuse, prior chronic medical illness, and recent diagnoses with a life-threatening illness. Eighty-six per-

cent were covered by some form of managed care (local average was 35%), 83% had seen a "mental health specialist" during the previous month, and 84% had no specific suicidal plan prior to their impulsive suicide attempt. This was a first attempt for 67%. Only 10% left a note. Sixty-nine percent had no suicidal rumination prior to their attempt. Most of these serious attempts appeared more spontaneous and impulsive than planned.

The lack of previous suicide planning and specific suicidal intent with rumination is important because many managed care protocols require that suicidal thoughts be present and that there be a previous suicide attempt or a well-formulated suicide plan for a patient to meet admission guidelines. This study suggests that such criteria are not valid.

No. 79B
MANAGEMENT OF SUICIDALITY IN PATIENTS WITH BPD

Michael H. Stone, M.D., *Department of Psychiatry, Columbia College, 225 Central Park West, #114, New York NY 10024-6027*

SUMMARY:

Optimal management of suicidality in patients with borderline personality disorder (BPD) depends on both understanding the underlying motivations ("dynamics") and the development of effective treatment strategies. Suicidality may take the form of genuine despair (that may lead to highly lethal acts), of manipulation (generally associated with nonlethal gestures), or of tension-relieving acts (self-mutilation, reckless acts, swallowing objects, etc.). Often, more than one dynamic is operative at any one time. Despair is usually an accompaniment of depression and usually requires antidepressants as well as exploration of the dynamics (by either cognitive-behavioral or analytically oriented techniques, depending on patient and therapist variables). Common dynamics include torment (with guilt and rage) over incest experiences manipulation to achieve revenge, or coercion (of intimates or of therapists, forcing the latter to experience the patient's own humiliation and ineffectiveness). Also common are attention seeking, relief of tension, or feelings of nonexistence. Treatment aims at reducing secondary gain; education and skill-training are useful in lessening feelings of helplessness.

No. 79C
CHRONIC SUICIDALITY: A LIFE AND DEATH PROJECT

Roger A. Lewin, M.D., *504 Club Lane, Towson MD 21286-7302*

SUMMARY:

Chronic suicidality requires of clinicians an ability to tolerate high levels of uncertainty, without either too much or too little anxiety. It requires a capacity to be judicious about actions to protect and to be capable of using a collaborative approach to safety that recognizes the patient's desperate need for autonomy and desperate need for support. For some patients, suicidality is a central self-soothing device. Suicidality is not suicide. Responsibility means response, not control. Suicidality is important for these patients in complex ways as fantasy, interpersonal tactic, and adaptive tactic. In each realm, ego weaknesses—especially difficulties with loving investment of the body self, taming of aggression, and transitional functions—preclude less all-or-nothing approaches.

Treatment of chronic suicidality calls for the use of all means, psychological, biological, and social, available to support and strengthen weak egos. Treatment must address the whole person. This may be even more taxing in the context of psychosis than of severe character disorders. Extensive case material is used to illustrate these points.

No. 79D
ASSESSING ADOLESCENT SUICIDE RISK

Cynthia R. Pfeffer, M.D., *Department of Psychiatry, Cornell University Med College, 21 Bloomingdale Road, White Plains NY 10605*

SUMMARY:

This presentation will discuss epidemiological and empirical information about risk for youth suicidal behavior. Youth suicidal behavior remains a significant mental health and sociocultural problem. In recent years, data have been collected suggesting that specific factors are associated with suicidal behavior occurring in various developmental periods. This presentation will provide an outline of assessment strategies for suicidal risk and highlight strategies for managing suicidal youth within a clinical continuum of care.

The presentation has implications for suggesting cost-effective approaches for suicide prevention and treating youth at significant risk for suicidal behavior.

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3. Lewin RA: Falling in Love With Death, Creative Collaboration In Psychotherapy: Making Room For Life. Northvale, Jason Aronson, Inc., 1997, pp. 105–124
4. Pfeffer CR: Childhood suicidal behavior: a developmental perspective. Psychiatric Clinics of North America 1997; 20:551–561

SYMPOSIUM 80—UPDATES ON THE TEXTBOOK OF PSYCHOPHARMACOLOGY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to select the most effective treatments for children and adolescents, cardiac disease patients, and those with mood disorders; to understand recent and anticipated developments in psychopharmacology.

No. 80A
UPDATE ON NEUROENDOCRINE ALTERATIONS IN PSYCHIATRIC ILLNESSES

Ned H. Kalin, M.D., *Department of Psychiatry, University of Wisconsin, 6001 Research Park Boulevard, Madison WI 53719*

SUMMARY:

This presentation will review advances in the neuroendocrine characterization of psychiatric illnesses, with a particular focus on depressive and anxiety disorders. In addition, basic preclinical and clinical strategies used to assess these alterations will be reviewed. Earlier studies demonstrated alterations in the hypothalamic-pituitary-adrenal (HPA) axis, the hypothalamic-pituitary-thyroid axis, and growth hormone in a number of psychiatric disorders. Recent evidence has extended these findings and suggests a pathophysiological role for some of these alterations. One of the most promising areas of research has been the basic and clinical studies implicating alterations in corticotropin releasing hormone (CRH) in mediating and maintaining depressive and anxiety disorders. The basic neurobiology of the CRH system will be presented in conjunction with animal and clinical studies. These studies have resulted in newly designed treatments aimed at antagonizing brain CRH systems, and

this novel approach will be discussed. Another potentially exciting finding relates to the role of substance P in depression. These findings, along with new treatment approaches targeted at substance P receptors, will also be presented.

No. 80B
DEPRESSION AND CARDIOVASCULAR DISEASE

Charles B. Nemeroff, M.D., *Department of Psychiatry, Emory University, 1639 Pierce Drive, Suite 4000, Atlanta GA 30322*

SUMMARY:

A wealth of data from a variety of disciplines, when taken together, supports the hypothesis that depression is a major independent risk factor for the development of both cardiovascular and cerebrovascular disease, as well as a risk factor for death after myocardial infarction. Epidemiological data will be presented, showing that depression is an independent risk factor substantially increasing risk for ischemic heart disease, both fatal and nonfatal. In addition, studies have revealed that after a myocardial infarction, death in the 18 months following this episode is substantially increased by the present of both depression and premature ventricular contractions. The mechanism by which depression increases risk for ischemic heart disease has been posited to be either increased platelet activation and aggregation and/or alterations in heart rate variability. There is evidence to support both of these hypotheses.

Data will be presented indicating that depressed patients, in response to orthostatic challenge, respond with increased platelet activation and aggregation compared with matched controls. Finally, studies reviewing the treatment of depression in patients with ischemic heart disease will be presented, including the recently published study demonstrating that the SSRI paroxetine is effective in the treatment of depression and carries with it a more benign side-effect profile than tricyclic antidepressants.

Supported by a NARSAD Established Investigator Award (Charles B. Nemeroff), NIH grants MH 01399 and MH 5176103.

No. 80C
PHARMACOLOGIC TREATMENT IN CHILDHOOD PSYCHIATRIC DISORDERS

Elizabeth B. Weller, M.D., *Department of Psychiatry, University of Pennsylvania, 34th and Civic Center Blvd, Philadelphia PA 19104*

SUMMARY:

Psychopharmacologic treatments of childhood psychiatric disorders have increased in the last decade. Polypharmacy has become the rule rather than the exception in childhood psychiatric disorders. However, there is the continuing saga of lack of scientifically designed studies that would allow us to come to the rational decision of how to treat psychiatric disorders in children and adolescents.

In this presentation, an update on double-blind, placebo-controlled studies justifying psychopharmacologic treatment of ADHD, conduct disorders, PTSD, self-injurious behavior, schizophrenia, depression, and bipolar disorder in children and adolescents will be presented.

No. 80D
OVERVIEW OF SSRIS

Jerrold F. Rosenbaum, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, ACC 812, Boston MA 02114*

SUMMARY:

This presentation is an overview of selective serotonin reuptake inhibitors designed to review the contributions of this class of drug to basic and clinical research into serotonin, psychopathology, and psychopharmacology. Beginning with serotonin's history and discovery, this paper will describe structure-activity relations of SSRIs, the pharmacological profile of SSRIs and their role as neuromodulators, SSRI pharmacokinetics, and their presumed mechanism of action. Issues of clinical relevance of SSRIs will be reviewed including the various indications for SSRIs: depression, obsessive-compulsive disorder, panic disorder, eating disorders, and their role in other conditions such as schizophrenia, posttraumatic stress disorder, premenstrual dysphoric disorder, premature ejaculation, pain syndromes, alcoholism, and obesity. The presentation will conclude with a discussion of side effects and toxicology of SSRIs and will address sleep disturbances, suicidality, pregnancy and lactation, and SSRI discontinuation, drug overdosage, and drug-drug interactions.

No. 80E
UPDATES ON ANTIEPILEPTIC DRUGS IN BIPOLAR DISORDER

Susan L. McElroy, M.D., *Department of Psychiatry, Univ of Cincinnati Col of Med, 231 Bethesda Avenue, ML 559, Cincinnati OH 45267-0559*

SUMMARY:

An increasing number of studies performed over the past several decades have shown that a variety of antiepileptic drugs (AEDs) are effective in the acute and prophylactic treatment of some patients with bipolar disorder, including those inadequately responsive to or intolerant of treatment with lithium. These agents include a number of standard AEDs (e.g., carbamazepine and valproate) and the investigational AED oxcarbazepine. Indeed, carbamazepine and valproate are considered by many authorities to be first-line mood-stabilizing agents, along with lithium, in the treatment of bipolar disorder. Although it is unknown whether the mechanisms of action underlying the antiepileptic properties of these drugs are responsible for their mood-stabilizing effects, it has been suggested that newer AEDs, including gabapentin, lamotrigine, and topiramate, should be screened for putative thymoleptic properties. In this talk, new data on the efficacy of VPA and CBZ in bipolar disorder will be reviewed. Also, preliminary experience with gabapentin, lamotrigine, and topiramate in the treatment of bipolar disorder will be discussed.

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SYMPOSIUM 81—TELEPSYCHIATRY: WHY DO IT?
APA Committee on Telemedical Services

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to describe the utility and promise of this enabling technology for present and future psychiatric applications.

No. 81A
TELEPSYCHIATRY: WHY BOTHER?

Ellen N. Rothchild, M.D., *Department of Psychiatry, Case Western Reserve, 2441 Kenilworth Road, Cleveland Heights OH 44106-2713*

SUMMARY:

Given the practical and psychologic obstacles to using telepsychiatry, such as cost, limited reimbursement, hassle factors, and technophobia, it may seem surprising that the number of programs and providers is proliferating. Increasing recognition of the value of telepsychiatry, growing experience with specific applications, closer attention to interpersonal factors, and developing solutions to practical obstacles are now combining to support its use. This brief overview will outline recent developments which will foster growth of this enabling technology in the 21st century.

No. 81B
TELEPSYCHIATRY FOR FUN AND PROFIT

Charles L. Zaylor, D.O., *8626 Overhill Road, Leawood KS 66206*

SUMMARY:

While on faculty at the University of Kansas Medical Center in Kansas City, Kansas, I have had the opportunity to develop a telepsychiatry practice. The practice has been operating for three years and has been both fun and profitable. I have had the opportunity to talk with many people involved in the telepsychiatry movement and a common question has surfaced. Why haven't more telepsychiatry practices evolved and grown, and what keeps them from doing so? This presentation will address the issues that I believe have made it possible for our program to grow with little outside financial support. Currently, our clinic sees over 120 patients a month. All of these visits are reimbursed by one means or another. We are currently seeing patients from Kansas and Missouri both in rural and urban settings. The real challenge is not the equipment, patient needs, or whether it works. Telepsychiatry is not for every patient in every situation. Finding the right patient and the right service is the real challenge. The second challenge is coordinating the necessary people and resources in order to bring the right patient and the right service together. Using my clinic as a model, I will illustrate how these principles have played a part in the successful development of our telepsychiatry clinic at the University of Kansas Medical Center.

No. 81C
SUCCESSFUL USE OF TELEPSYCHIATRY TO LINK THE ACADEMIC HEALTH SYSTEM WITH THE PRIMARY CARE SETTING

Donald M. Hilty, M.D., *Department of Psychiatry, University of CA at Davis, 4430 V Street, Sacramento CA 95817*

SUMMARY:

Telemedicine is a strategy to improve access to specialty care for patients in primary care settings. In the University of California, Davis, Health System, telepsychiatry service is provided by the department of psychiatry to seven primary care clinics of the health system in Northern and Central California. A study was designed to assess: 1) patient satisfaction with telepsychiatric (TP) care in comparison with in-person (IP) psychiatric care for a 60-minute evaluation or a 20-minute follow-up appointment; 2) psychiatric provider satisfaction with TP care in comparison with IP care; and 3) primary care provider (PCP) attitudes about telemedicine in general, and the effect of having them join the telepsychiatric interview for five to 10 minutes. The hypothesis of the study was that patients and providers would be less satisfied with TP care than IP care because the technology would adversely affect communication and the development of the doctor-patient relationship. To test this hypothesis, patients, psychiatrists, and PCPs completed a survey with Likert questions about demographic information, use of computers and other electronic devices, and satisfaction with services. A total of 30 patient, 30 psychiatrist, and 10 PCP surveys were completed. Patients and psychiatrists were equally satisfied with TP care and IP care. PCPs prefer patients to be seen IP for initial visits and more favorably view telemedicine after seeing it in action. Randomized trials are indicated for further evaluation of telemedicine in the primary care setting.

No. 81D
CHILD TELEPSYCHIATRY CLINICS

David J. Ermer, M.D., *Department of Psychiatry, Kansas University Medical Ctr, 3901 Rainbow Boulevard, Kansas City KS 66160*

SUMMARY:

Child and adolescent psychiatrists at the University of Kansas Medical Center have been utilizing telemedicine technology to serve their patients for over six years. In that period of time, we have developed several different clinical models for telepsychiatry. The busiest child telepsychiatry clinic provides child psychiatric services to a rural mental health center on a contracted basis. Another rural clinic operates as an extension of the outpatient clinic at KU Medical Center with the child psychiatrist seeing patients face-to-face and over televideo. A third clinic operates on an as-needed basis and provides consultation services to primary care physicians throughout Kansas. The most recently developed telepsychiatry clinic provides school consultation services to an urban elementary school district. This presentation will describe the development and operation of these different clinics, along with our observations and lessons learned while conducting these clinics.

No. 81E
TELEPSYCHIATRY IN GERIATRIC POPULATIONS

Beverly N. Jones, M.D., *Department of Psychiatry, Wake Forest University, Medical Center Boulevard, Winston-Salem NC 27157*

SUMMARY:

There is a need to expand mental health services to geriatric populations, particularly in institutional settings such as nursing homes, where there is a high prevalence of mental disorders. Geographic distance often separates geropsychiatrists from patients who need services. This presentation will describe research on the reliability of videoconferencing as an assessment tool in geriatric depression and the clinical application of videoconferencing to provide psychiatric consultations to nursing home residents of a rural county. Research at Wake Forest University on over 100 elderly patients has demonstrated that telepsychiatry can provide reliable evaluations of

depression compared with face-to-face assessments. Satisfaction of patients with the telepsychiatry assessment is comparable to face-to-face assessments. This research experience has lead to the development of a consultation service using low-cost videoconferencing equipment to expand mental health services to a rural hospital with nursing home beds. The experience of this clinical service will be described and typical patients discussed. This presentation will be of value to those interested in using telemedicine equipment to expand their psychiatric practice.

No. 81F
USE OF TELEPSYCHIATRY IN FORENSIC SETTINGS

Philip T. Merideth, M.D., *Forensic Services, MS State Hospital, PO Box 126A, Whitfield MS 39193*

SUMMARY:

Telepsychiatry is a valuable tool for education, consultation, and the clinical practice of forensic psychiatry. However, telepsychiatry is currently underutilized in the practice of forensic psychiatry.

The presentation will focus on the use of telepsychiatry for forensic purposes in state hospitals, court clinics, teaching hospitals, and prisons. Special emphasis will be given to legal considerations and practical aspects of doing forensic work by telepsychiatry. The interpersonal dynamics of the clinical interaction by telepsychiatry in forensic settings will be discussed. Information on the use of telepsychiatry in forensic education and consultation will be presented.

Videotape of an interview with a forensic patient by telepsychiatry will be shown to demonstrate these teaching points. There will be time reserved for audience members to ask questions and share their experiences regarding forensic telepsychiatry.

No. 81G
TELEMEDICINE AND DISTANCE LEARNING

Charles L. Zaylor, D.O., *8626 Overhill Road, Leawood KS 66206;*

SUMMARY:

The telemedicine department at the University of Kansas has been in place since 1991. One of the goals of the program has been to provide educational services to rural Kansas through the use of interactive televideo. Since the time of the department's inception it has provided a broad range of educational programs to the medical community. It has also brought educational programing to the lay public. This presentation will describe the services that have been provided and the lessons learned. The issues to be discussed will include, but not be limited to, acceptance, logistics of providing educational services, and multipoint programing.

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SYMPOSIUM 82—DEFINING PERSONALITY IN THE 21ST CENTURY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to have an enhanced knowledge of the differences between different approaches to the conceptualizations of personality and personality disorders, and to refine understanding of the relationship between treatment of Axis I disorders and changes in personality assessment in the patients.

No. 82A
A PSYCHOBIOLOGICAL APPROACH TO PERSONALITY

C. Robert Cloninger, M.D., *Department of Psychiatry, Washington Univ Medical School, 4940 Children's Place, Saint Louis MO 63110*

SUMMARY:

A developmental approach to integrative psychobiology provides a flexible framework for both clinical assessment and treatment planning. Assessment of seven dimensions of personality using the Temperament and Character Inventory (TCI) allows for comprehensive description of individual differences in feelings, thoughts, and actions. Four temperament factors that are stable throughout life can be decomposed in terms of their underlying genetic structure. Character factors that mature in response to social learning can be decomposed in terms of the components that unfold in a stepwise fashion from infancy through adulthood. Pharmacotherapy and psychotherapy can be systematically matched to the personality structure and stage of character development of each individual. This provides a comprehensive paradigm that integrates psychodynamic, cognitive-behavioral, interpersonal, and neurobiological insights into case formulation.

No. 82B
DEFENSE MECHANISMS AND AXIS I: AN EMPIRICAL SEARCH FOR STABILITY

Linda S. Mullen, M.D., *Department of Psychiatry, Columbia University, 722 West 168th St, Unit 103, New York NY 10032;* Carlos Blanco-Jerez, M.D., Susan C. Vaughan, M.D., James H. Kocsis, M.D., Steven P. Roose, M.D.

SUMMARY:

There is a longstanding belief that personality represents a structure that is stable over time and changes, if at all, very slowly. Nonetheless, clinical and empirical evidence supports the notion that the diagnosis of personality disorders using DSM criteria may vary with comorbid Axis I disorders, suggesting that personality as assessed by phenomenological systems is state dependent. An alternative to the DSM phenomenological system of conceptualizing personality is the dynamic concept of character; that is, a predictable pattern of both adaptive and pathological defense mechanisms. This presentation will review data from a study designed to test the hypothesis

that defense mechanisms remain relatively stable in patients treated for Axis I disorders, irrespective of clinical improvement. One hundred fifty patients meeting DSM-IV criteria for dysthymic disorder or major depressive disorder entered randomized, controlled, medication trials. Defensive style was evaluated with the Defense Style Questionnaire (Bond, et al, 1983) both at baseline and at the completion of the clinical trial. Data were analyzed for whether either Axis I disorder was associated with a particular pattern of defensive functioning and whether an individual's pattern of defense mechanisms was stable regardless of response to treatment of the mood disorder. Results of the study address the question of whether there are personality characteristics that are enduring and can be appreciated irrespective of an Axis I disorder.

No. 82C
PHENOMENOLOGY OF BPD

Mary C. Zanarini, Ed.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont MA 02478;* Frances R. Frankenburg, M.D.

SUMMARY:

Objective: The purpose of this study was to assess the diagnostic efficiency of the 22 symptom patterns assessed by the Revised Diagnostic Interview for Borderlines (DIB-R).

Method: The DIB-R and the Diagnostic Interview for DSM-III-R Personality Disorders were administered to 504 personality-disordered inpatients.

Results: Three hundred and seventy-nine patients met DIB-R and DSM-III-R criteria for borderline personality disorder (BPD) and 125 met DSM-III-R criteria for another type of Axis II disorder. Borderline patients were significantly more likely than Axis II controls to report having experienced 20 of the 22 symptom patterns at a probability level of $p < 0.0001$. In an effort to arrive at a more efficient diagnostic model, a logistic regression was performed with diagnostic status as the dependent variable and the 20 summary statements that successfully distinguished the groups as the independent variables. A highly statistically significant model emerged that correctly classifed 94% of the patients in the study and attained a sensitivity of .97, a specificity of .86, a positive predictive power of .95, and a negative predictive power of .91. The model consisted of the following 14 symptom patterns co-occurring: major/chronic depression, chronic feelings of helplessness/hopelessness/worthlessness/guilt, chronic anger/frequent angry acts, chronic anxiety, odd thinking/unusual perceptual experiences, nondelusional paranoia, quasi-psychotic thought, self-mutilation, manipulative suicide efforts, other forms of impulsivity, intolerance of aloneness, stormy relationships, dependency/masochism, and devaluation/manipulation/sadism.

Conclusions: The results of this study suggest that diagnostic efficiency is enhanced when symptom patterns from all four areas of borderline psychopathology (dysphoric affects, cognitive difficulties, impulsivity, and troubled close relationships) are required. The implications for DSM-V are discussed.

Supported in part by NIMH grant MH47588.

No. 82D
CAN MEDICATION CHANGE PERSONALITY?

Carlos Blanco-Jerez, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, Box 81, New York NY 10032;* Linda S. Mullen, M.D., Susan C. Vaughn, M.D., John F. Clarkin, M.D., Roger Vaughn, Ph.D., Christopher Tsai, B.A., Steven P. Roose, M.D.

SUMMARY:

Many clinicians believe that an individual's personality is a stable structure that is identifiable regardless of affective state and has a slow rate of change over time. However, a number of studies have shown that personality diagnoses based on phenomenological systems such as DSM-IV are in fact state dependent. It is possible that the phenomenological approach might not capture what clinicians consider to be enduring about a person. An alternative to the phenomenological approach is Otto Kernberg's model of levels of personality organization, i.e., neurotic, borderline, and psychotic. In this study, 100 patients with Axis I diagnoses of anxiety and affective disorders completed the Inventory of Personality Organization, a self-report measure, at baseline and at the completion of randomized clinical trial of medication. Data analysis will answer the following questions: (1) Does personality organization correlate with type or severity of Axis I disorder?, (2) Is personality organization stable over time or does it change depending on response to medication?, (3) Is personality organization a predictor of drop-out independently of the severity of Axis I diagnosis?

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SYMPOSIUM 83—WHEN YOUR PATIENT SUICIDES AND YOU ARE A RESIDENT

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize the impact of patient suicide on residents and the supportive, educational, and legal role of the residency program.

No. 83A
CASE PRESENTATION AND PHENOMENOLOGY OF SUICIDE

Peter Betz, M.D., *Department of Psychiatry, Johns Hopkins University, 600 North Wolfe Street, Baltimore MD 21287*

SUMMARY:

The case presentation of a young male patient who committed suicide a few weeks after a psychiatric hospitalization is presented. This case presentation will emphasize clinical aspects that had the greatest impact on the resident who was caring for him. This is followed by a discussion of the phenomenology, epidemiology, and differential diagnosis of suicide. The suicide rate, 13 per 100,000 population, has essentially remained unchanged over the past two decades. Suicide is most commonly associated with mood disorders and chronic alcoholism. However, suicide also frequently occurs in the context of personality vulnerabilities and life stresses. The discussion will explore aspects of suicide that transcend the circumstances in which it occurs. This is compared with aspects of suicide that relate to the unique nature of each patient. Ultimately, suicide

is a social behavior that needs to be specifically addressed and treated and not simply accepted as the consequence of other illness.

No. 83B
PSYCHOLOGICAL VULNERABILITIES IN PSYCHIATRIC RESIDENTS

James W. Ethier, M.D., *Department of Psychiatry, Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore MD 21287;*

SUMMARY:

This presentation will discuss psychological vulnerabilities of residents and potential morbidity in response to patient suicide. Personality inventories demonstrate that resident characteristics often include a marked tendency toward introversion, past and future orientation, and conscientiousness. These traits affect the resident's response to stressors. After a patient commits suicide, residents report intrusive thoughts, interrupted sleep, and avoidant behaviors. Residents and their training programs need to recognize the signs and symptoms of distress after a resident loses a patient who suicides. Once recognized, residency training programs should address the psychological and professional needs of the resident.

No. 83C
IN THE DARKEST HOUR: THE RESIDENCY PROGRAM RESPONDS

Edward A. Minor, M.D., *Department of Psychiatry, Medical College of Georgia, 1515 Pope Avenue, Augusta GA 30912;*

SUMMARY:

Losing a patient to suicide is a traumatic event at any point in a psychiatrist's career. It may be a particularly difficult event for a resident. Many emotions are unleashed in a psychiatry resident by the suicide of a patient, not the least of which include fears regarding adverse or unsupportive reactions on the part of supervisors or the training director, the condemnation of peers, and legal repercussions. The reactions of a residency program to the suicide of a trainee's patient influence not only how the involved resident deals with the event, but also serve as a model for other residents as to how they might be treated in a similar situation. Thus, a training program may facilitate or hinder the processing of a patient suicide by all of the residents in the program. This presentation will outline beneficial and counterproductive program responses to the suicide of a resident's patient. Issues discussed will include real or perceived abandonment of the resident, supervisor, and program director countertransference, subsequent interactions with surviving family members, and fears of, as well as preparation for, possible medicolegal consequences. Recommendations will be provided for enhancing appropriate residency program responses as well as avoiding potential pitfalls.

No. 83D
RESIDENT'S PATIENT COMMITS SUICIDE: LEGAL LIABILITY

Vani A. Rao, M.D., *Department of Psychiatry, Johns Hopkins, 600 North Wolfe Street, Baltimore MD 21287;*

SUMMARY:

Psychiatric malpractice is not an uncommon occurrence. Suicide of a patient under treatment often leads to legal action. The plaintiff, however, must be able to prove clearly and convincingly that there was dereliction of duty that directly led to the patient's death. In this presentation, we will explore the ways by which a resident might prevent, anticipate, and manage a malpractice suit.

Even though suicide is not always preventable, the resident should be aware of the risk factors associated with suicide for his or her patient. Careful documentation of clinical history, diagnosis, and treatment is essential. The clinical signs of deterioration, if any, and the response and the measures taken by the resident should also be recorded. It is imperative to document a supervisor's recommendations and notes on discussion with family members.

The next part of the presentation will focus on the legal and ethical issues a resident may face when he or she learns of a patient's suicide. For example, 1) Can the resident discuss the event with his friends? 2) Will the supervisor still play the advisory role. 3) When and how should the resident contact the legal department? and 4) What should the resident involvement be with the patient's family?

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SYMPOSIUM 84—CULTURAL IDENTITY AND MENTAL HEALTH

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participants should be able to recognize key approaches to the assessment of cultural identity and their relationship to the promotion of mental health.

No. 84A
BICULTURAL IDENTIFICATION AND ITS MULTI-ETHNIC VALIDATION

Juan E. Mezzich, M.D., *Department of Psychiatry, Mt. Sinai School of Medicine, Fifth Avenue & 100th Street, New York NY 10029;* Maria A. Ruiperez, Ph.D., Gihyun Yoon, M.D., Carlos Perez, M.D., Jason S. Liu, M.D., Saeed Iqbal, M.D., Syed A. Mahmud, M.D.

SUMMARY:

Biculturality is emerging as a promising alternative to the traditional, unidimensional acculturation or assimilation model of cultural identification among immigrants. Bicultural assessment involves determining the extent to which an immigrant is identified with his/her original culture and, separately, with the mainstream host culture. To accomplish this assessment, a bicultural scale developed by Cortés et al. for Puerto Ricans was slightly modified and then extended for use with immigrants of various ancestries.

An empirical validation of this Multi-Ethnic Bicultural Scale (MEBS) has been conducted on Latinos, Chinese, and Korean samples in New York City and a comparison sample of Euro-Americans. Across these samples, the time to complete the MEBS ranged from 1 to 4 minutes, and the vast majority of the individuals involved judged that the scale was easy to complete. Test-retest reliability of the scale was quite high, with correlation coefficients between 0.83

and 0.85. Latino, Chinese, and Korean samples tended to rate themselves high on the original-culture half of the scale and about medium on the mainstream half, revealing different degrees of biculturality. In contrast, the Euro-American, third-generation sample tended to rate themselves very high on the mainstream half and very low on the ethnic-minority half.

When the relationship between biculturality and quality of life was assessed, substantial biculturality tended to correlate with high quality of life, hypoculturality (low identification with both original and mainstream cultures) tended to correlate with low quality of life, and monocultural polarization (high on either the original or the mainstream cultures) appeared to have a variable relationship to quality of life.

No. 84B
CULTURAL IDENTITY AND MENTAL HEALTH: ASIAN-AMERICAN PERSPECTIVES

Keh-Ming Lin, M.D., *Department of Psychiatry, Harbor-UCLA Medical Center REI, 1124 West Carson Street/B4 S, Torrance CA 90002*

SUMMARY:

Issues related to the identity of Asian Americans and the relationship of the identity to mental health care is of particular relevance for psychiatric research and practice as we enter the next millennium. The recent growth of the Asian-American populations has been phenomenal (at approximately 100% per decade) and is expected to continue well into the next century. Coming from a vast geographic area with rich and varied cultural traditions, recent Asian immigrants share similarities but also diverge in significant ways in their process of "acculturation." An adequate understanding of such a process is essential for the identification of mental health problems in these populations as well as for the planning and provision of psychiatric care of patients with Asian-American ethnic and cultural backgrounds.

In this presentation, the author will review literature on the relationship between "acculturation" (and ethnic identity) and mental health in Asian Americans. Unique issues including the concept of self, the meaning of the family, and the relationship between the body and the mind will also be highlighted in this presentation.

No. 84C
ALIENATION AND MENTAL HEALTH: AFRICAN-AMERICAN VIEWPOINTS

Carl C. Bell, M.D., *Community Mental Health Council, 8704 South Constance Avenue, Chicago IL 60617-2746*

SUMMARY:

Cultural identity and mental health are intimately related. Dr. Bell will propose that the increasing rates of young African-American male suicide are due to the alienation found in this population. His argument will be supported by the findings that other populations that are alienated (e.g., white males who are alienated from their culture/society, middle-aged military African-American males who are alienated from their culture/society, and middle-class African Americans who are alienated from poor African Americans and alienated from white middle-class Americans) have higher than average suicide rates. He will conclude with a discussion on levels of racial and cultural identity and how these issues of identity promote alienation or promote a connectedness that influences mental health outcomes.

No. 84D
BICULTURAL ISSUES IN GENEVA

Ariel Eytan, M.D., *Department of Psychiatry, Hug Belle-Idee, 2 Ch Petit-Bel-Air 1225, Geneva, Switzerland*

SUMMARY:

The proportion of resident foreigners in the Geneva area is approximately 38% of 400,000 inhabitants. Foreign resident population is heterogeneous in terms of countries of origin, spoken languages, legal status, and access to health care. The largest foreign communities are made of citizens from Italy, Spain, Portugal, and France. They are mainly permanent stable residents, while refugees and asylum seekers come from Eastern Europe, former Yugoslavia, and Africa.

In order to evaluate cultural identities of immigrants and outline subgroups with specific mental health care needs, we reviewed available data about ethnicity, mental disorders, and utilization of services of clients in Geneva, and assessed consulting clients of Italian, Spanish, and Portuguese origins with culture-informed standardized instruments for quality of life and bicultural identity (the Quality of Life Index and Bicultural Scale) in addition to the standard diagnostic evaluation. This was conducted in outpatient and inpatient facilities of Geneva Hospital's psychiatry department. Data thus generated indicate specific culture-related patterns of utilization of psychiatric services and mental health problems. Comparison with figures for the Swiss mainstream population is discussed.

No. 84E
IMMIGRATION, CULTURE, AND MENTAL HEALTH IN ISRAEL

Yair C. Bar-El, M.D., *Department of Psychiatry, Jerusalem District, Givat Shaul, Kfar Shaul Hosp, Jerusalem 91060, Israel;* Haim Y. Knobler, M.D.

SUMMARY:

The recent immigration of over half a million Jews from the former USSR to Israel, the "melting point" of immigrations for over a century, provided unique settings, including: Russian-speaking psychiatrists, who are familiar with both cultures, Russian and Israeli; distinct cultural differences; and genetic similarities between the immigrant and the absorbing population. These settings allowed studies of immigrant patients and of immigrant psychiatrists.

A comparison between immigrant and nonimmigrant psychiatric patients revealed no differences in the rate of schizophrenia, gender distribution, age of onset, the present age of the patients, or past treatment. However, immigrant patients had prominent suicidal ideation, and suicidal attempts were a common reason for their psychiatric admission. Immigrants with schizophrenia did not have different rates of PANSS symptoms, including positive, negative, and depressive symptoms. They did have more paranoid delusions of being persecuted by secret services.

The recent immigration almost doubled the number of physicians in Israel. The orientation of most of the immigrant psychiatrists from the former USSR changed through their acculturation, from phenomenological-biologic to biologic-psychodynamic. Furthermore, the importance of understanding the local culture and enhancing cultural sensitivity became evident during the supervision of immigrant psychiatrists. The enhancement of cultural sensitivity accelerated the absorption of the immigrant psychiatrists themselves.

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SYMPOSIUM 85—PSYCHIATRIC ISSUES IN DESIRE FOR DEATH

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium the participant should be able to describe an observational study of HIV seropositive physicians including their experiences both as patients and physicians and specifically how they handled discussions of physician-assisted suicide; to describe a prospective study of the experience of caregivers whose partners did and did not desire a hastened death and the bereavement process

No. 85A
DESIRE FOR DEATH AMONG CANCER AND AIDS PATIENTS

William Breitbart, M.D., *Department of Psychiatry, Memorial Hospital, 1275 York Avenue/Box 421, New York NY 10021-6007*

SUMMARY:

Despite the hope created by the introduction of protease inhibitors, patients with AIDS are still dying in large numbers. Cancer continues to be a leading cause of death in the U.S. Palliative care of patients with cancer and AIDS is a clinical and research area in which psychiatry is being asked to play a greater role. This expansion of the role of psychiatry in palliative care is in part stimulated by the debate over physician-assisted suicide (PAS) and patients' desire for hastened death. Despite recent Supreme Court decisions not to legalize assisted suicide, it is anticipated that several states will legalize PAS and develop guidelines that involve psychiatric evaluation as an important component (e.g., Oregon). There have been several studies of patients with cancer or AIDS demonstrating that depression plays an important and perhaps central role in patients' desire for death or interest in PAS. These studies support the contention that mental health professionals must become more involved in the care of patients with life-threatening illness, particularly in the arena of psychiatric dimensions of palliative care and the recognition and treatment of depression. This paper will review the studies of desire for death and interest in PAS among terminally ill cancer patients and AIDS patients, with particular emphasis on the role of depression in the context of pain, social support, and medical variables. This paper will also describe the development and validation of new self-report measures of desire for death in samples of terminally ill AIDS and cancer patients. Finally, preliminary results of an intervention trial examining the impact of treating depression on desire for death in terminally ill AIDS patients will be presented.

No. 85B
COPING STYLE, DEPRESSION AND GROUP THERAPY IN TERMINAL ILLNESS

David Spiegel, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Room 2325, Stanford CA 94305-5544*

SUMMARY:

Preparation for dying and death is an important component of coping with terminal cancer and AIDS. Recent studies have shown that the prevalence of major depression rises with the severity and terminal prognosis of medical illness, from 12% among medical inpatients to 20% among the terminally ill, to 60% among those requesting assisted suicide. Thus the diagnosis and treatment of concurrent depression is one crucial aspect of terminal care. In addition, coping styles throughout the course of the illness may affect ultimate mood disturbance and adjustment. In our study of the effects of supportive/expressive group psychotherapy on women with metastatic breast cancer, we have found in a sample of 101 women that emotional control (Courtault Emotional Control Scale) is related to significantly higher mood disturbance on the Profile of Mood States (POMS; beta = .32, $t = 3.5$, $p < .001$). Furthermore, aversive social support also increases mood disturbance (beta = .34, $t = 3.4$, $p < .001$). Thus, those individuals who cannot communicate their distress and live in a social environment that adds to rather than buffers stress are at high risk for depression and anxiety, which complicates end-of-life decisions. Prior work has shown an increase in mood disturbance in the immediate preterminal period. This presentation will examine for this effect in our current metastatic breast cancer sample and in a sample of 200 women and men with HIV infection who have been randomized in a prospective trial of supportive/expressive group therapy. The intervention is designed to facilitate open discussion of death and dying, provide intense social support, and ameliorate depression and anxiety. These data should provide guidance to psychiatrists and other health care providers to address problems that complicate terminal care.

No. 85C
TREATING TERMINALLY ILL PATIENTS WITH HIV

Robert L. Klitzman, M.D., *Department of Psychiatry, Columbia University, 630 West 168th Street, New York NY 10032*

SUMMARY:

This paper will present issues confronted by HIV-infected physicians when treating terminally ill patients with HIV. Issues concerning terminally ill patients raise a variety of psychological, social, and ethical issues for HIV-infected physicians concerning transference, countertransference, and assisted suicide. The data will be from in-depth semistructured interviews that were conducted with 36 HIV-positive physicians on a variety of issues, including participants' experiences as physicians and as patients. HIV-infected physicians have been understudied, but can potentially provide important and unique insights—being both providers and patients—into psychological, sociological, and ethical issues that are raised by the HIV epidemic and that are relevant to other chronic and potentially fatal diseases. Issues concerning how to deal with terminally ill patients frequently arose during the interviews. Participants reported that these issues emerged less frequently now than several years ago, due largely to improvements in treatment, but have been and remain extremely important. HIV-infected physicians faced significant boundary issues in treating HIV-infected patients confronting the same illness themselves. Physicians overidentified with patients—many of whom are gay men and thus members of the same stigmatized community (e.g., "my friends are my patients and my patients are my friends," "it's almost as if one of my close friends was passing," "we're part of family"). Death and dying become "very

draining," and physicians risk "becoming calloused from death." Physicians referred patients to therapists, encouraged patients to discuss the issue with loved ones and family as well, and often continue to discuss the issue with patients over several months. This study will provide guidance to physicians and patients who are grappling with similar clinical and treatment issues.

No. 85D
DESIRE FOR HASTENED DEATH IN END-STAGE AIDS DISEASE

Susan Folkman, Ph.D., *University of CA at San Fran, 74 New Montgomery, Suite 600, San Francisco CA 94105*

SUMMARY:

One hundred forty participants whose partners became bereaved during the course of a longitudinal study of care-giving partners of men with AIDS were assessed at study entry and one month before the partner's death, one month following the partner's death, and three months following the partner's death. At the interview three months post bereavement, participants were asked whether their partner had received an increased narcotic and/or sedative hypnotic medication dose and if so, what had been the objective of the increase, and their comfort with the medication decisions. Of 140 partners who died of AIDS, 17 (12.1%) received an increase in the use of medications immediately before death that was intended to hasten death. Caregivers who had partners who had desired a hastened death did not differ from those whose partners did not in level of distress, care-giving burden, relationship characteristics, or comfort with the medication decision. They did report more social support and more positive meaning in care giving.

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2. Classen C, Koopman C, Angell K, Spiegel D: Coping styles associated with psychological adjustment to advanced breast cancer. Health Psychology 1996; 15:434–437
3. Cooke M, Gourlay L, Collette L, et al: Informal cargivers and the intention to hasten AIDS-related death. Arch Internal Medicine 1998; 158:69–75
4. Slome L, Mitchell T, et al: Physician-assisted suicide and patients with human immunodeficiency virus disease. NEJM 1997; 336:416–421

SYMPOSIUM 86—IMPROVING EARLY PSYCHOSIS OUTCOMES IN CANADA

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant will optimize outcomes in early psychosis by applying knowledge of the implications of perinatal injury and neurocognition for outcome and clinical management, by applying knowledge of pharmacotherapy and program monitoring using process and outcome indicators, and finally by aiming to match outcomes achieved by cohorts receiving optimal patient care.

No. 86A
THE EFFECT OF PERINATAL EVENTS ON OUTCOME IN EARLY PSYCHOSIS

Lili C. Kopala, M.D., *Department of Psychiatry, Dalhousie University, 5909 Jubilee Rd. Rm. 4083 AJLB, Halifax, NS B3H 2E2, Canada*

SUMMARY:

This presentation is designed to help the attendee understand the concept of schizophrenia as a neurodevelopmental disorder and the role of perinatal events as both a risk factor for schizophrenia and a predictor of poor neuroleptic response. A number of factors impact the developing brain and have been suggested as risk factors for the development of schizophrenia. These include infection, starvation, and obstetric complications. Genetic factors have also been identified as risk factors for the development of psychosis. These concepts raise the issue of whether schizophrenia represents a deteriorating disorder or a static encephalopathy. Recent findings in a large Canadian cohort study showed that patients with an early onset were likely to have a history of obstetric complications, a poor response to neuroleptic treatment, and show no relationship between ventricle size and duration of illness. Adult-onset patients were less likely to have obstetric complications, more likely to respond to treatment in the first year of illness, and show an association between brain structure and duration of illness.

No. 86B
NEUROCOGNITIVE OUTCOMES IN EARLY PSYCHOSIS

Jean M. Addington, Ph.D., *Department of Psychiatry, University of Calgary, FMC 1403 29th Street, NW, Calgary AB T2N 2T9, Canada*

SUMMARY:

Cognitive deficits are a core feature of schizophrenia. It has been suggested that individuals experiencing their first episode of schizophrenia are already exhibiting neurocognitive deficits. This presentation will present results from the first part of a longitudinal study comparing the neurocognitive functioning of 88 individuals who had recently been diagnosed with schizophrenia or schizophreniform disorder (FE) with 76 individuals with a diagnosis of schizophrenia who had been ill for many years (ME).

Measures included the PANSS, visual and verbal memory, early information processing, sustained attention, and executive functioning. Of the first episode sample 55 were reassessed one year later.

The ME group had more negative symptoms ($p < 0.05$) and performed more poorly on executive functioning tasks ($p < 0.01$). The groups did not differ on the other cognitive tasks. Neurocognitive functioning was associated with negative symptoms but not with positive symptoms in both groups. At one-year follow-up the FE group demonstrated significant improvement in verbal memory ($p < 0.01$), visual attention ($p < 0.01$), early information processing ($p < 0.05$), and executive functioning ($p < 0.05$). These results suggest that FE subjects have early signs of neurocognitive impairment that improve over time. The implications of these data for outcome in early psychosis will be discussed.

No. 86C
POPULATION-BASED PROGRAMS: PROCESS AND OUTCOME INDICATORS

Donald E. Addington, M.D., *Department of Psychiatry, University of Calgary, FMC 1403-29th Street, NW, Calgary AB T2N 2T9, Canada*

SUMMARY:

This presentation is designed to enhance the attendees' ability to understand and use the principles of population-based program design and evaluation for early psychosis programs. Agreement on process and outcome indicators is needed to compare programs and monitor cost-effectiveness. This agreement is required if the field of early psychosis treatment and prevention is to progress to become part of routine and effective care. The Calgary Early Psychosis

Treatment and Prevention Program is a population-based, needs-driven program serving a population of 850,000 under a single Regional Health Authority, which monitors patient costs and service utilization. Key process indicators include the proportion of all patients with appropriate diagnoses who are referred to the program, the duration of untreated psychosis, and the proportion who remain in the region and in contact with the service at one year. Treatment use and adherence is evaluated for major program services. For example, 93% of families are seen at least once by the family worker. All patients are offered second-generation antipsychotics as first-line treatment, and 5% progress to clozapine within one year. Other indicators include hospital days, readmission rates, rates of attempted suicide, and proportions employed or in full-time work.

No. 86D
OUTCOME IN A FIRST-EPISODE PSYCHOSIS COHORT

Ashok K. Malla, M.D., *Department of Psychiatry, University of West Ontario, WMCH Bldg LHSC/392 S Street, London ON N6A 4G5, Canada;* Ross M.G. Norman, Ph.D., Panth L. Voruganti, M.D., Leonardo Cortese, M.D., Rajinder Haricharan, M.D., Rahul Manchanda, M.D.

SUMMARY:

Fifty patients with a first episode of nonaffective psychosis were assessed and treated in an early intervention program utilizing interventions specifically designed for the treatment of this patient population, who are generally younger. The treatment consisted of low-dose novel antipsychotics (risperidone, olanzepine, or quetiapine), and a comprehensive psychosocial treatment program. The latter consisted of individual and group interventions for family intervention (psychoeducation, support, and behavioral interventions); a transitional group intervention during the early part of the treatment (usually 12 weeks); a personal support, educational, and skills training group (eight weeks); and intensive needs-driven clinical case management, which included individual therapy. The patients had a mean age of 25, a mean age of onset of 23.2 years, a mean duration of untreated psychosis of 73 weeks, a symptom score respectively for: total SAPS & SANS 56.3, reality distortion 17.7, disorganization 9.2, and psychomotor poverty 23.3, Calgary Depression Scale score 4.4, and Hamilton Anxiety Scale 84. Patients were also assessed for EPS using ESRS, and quality of life using the Wisconsin Quality of Life Index (mean total average weighted domain score 1.01) and on a battery of cognitive tests. Patient were assessed repeatedly using a protocol that included repeated measures of symptoms and side effects. Here we report results of two types of analyses on symptom ratings across time: percentage change in each dimension of symptoms over a number of time points across a minimum of six months, and time to remission as a function of duration of untreated psychosis (using survival analysis). In addition, for patients who have completed one year of treatment, change in each domain of the QOL index will be reported.

No. 86E
PHARMACOLOGIC STRATEGIES FOR FIRST-EPISODE PSYCHOSIS

Robert B. Zipursky, M.D., *Schizophrenia, Clarke Institute, 250 College Street, Room 732, Toronto ON M5T 1R8, Canada*

SUMMARY:

Effective antipsychotic therapy is the foundation upon which recovery from a first episode of schizophrenia must be built. It is critical, therefore, that medical treatment be initiated that will have the greatest likelihood of bringing about the fullest degree of both symptom remission and functional recovery. Aggressive efforts also need to be made to minimize medication side effects, as they can have direct effects on quality of life and functional ability as well as a profound indirect impact on recovery through compliance.

In the face of increasing focus on the management of the first episode of psychosis, two general treatment strategies have emerged: 1) use of the new atypical antipsychotics and 2) use of low doses of typical antipsychotics. It is necessary to understand how these options compare in terms of efficacy, tolerability, and the risk of tardive dyskinesia. A recent study completed at our center using positron emission tomography (PET) has explored the use of low-dose typical antipsychotics. We have also used PET to characterize the receptor binding properties of the new atypical antipsychotic agents. Recommendations for treatment will be discussed in light of new research in this field.

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SYMPOSIUM 87—THE PSYCHOPHARMACOLOGY OF SEVERE MENTAL DISORDERS Collaborative Session with the National Institute of Mental Health

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to identify new developments in the treatment of severe mental disorders.

No. 87A
NEW ANTIPSYCHOTICS: DATA AND METHODS

John M. Kane, M.D., *Department of Psychiatry, Hillside Hospital, 75-59 263rd Street, Glen Oaks NY 11004-1150*

SUMMARY:

There has been tremendous activity in the development of new antipsychotic drugs in recent years. New and better drugs are sorely needed to improve functional outcome in diseases such as schizophrenia. Increasingly, multiple domains (i.e., negative symptoms, cognitive dysfunction, and psychosocial adjustment) are being targeted and assessed. The extent to which new drugs are superior to conventional agents in these areas is now the focus of extensive research.

The methodologic issues that need to be addressed given multiple domains of interest are expanding in scope. Problems remain in differentiating primary negative symptoms from drug-induced im-

pairments in affect and motivation. The long-term consequences of reduced adverse effects on compliance and rates of relapse also need to be assessed. Ultimately, whatever gains are attributed to new drugs must be measured by impact on functional outcome. Given the nature of, and expense associated with, drug development, the pharmaceutical industry plays a major role in establishing the initial parameters of clinical testing; however, many gaps in knowledge remain to be filled after drugs are marketed. Also, mechanisms must be in place to facilitate the research necessary to inform clinical practice.

No. 87B
ADVANCES IN THE TREATMENT OF CHILDBEARING AGED WOMEN

Katherine L. Wisner, M.D., *Department of Psychiatry, Case Western Reserve Univ, 11400 Euclid Avenue, Suite 280, Cleveland OH 44106*

SUMMARY:

Childbearing-aged women are at high risk for major depression and other mood disorders. Treatment during pregnancy and lactation requires skilled decision making on the part of the physician. Areas to be discussed in this paper are (1) a model to structure the process of treatment decision making for pregnant women; (2) serum levels of tricyclic antidepressants (TCA) have been evaluated through pregnancy and postpartum; (3) mother and nursling serum levels of many TCA and serotonin-specific reuptake inhibitors (SSRI) are typically very low; (4) women with postpartum depression may respond more favorably to an SSRI, and an RCT that compares response to nortriptyline (NTP) with response to sertraline is underway; (5) an RCT designed to test the efficacy of NTP in the prevention of recurrent postpartum depression has been completed. We found that there was no difference in the rate of occurrence or time to recurrence in women treated preventively with NTP compared with placebo (PL). The observed recurrence rates are 25% for the PL group and 21% for the NTP group. We propose to substitute the SSRI sertraline for NTP as our preventive intervention.

No. 87C
MOOD STABILIZERS AND SIGNAL TRANSDUCTION REGULATION

Husseini K. Manji, M.D., *Department of Psychiatry, Wayne State University, 4201 St. Antoine Dr. H5V, Detroit MI 48201*

SUMMARY:

Lithium, valproic acid, and carbamazepine are widely used to treat manic-depressive illness, but the molecular mechanisms underlying their therapeutic actions have not fully been elucidated. In recent years it has become increasingly clear that rather than any single neurotransmitter system being responsible for depression or mania, multiple interacting and overlapping systems are involved in regulating mood, and that most effective drugs may exert their therapeutic efficacy by affecting the functional balance between interacting systems. In this context, we have found that in both rodents and humans, chronic administration of these agents at therapeutically relevant concentrations produces significant effects on signal transduction pathways, in particular on G proteins, the protein kinase C isozymes, and the AP-1 family of transcription factors. Regulation of signal transduction within critical regions of the brain affects the intracellular signal generated by multiple neurotransmitter systems and may thus explain the efficacy of these agents in treating multiple aspects of manic-depressive illness. Given the key roles of these signaling cascades in the amplification and integration of signals in the CNS, these findings have clear implications not only for research into the etiology/pathophysiology of manic-depressive illness, but also for the development of innovative treatment strategies.

No. 87D
ANTIPSYCHOTICS IN CHILD AND ADOLESCENT PSYCHIATRY

Robert J. Nicolson, M.D., *Child Psych. Branch, NIMH, 10 Center Drive, Bethesda MD 20892;* Marge Lenane, M.S.W., Sanjiv Kumra, M.D., Judith H.L. Rapoport, M.D.

SUMMARY:

In addition to their use in psychotic disorders in children and adolescents, antipsychotics are used for pervasive developmental disorders, tic disorders, and mental retardation. Although there have been a number of open studies of antipsychotics in these populations, there have been few rigorously controlled studies. The introduction of the new antipsychotics has provided an important therapeutic advancement, since the older antipsychotics cause extrapyramidal symptoms and dyskinesias at greater rates than in adults. A double-blind study of clozapine demonstrated clear superiority over haloperidol in patients with childhood-onset schizophrenia. Two controlled studies of risperidone in childhood-onset disorders have demonstrated efficacy, one with adults with pervasive developmental disorders and another with adults with mental retardation and aggressive behavior. Open studies of new antipsychotics have also suggested a beneficial effect in children and adolescents with autism. Although these agents have a lower risk of neurological side effects, younger patients are still at increased risk of experiencing a number of side effects, particularly weight gain, and need to be monitored closely. Further controlled studies, such as our ongoing blinded comparison of olanzapine and clozapine in patients with childhood-onset psychotic disorders, are needed to delineate the efficacy and side-effect profile of these medications in children and adolescents.

No. 87E
ISOZYME-SPECIFIC DRUG METABOLISM IN THE ELDERLY

Bruce G. Pollock, M.D., *Department of Psychiatry, Western Psychiatric Institute, 3811 O'Hara Street, Pittsburgh PA 15213-2593*

SUMMARY:

A drug's dose seldom has an unambiguous relationship to its blood concentration. Diversity in drug concentration is due to poor compliance and/or pharmacokinetic differences between patients. Inter-individual differences in drug oxidation are the most important cause of pharmacokinetic heterogeneity for psychotropics and may have important therapeutic and toxic consequences. This is particularly pertinent for an older population, since adverse drug reactions increase exponentially with age. Knowledge of cytochrome P450 isoenzyme-specific metabolism has proved important for the understanding of drug-drug interactions. In older patients, age-associated factors, genetics, and multiple interacting medications differentially affect drug metabolizing isoenzymes. Our research suggests that CYP2D6 does not undergo an age-associated decline, but that CYP2D6 phenotyping may nonetheless be useful for prospectively identifying elderly patients at risk for antipsychotic side effects. Recently, we have found that CYP2C19-mediated metabolism may be inhibited in association with elevations of inflammatory cytokines in frail patients, and that CYP1A2 metabolism is inhibited in older women undergoing estrogen-replacement therapy. With regard to CYP3A4, pharmacokinetic data suggest that metabolism is reduced in older compared with younger women, but not significantly changed in men.

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SYMPOSIUM 88—PSYCHIATRY AND CRIME VICTIMS: BRIDGING THE GAP U.S. Department of Justice's Office for Victims of Crime, the APA Task Force on Violence and the APA Committee on Family Violence & Sex Abuse

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to have increased awareness of the mental health needs of crime victims, effective interventions for them, and methods of financing access to mental health care for them.

No. 88A
CRIME VICTIMIZATION AND PSYCHIATRIC DISORDERS: EPIDEMIOLOGY

Timothy D. Brewerton, M.D., *Department of Psychiatry, Medical University of SC, 67 President St/PO Box 250861, Charleston SC 29425-002;* Dean G. Kilpatrick, Ph.D., Heidi S. Resnick, Ph.D., Benjamin E. Saunders, Ph.D., Connie L. Best, Ph.D., Ron Acierno, Ph.D., Bonnie S. Dansky, Ph.D.

SUMMARY:

Objective: Crime victimization has become an all too common experience for all too many people in the U.S., especially women and children. The impact of sexual and physical assault on the development of psychiatric disorders is of great clinical and research relevance and has enormous implications for prevention. Published studies, particularly those involving representative, non-treatment-seeking samples, on the effects of crime victimization on the development of psychiatric disorders will be reviewed.

Methods: This presentation will focus on results from the National Women's Study (NWS), in which over 4000 adult women selected by random-digit dialing from four stratified regions of the U.S. completed a structured telephone interview designed to assess histories of victimization (including rape, molestation, attempted sexual assault, aggravated assault, and witnessing homicide) and symptoms of DSM-III-R defined post-traumatic stress disorder (PTSD), major depression, alcohol/substance abuse, and eating disorders.

Results: Results indicate that crime victimization occurring at any age (especially during childhood) is a potent but nonspecific risk factor for the development of a variety of psychiatric disorders, including (but not limited to) anxiety, affective, substance use, and eating disorders. Furthermore, data indicate that increasing comorbidity among these disorders is associated with increasing rates of crime victimization.

Conclusions: It is essential for psychiatrists and mental health professionals to recognize and understand the extent to which criminal victimization, especially sexual and physical assault, not only occurs but is of major etiological importance to a spectrum of psychiatric disorders. Opportunities for primary, secondary, and tertiary prevention are huge.

No. 88B
CRIME VICTIM COMPENSATION PROGRAM DIRECTORY

Dan M. Eddy, J.D., *National Assoc Crime Victims, 4418 Taney Avenue, Alexandria VA 22304*

SUMMARY:

Each state government has a crime victim compensation program that can pay for the costs of mental helth counseling for victims of violent crime, including rape, child abuse, and homicide (benefits are available for family members of murder victims). The programs also pay for medical care, lost wages and support, and funerals. All of the government compensation programs operate under similar rules and procedures, and offer provide broadly comparable benefits. The programs are payers of last resort, filling gaps in services uncovered by private insurance and other public benefit programs. To be eligible for payment, victims are required to report crimes and cooperate with law enforcement, file timely applications, and be innocent of criminal wrongdoing. Therapists may be required to submit treatment plans and other documentation. Reimbursable treatment is limited to conditions and symptoms directly related to the criminal victimization, rather than for other problems or pre-existing conditions. A number of states have limits on available benefits, averaging between $2,000 and $5,000, or one to two years of treatment. There is no federal or national victim compensation program, but the federal government does provide supplementary funding to the state victim compensation programs.

No. 88C
THE PHILADELPHIA YOUTH HOMICIDE COMMITTEE

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

SUMMARY:

The Youth Homicide Committee of Philadelphia is a subcommittee of the Philadelphia Interdisciplinary Youth Fatality Review Team (PIYFRT) which is under the aegis of the Philadelphia Department of Public Health. Its purpose is to examine the murders and suicides of everyone under the age of 22 in Philadelphia. The names of victims for a given month are distributed prior to the meeting. Every Committee member is asked to gather whatever information they can on the victims from their respective agencies, such as the schools, DHS, the courts, health and mental health agencies, etc. We collect data on each victim to see if the murder was preventable and if any conclusions can be drawn from all the data to change public policy. In this presentation the many activities shich have resulted from the work of this Committee will be explained and discussed.

The Youth Homicide Committee has served the community very well over the last four years. Prevention is key and public health work by psychiatrists in an effort to prevent murder is serious endeavor.

No. 88D
A SUPPORT PROJECT FOR HOMICIDE

Edward K. Rynearson, M.D., *The Mason Medical Center, 1100 9th Avenue, Seattle WA 98101*

SUMMARY:

In 1998 the Office of Victims of Crime funded a training program to replicate a community based wupport program for family members after a homicide, developed in Seattle, WA in 1988. This funding brings teams of therapists from three U.S. sites (San Diego, New Haven and NYC) to Seattle for a 4 day training workshop to learn the administrative and clinical functions of the program before launching their own. Site visits and on-going consultation are provided. Standardized screening and follow-up measures will permit a mult-site venue for clinical monitoring.

No. 88E
OVERVIEW OF RESEARCH ON EFFECTS OF CRIME VICTIMIZATION ON MENTAL HEALTH

Deborah Spungen, M.S.S., *AVP, 633 West Rittenhouse St, #C-14, Philadelphia PA 19144*

SUMMARY:

The presenter will give a brief overview on the projects of the Anti-Violence Partnership of Philadelphia (AVP), which serves the mental health of crime victims, specifically focusing on the uniqueness of co-victims (family and friends) of homicide victims. Next, a discussion of the best practices in bringing victim assistance and mental health fields together to forge a better understanding of co-victims' needs and commitment to appropriate service delivery methods. Included in this section will be how, when, and why victim assistance professionals should refer crime victims to mental health practitioners and an exploration of opportunities for further understanding and collaboration between the fields.

No. 88F
PENNSYLVANIA COALITION AGAINST RAPE

B.J. Horn, *PA Coalition Against Rape, 1809 Spring Garden Street, Philadelphia PA 19139*

REFERENCES:

1. Resnick HS, Kilpatrick DG, Dansky BS, et al: Prevalence of civilian trauma and posttraumatic stress disorder in a representative national sample of women. J Consul Clin Psychology 1993; 61:984–991
2. Green AH: Dimensions of psychological trauma in abused children. J Am Acad Child Psychiat 1983; 22:231–237
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4. Rynearson EK: Breavement After Homicide: A Comparison of Treatment Seekers and Refusers British J Psychiatry 166:507-510, 1995
5. Program Directory, National Associations of Crime Victim Compensation Boards, Washington, D.C., March 1999, National Association of Crime Victim Compensation Boards

SYMPOSIUM 89—ADVANCED RISK MANAGEMENT ISSUES AND STRATEGIES

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to think through difficult risk-management issues using the most recent clinical information in the context of recent case law and legislation.

No. 89A
RISK MANAGEMENT IN CHILD AND ADOLESCENT PSYCHOPHARMACOLOGY

Diane H. Schetky, M.D., *PO Box 220, Rockport ME 04856*

SUMMARY:

Issues of informed consent and assent in medicating minors are discussed along with the question of how much information should be shared with children and parents regarding side effects, potential adverse reactions, and off-label usage. Frequency and cost of medication monitoring may be problematic for families who lack insurance or live great distances from hospitals. Standards of care may differ greatly between university hospitals and rural communities.

Power struggles over medication compliance often arise in adolescents, and ethical questions arise as to when and if adolescents should be coerced into taking medication.

Special populations will be addressed such as children and youths who are in the state's custody in foster care, correctional facilities, or other institutions. How much informed consent is required to medicate under these conditions and from whom? Pressures may be brought upon psychiatrists to medicate out-of-control children for the sake of staff rather than the child. When is one justified in using psychotropic medication or neuroleptics to sedate children whose problems are primarily behavioral?

New dilemmas arise when managed care organizations pressure hospital staff to initiate drug therapy before adequate assessments of patients can be done. Many children are rapidly processed and discharged heavily medicated into communities where there are no child psychiatrists to provide aftercare. Primary care providers may lack familiarity with certain drugs or their novel uses and fail to appreciate potentials for adverse drug interactions. Further high-risk situations arise when medications are administered by school personnel or camp staff who are not trained to do so. Case examples will be provided.

No. 89B
RISK MANAGEMENT AND THE DUAL DIAGNOSIS PATIENT

Patricia R. Recupero, M.D., *Department of Psychiatry, Brown Univ/ Butler Hospital, 345 Blackstone Boulevard, Providence RI 02906*

SUMMARY:

Dual diagnosis (mentally ill chemically addicted) patients constitute 25%–40% of most psychiatric practices. Psychiatrists should be aware of the multiple risks associated with treating these patients. Recent research suggests that the efficacy of antidepressants is diminished when combined with even small amounts of alcohol. Drug-drug interactions between psychiatric drugs and abusable substances may also occur, such as respiratory depression secondary to the combined effects of alcohol, opiates, and benzodiazepines.

Physicians have been sued for: (1) causing the patient's addiction, (2) failing to warn the patient of the potential of drug/drug interac-

tions, (3) injury suffered by the patient or others while the patient was operating an automobile, (4) criminal acts of the patient allegedly committed while under the influence of medication or other substances, (5) suicide of a patient, as well as many other reasons. Prescribing for a drug-dependent person may also place a physician's license at risk and expose the physician to criminal charges.

This presentation will address several court cases raising these issues and examine the various legal arguments supporting or opposing liability on the part of the physician. Several strategies for preventing adverse outcomes and responding to difficult clinical situations will be explored.

No. 89C
RISK MANAGEMENT AND MANAGED CARE

Paul S. Appelbaum, M.D., *Department of Psychiatry, University of Massachusetts, 55 Lake Avenue North, Worcester MA 01655*

SUMMARY:

The growth of managed care has changed the nature of malpractice risks faced by psychiatrists in the United States. For many years, the courts have assumed that psychiatrists and other physicians could, if they thought it appropriate, access whatever services were needed for their patients. Thus, the failure to provide services that conformed to prevailing standards of care (e.g., inpatient hospitalization, intensive outpatient treatment) reflected negligence on the part of the psychiatrist. Under systems of managed care, however, psychiatrists are no longer in control of the treatment resources needed by their patients; access to these resources is determined by managed care reviewers. Thus, psychiatrists may be faced with situations in which patients need treatment for which authorization of payment has been denied. In such situations, clinicians appear to have four duties, the fulfillment of which is likely to minimize their risk of subsequent liability. These duties involve: 1) advocacy for patients' needs with reviewers and facilities, 2) formulation of alternative treatment strategies, 3) provision of information to patients regarding their options in the face of denial of payment for recommended services, 4) continuation of treatment in emergency circumstances, even if payment authorization has been denied. Fulfillment of these duties in a reasonable fashion should insulate psychiatrists from major risks of liability. Nonetheless, it is clear that the new environment poses previously unknown risks and imposes a new set of burdens for practicing clinicians.

No. 89D
RISK MANAGEMENT ISSUES WITH INCARCERATED PATIENTS

Jeffrey L. Metzner, M.D., *3300 East 1st Avenue, Ste 590, Denver CO 80206-5808*

SUMMARY:

The correctional population of the United States increased more than two-and-one-half times from 1980 through 1993. During 1993, approximately 2.6% of the U.S. population, 4.9 million adults, were on parole, probation, or in correctional facilities. Not surprisingly, studies and clinical experience indicate 8%-19% of prisoners have significant psychiatric or functional disabilities and another 15%-20% will require some form of psychiatric intervention during their incarceration.

Correctional systems have experienced significant difficulties in identifying and providing treatment to prisoners with mental illnesses. Efforts to establish adequate mental health systems in prisons were accelerated during the 1970s as a result of successful class action lawsuits.

This talk will summarize the legal basis for mandated mental health care, review relevant national guidelines (with an emphasis on the APA's Jail and Prison Task Force report) and standards for providing such services, and discuss essential characteristics of a mental health system designed to meet constitutional standards. Risk management issues for the individual practitioner will also be reviewed in order to decrease the risk of a successful malpractice suit.

No. 89E
ADVANCED RISK MANAGEMENT ISSUES AND STRATEGIES

Renée L. Binder, M.D., *Department of Psychiatry, Langley Porter Institute, 401 Parnassus Avenue, Box F, San Francisco CA 94143*

SUMMARY:

There are clear risk management issues when evaluating and treating patients who are potentially violent. In most jurisdictions, the courts have determined that clinicians have a duty to protect potential victims. This duty includes completing an evaluation of violence risk. If the risk is high, clinicians have an obligation to try to prevent the violence form occurring. Litigation often results when psychiatrists do not complete a thorough evaluation or do not gather essential information, and when violent acts occur. This presentation will review the components of a thorough violence risk assessment. Information will be presented about what should be considered as relevant history, how to obtain collateral information and records, and what are considered to be significant demographic and clinical risk factors for violence including the use of drugs and/or alcohol, and noncompliance with treatment. The presenter will discuss clinical and legal issues related to implementing a range of preventive actions including Tarasoff reporting. She will also present clinical recommendations about making Tarasoff notifications. She will discuss the use of risk-management techniques of documentation, consultation, and involvement of patients, their family and their potential victims in the decision-making process. In addition, the presenter will discuss personal safety issues and how to maintain a secure environment in which to treat violent patients.

REFERENCES:

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2. Recent developments in alcholism. v. 13. In Alcoholism and Violence, edited by Galanter M. New York, Plenum Press, 1997
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SYMPOSIUM 90—BEYOND IMAGING: MR SCANNING IN PSYCHIATRY

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the capabilities of different types of magnetic resonance scanning, including MR imaging, MR spectroscopy, and

functional MR, as well as the potential use of these modalities in psychiatric diagnosis and treatment.

No. 90A
CLINICAL PHARMACOLOGY BY MR SCANNING

Bruce M. Cohen, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont MA 02178-1048;* Deborah A. Yurgelun-Todd, Ph.D., Suzann M. Babb, Marc J. Kaufman, Ph.D., Perry F. Renshaw, M.D.

SUMMARY:

An increasing number of medications are available for the treatment of psychiatric illnesses. However, current agents especially those for affective and psychotic disorders, remain extremely slow in producing therapeutic effects. In addition, they frequently produce uncomfortable, disabling, and even dangerous side effects. There is a limited understanding of how these psychotherapeutic medications act in patients, and many patients do not benefit or cannot tolerate standard drugs, no matter how effective they are, on average, in clinical trials. In fact, in choosing among treatment options, there are no clear ways to match specific drugs to individual patients in order to optimize treatment.

Studies using magnetic resonance scanning suggest powerful new approaches to help solve these problems. Properly applied, MRI can directly observe the concentration of many drugs in brain. In addition, MRI and functional MR can be used to document baseline abnormalities of regional brain biochemistry or activation during illness as well as response of these abnormalities to treatment. Examples will be given for antidepressant, antipsychotic, and mood-stabilizing drugs. Further use of MR techniques is likely to lead to improved choice of drugs and better monitoring of their effects during treatment. Also, based on the direct observation of the effects of available drugs, new and better medications might be designed.

No. 90B
PANIC DISORDER: MR STUDIES OF CAUSE AND TREATMENT

Stephen R. Dager, M.D., *Department of Psychiatry, University of Washington, 4225 Roosevelt Way NE Ste 306C, Seattle WA 98105-6099;* Seth D. Friedman, Ph.D., Matthew E. Layton, M.D., Todd L. Richards, Ph.D., Wayne Strauss, Ph.D., Stefan Posse, Ph.D.

SUMMARY:

There is increasing evidence to suggest CNS mechanisms in the etiology of panic disorder. The purpose of this study was to investigate regional versus global brain metabolic changes during lactate-induced panic using a new MR technique, proton echo-planar spectroscopic imaging (PEPSI).

Fifteen medication-free panic disorder subjects and 10 healthy controls were studied using a 1.5T SIGNA MRI scanner to sample an axial slice (nominal voxel size = $1cm^3$) at the level of the lateral ventricles every 6.5 minutes during a 20-minute baseline, 20-minute lactate infusion, and for 15-minute post-infusion period. NAA and lactate metabolite images were calculated. Six subjects were restudied during gabapentin treatment.

Widely distributed brain lactate increases were measured during lactate infusion that were significantly greater among panic subjects ($p = .01$). NAA remained unchanged across the experiment. Treatment blocked the lactate-induced panic response but not abnormal brain lactate rises.

Functional spectroscopic imaging using PEPSI offers a new approach to rapidly assess changing neurochemistry in relationship to brain anatomy. These findings of widespread brain lactate increases extend our prior MR studies of panic that were limited to a single brain region. Findings will be contrasted to similarly designed caffeine challenge studies, and effects of treatment will be discussed. These studies should lead to a better understanding of the pathophysiology underlying panic and the development of improved treatment interventions. (Work supported by NIMH (R01-MH50579).

No. 90C
FUNCTIONAL MRI IN SCHIZOPHRENIA: EFFECTS OF TREATMENT ON REGIONAL ACTIVATION

Deborah A. Yurgelun-Todd, Ph.D., *Brain Imaging, McLean Hospital, 115 Mill Street, Belmont MA 02178;* Donald C. Goff, M.D., Staci Gruber, M.A., Abigail Baird, M.S., Perry F. Renshaw, M.D., Bruce J. Cohen, M.D.

SUMMARY:

Recent functional imaging studies of schizophrenic patients have reported decreased frontal and increased temporal lobe activation in subjects with schizophrenia during word generation. Additionally, the amelioration of both negative symptoms and performance on some cognitive tasks has been demonstrated in schizophrenic patients after treatment with atypical antipsychotics and when d-cycloserine is added to conventional neuroleptics. We now report the results of two studies designed to assess changes in regional activation associated with antipsychotic treatment. For both studies, fMRI measures were obtained at two phases of treatment: at baseline and after eight weeks of medication. We studied two groups of schizophrenic patients. The first group included nine DSM-IV-diagnosed schizophrenic patients who were treated with an atypical antipsychotic agent. The second group included 12 DSM-IV-diagnosed schizophrenic patients enrolled in a double-blind study examining the efficacy of the coadministration of d-cycloserine and conventional neuroleptics. Cortical activation was measured using neuroanatomically defined regions of interest based on both conventional MR and fMR images and included the frontal and temporal lobes. In both studies, the active medication groups showed an increase in temporal activation during word production after treatment, which distinguished them from healthy volunteers who demonstrated frontal lobe activation. These results indicate that treatment with atypical antipsychotics and d-cycloserine added to conventional neuroleptics produce similar effects through modulation of fronto-temporal networks without normalizing brain activity.

No. 90D
MR STUDIES OF DRUG ABUSE

Perry F. Renshaw, M.D., *Brain Imaging, McLean Hospital, 115 Mill Street, Belmont MA 02178;* Marc J. Kaufman, Ph.D., Jonathan M. Levin, M.D., Luis C. Maas, M.S., James D. Christensen, Ph.D., Deborah A. Yurgelun-Todd, Ph.D., Bruce M. Cohen, M.D.

SUMMARY:

Magnetic resonance methods provide a safe, noninvasive means by which to observe changes in human brain anatomy (using magnetic resonance imaging; MRI), chemistry (using magnetic resonance spectroscopy; MRS), and function (using functional magnetic resonance imaging; fMRI). Over the last several years, MRI, MRS, and fMRI have been used to document changes in brain that are associated with both acute and chronic use of drugs of abuse. Substances that have been studied include alcohol, benzodiazepines, cocaine, methylphenidate, opiates, marijuana, and nicotine. Findings to date include the identification of specific areas of neuronal loss associated with substance abuse, distinct alterations in brain phospholipid metabolism in opiate and cocaine dependent persons; differential vasoactive effects of cocaine in men and women, and brain regions that mediate cue-induced craving. In addition, improvements in brain chemistry

and metabolism following the initiation of abstinence have been observed in cocaine, marijuana, and nicotine dependent persons. These observations suggest that MRS and fMRI may play a role in assessing the central nervous system effects of drug use and therapeutic interventions. Finally, at least one new candidate treatment for cocaine dependence has been developed on the basis of these magnetic resonance studies.

REFERENCES:

1. Cohen BM, Renshaw PF, Yurgelun-Todd DA: Imaging the mind: magnetic resonance spectroscopy and functional brain imaging. Invited Editorial. Am J Psychiatry, 1995; 152:655–658
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3. Yurgelun-Todd DA, Waternaux CM, Cohen BM, et al: Functional magnetic resonance imaging of schizophrenics and controls during word production. Am J Psychiatry 1996; 153:200–205
4. Kaufman MJ, Levin JM, Christensen JD, Renshaw PF: Magnetic studies of substance abuse. Sem Clin Neuropsychiatry 1996, 1:61–75

SYMPOSIUM 91—THE TREATMENT OF DEPRESSION IN WOMEN

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the biological basis for increased vulnerability to depression in women, including differences in their stress response system, and the response differences to reproductive endocrine changes to provide up-to-date gender-specific care, with specific attention to selection and use of optimal pharmacological/psychological treatments for PMDD, depression in pregnancy, lactation, and perimenopause, and prevention of next-generation transmission of depression.

No. 91A
BIOLOGICAL BASIS FOR GENDER DIFFERENCES IN DEPRESSION

Philip W. Gold, M.D., *Research NIMH, Bldg 10/2D46, 10 Center Drive, Bethesda MD 20892-1284*

SUMMARY:

Major depression occurs twice as frequently in women as in men. In addition, more women exhibit differential responses to treatment. This presentation reviews the biological basis for these differences, rooted in essential differences in the stress response system between women and men. Several disorders that are thought to occur as a consequence of a dysregulation in the stress response have been identified, including major depression, inflammatory disease, and Cushing's disease. Each of these syndromes occurs much more frequently in women than men. This may reflect the fact that it was essential that the stress response system in women evolve to undergo a far greater range of excursion during the course of a lifetime (e.g., profound activation during parturition, pronounced suppression during lactation). Moreover, the demands of maternal care require a stress system that can be readily activated during sleep and that can respond profoundly over a short period of time. Central effectors of the generalized stress response, the corticotropin releasing hormone (CRH) and locus ceruleus-norepinephrine systems, are significantly more responsive to stressors in women and significantly more resistant to counterregulatory factors that restrain the stress system. The biochemical mechanisms underlying this enhanced responsiveness will be described, including an estrogen response element in the promoter region of the CRH gene that significantly increases the rate of its transcription, and relative glucocorticoid resistance in women in disparate tissue types. The implications of these mechanisms for new approaches to treatment will be discussed.

No. 91B
PREMENSTRUAL DYSPHORIC DISORDER

Barbara L. Parry, M.D., *Department of Psychiatry, University of California, 9500 Gilman Drive, La Jolla CA 92093*

SUMMARY:

Many theories of the etiology and treatment of premenstrual dysphoric disorder have been proposed, but only recently have they been substantiated with consistent evidence. A hypothesis of serotonin dysregulation presently has the most support, and clinical trials using selective serotonin reuptake inhibitors have shown the most promise. Current investigations focus on whether these treatments can be confined to the symptomatic luteal phase. Experimental manipulations of sleep and light potentially may offer nonpharmacologic treatment alternatives. The evidence for the efficacy and effectiveness of current treatment will be revisited, new findings highlighted, and recommendations for the appropriate state-of-the-art treatment of key clinical presentations given.

No. 91C
PHARMACOLOGIC MANAGEMENT OF DEPRESSION DURING PREGNANCY AND POSTPARTUM

Lori L. Altshuler, M.D., *Department of Psychiatry, VA Med Cntr, Bldg. 158, Rm 104, 11301 Wilshire Blvd, B116AA, Los Angeles CA 90073;* Lee S. Cohen, M.D., Martin P. Szuba, M.D., Vivien K. Burt, M.D., Michael J. Gitlin, M.D.

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 histories of depression. In this talk, the literature on the natural history of depression in pregnancy will be reviewed. The potential risks to mother and fetus of untreated psychiatric illness during pregnancy will be reviewed. 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, will also be discussed. Decision-making guidelines regarding whether to discontinue medications during pregnancy will be presented. The risk for major depression in the postpartum period and the likelihood of postpartum recurrence after a postpartum event will be reviewed, and prophylactic strategies will be covered.

No. 91D
GONADAL STEROIDS AND PERIMENOPAUSAL DEPRESSION

David R. Rubinow, M.D., *National Inst of Mental Hlth, 10 Center Dr/Bldg 10/MSC 1276, Bethesda MD 20892*

SUMMARY:

The impact of reproductive endocrine change on mood and behavior is suggested by both the profound neuroregulatory and neurodevelopmental effects of gonadal steroids and by at least 150 years of clinical observation. Yet the precise role of gonadal steroids

in perimenopausal depression is largely unclear and the subject of controversy. This controversy reflects the misassumption that the effects of gonadal steroids on brain function and mood will be similar in all persons and contexts. A series of endocrine manipulation studies that we have performed have revealed the following: 1) ovarian suppression eliminates the symptoms of premenstrual dysphoria, while addition of either estrogen or pregesterone can trigger return of symptoms; 2) women with a history of premenstrual syndrome are differentially sensitive to the dysphoria-inducing effects of the gonadal steroids, yet the same hormone manipulations in women lacking that history are without the effect on mood; 3) in perimenopausal depression, estrogen acts as an antidepressant. In contrast to suggestions in the literature, it appears that many reproductive endocrine-related mood disorder are not hormone deficiency syndromes but rather reflect "abnormal" responses to normal hormonal changes. Within this framework of understanding, specific recommendations will be made for the effective use of gonadal steroids in the treatment of perimenopausal dysphoria.

No. 91E
DEPRESSED GRANDMOTHERS, MOTHERS AND CHILDREN

Myrna M. Weissman, Ph.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, Unit 14, New York NY 10032-2603*

SUMMARY:

This presentation will review data describing the important clinical problem of the transmission of depression from depressed women to their children and grandchildren. Numerous studies have shown that depression runs in families. None have followed the cohort over time and determined the continuity and persistence of depression over the generations. This paper will report findings from a three-generational study. The original probands met criteria for major depression with evidence of impairment in social roles. A control group of never-mentally-ill subjects was also followed. The offspring of the depressed mothers and controls were followed over 10 years, from adolescence to adulthood. Recently, the grandchildren were also studied. Results show the persistence of depression across three generations and the early presentation first of anxiety disorder. The implication of these findings for treatment and psychoeducation will be delineated.

REFERENCES:

1. Chorusos GP, Torpy DJ, Gold PW: Interactions between the hypothalamic-pituitary-adrenal axis and the female reproductive system: clinical implications Annals of Internal Medicine, 1998; 129:229–240
2. American Psychiatric Association: DSM-IV Sourcebook, Vol. 4, Edited by Widiger TA, Frances AJ, Pincus HA et al. Washington, D.C., 1998
3. Altshuler LL, Cohen L, Szuba M, et al: Psychopharmacologic management of psychiatric illness in pregnancy. Am J Psychiatry 1996; 153:592–606
4. Rubinow DR, Schmidt PJ: Menstrual cycle and perimenopausal-related affective disorders. In Psychoneuroendocrinology for the Clinician, edited by Wolkowitz OM. Washington, DC, American Psychiatric Press, Inc. In Press
5. Weissman M, et al: Offspring of depressed parents: Arch Gen Psychiatry 1997; 54:932–940

SYMPOSIUM 92—DIAGNOSTIC ISSUES IN THE 21ST CENTURY: ISSUES FOR DSM-V
APA Committee on Psychiatric Diagnosis and Assessment

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participants will have greater understanding of the issues confronting clinicians and researchers regarding the development of future diagnostic classifications. They will participate in dialogue on topics such as the role of laboratory testing in diagnosis, the reorganization of diagnostic groupings, issues in child psychiatry, and the definition of mental disorders.

No. 92A
THE ROLE OF LABORATORY TESTING IN PSYCHIATRIC PRACTICE

K. Ranga R. Krishnan, M.D., *Department of Psychiatry, Duke University Medical Center, Box 3950, Durham NC 27710*

SUMMARY:

While laboratory tests are mentioned as an associated feature in the text for certain DSM-IV disorders, they are not part of the criteria sets (except for mental retardation and learning disorders). The question of whether such tests should be added to criteria sets was debated for the sleep disorders during the DSM-IV process. It is likely to be raised during the DSM-V process for other disorders as well (e.g., Alzheimer's), especially in light of the progress being made in this area. Such laboratory testing already is included in many neurological and general medical diagnoses. ROC analyses of existing databases may provide an empirical basis for addressing this question.

This presentation will address this issue by focusing on a relevant disorder, such as Alzheimer's disease, and then discussing these questions more broadly, noting the advantages and disadvantages of incorporating laboratory results into diagnostic criteria. The questions include: Should laboratory tests be incorporated into DSM criteria?; What should be the criteria (e.g., sensitivity, specificity, cost, availability) for incorporating them into either text or diagnostic criteria?; and Should guidelines for their inclusion in DSM-V be developed? The cost of such testing will also be addressed.

No. 92B
THE DEFINITION OF MENTAL DISORDER REVISED

Jerome Wakefield, M.D., *309 West 104th Street, #9-C, New York NY 10025*

SUMMARY:

The issue of how to define mental disorders is at the heart of DSM. What are the boundaries between mental disorder and "normal" and "non-disordered"? What role, if any, should distress/impairment play in distinguishing disorder from non-disorder? To what extent should social or ethical values be considered when defining disorders? How should beliefs and norms of subcultures be taken into account?

One controversial issue involves the addition of a criterion to a number of disorders in DSM-IV requiring the presence of distress/impairment. Such a criterion seems useful for some disorders (e.g., those involving concerns common in the population); however, the addition of this criterion to certain disorders (e.g., Tourette's disorder and the paraphilias) has raised considerable controversy. Criteria

for determining which disorders should have a distress/impairment criterion have yet to be developed.

This presentation will consider the ways in which mental disorder has been defined in the past, including the problems that motivated past definitions and the further problems that have resulted from those definitions. The speaker will consider alternative definitions—including the pros and cons of such approaches—and explore ways in which the limitations of DSM-IV might be addressed.

No. 92C
SHOULD THE DIAGNOSTIC GROUPINGS BE REORGANIZED?

Katharine A. Phillips, M.D., *Butler Hospital/Brown Univ, 345 Blackstone Boulevard, Providence RI 02906*

SUMMARY:

During the DSM-IV development process, questions were raised about the grouping of disorders and whether some disorders should be moved to different categories. Such questions are likely to be raised for DSM-V. For example, the delusional variants of a number of disorders (OCD, body dysmorphic disorder) are classified separately from the nondelusional (i.e., nonpsychotic) variants. The question of whether these delusional and nondelusional variants actually constitute the same rather than different disorders was debated for DSM-IV, and this issue was handled inconsistently for these disorders. Should these disorders be classified like major depression, with the psychotic variant a subtype of depression rather than a separate disorder? This issue potentially applies to a number of other disorders (such as anorexia nervosa, phobias). What criteria should be used to determine whether disorders are grouped together?

As more is learned about disorders' etiology and pathophysiology, should the classification system be reorganized? How should information on etiology and pathophysiology (e.g., PET data) affect the organization of the DSM, and what guiding principles for reorganization should be used? This presentation will explore these questions and will discuss the pros and cons of such changes. The level of evidence needed for these changes will also be addressed.

No. 92D
DIAGNOSTIC DILEMMAS IN CHILD PSYCHIATRY

David Shaffer, M.D., *722 West 168th Street, Unit 78, New York NY 10032-2603*

SUMMARY:

The diagnosis of childhood disorders has numerous peculiarities, such as a paucity of pathognomonic clinical phenomena, occurrence of behaviors considered normal at one age but not at another, and dependence on multiple informants to establish diagnosis. Additional dilemmas are varying approaches to caseness and high comorbidity rates.

There are many questions regarding the validity of current diagnostic constructs in child psychiatry. There is little research on discriminant validity of anxiety disorders, many of ADHD's clinical features are nonspecific, and risk factors for oppositional-defiant disorder and conduct disorder are similar. There are varying approaches to caseness, (e.g., impairment is required for some diagnoses), which conflicts with the scientific need to identify phenotypes, regardless of their impact on function.

An outline of the history of diagnosis in child psychiatry will be presented, noting the influence of dimensional approaches, briefly review the diagnoses for which "Guzeian" criteria have been fulfilled, and it will put particular emphasis on validity issues noted above. Different approaches to caseness are discussed as are possible reasons (e.g., measurement techniques used) for high rates of co-occurrence between certain disorders (e.g., ODD and ADHD). The problem of multiple informants is addressed including explanations for parent/child disagreement and strategies for dealing with conflicting information.

No. 92E
PERSONALITY DISORDERS: CLINICAL UTILITY OF CLASSIFICATION APPROACHES

John Livesley, M.D., *Department of Psychiatry, University of British Columbia, 2255 Westbrook Mall, Vancouver, BC V6T 2A1, Canada*

SUMMARY:

The issue of whether personality disorders should be classified using a dimensional approach rather than categorically was debated for DSM-IV and discussed in the DSM-IV Options Book. A dimensional approach, especially if attainable by self-report, has some practical and conceptual advantages but may be difficult to apply in clinical settings. The current categorical system has also been criticized as not being adequately useful for clinicians. Another controversial issue involves the Axis I/Axis II dichotomy. While many felt that putting the personality disorders on a separate axis in DSM-III was valuable, questions have arisen regarding the wisdom of maintaining them on a separate axis. Do the advantages outweigh the disadvantages? Should DSM-V adopt the ICD system in which personality disorders are not on a separate axis?

This presentation will review the classification of personality disorders in the different editions of DSM. It will critique the categorical and dimensional models, with a focus on clinical utility. Alternative classification models (e.g., a hierarchical approach or a combined dimensional/categorical approach) will be explored and advantages and disadvantages considered. The pros and cons of maintaining a separate axis for personality disorders and alternatives to the current system will be discussed and critiqued.

REFERENCES:

1. Johnson KA, Jones K, Holman BL, et al: Preclinical prediction of Alzheimer's disease using SPECT. Neurology 1998; 50:1563–1571
2. Rauch SL: Advances in neuroimaging: how might they influence our diagnostic classification scheme? Harv Rev Psychiatry 1996; 4:159–162
3. Wakefield JC: The concept of mental disorder: on the boundary between biological facts and social values. American Psychologist 1992; 47:373–388
4. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, DC, American Psychiatric Association, 1994

SYMPOSIUM 93—THE DREAM 100 YEARS LATER: NEW FACTS, NEW THEORIES

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand and discuss several new views of dreaming, all of which emphasize the importance of emotions in dreams.

No. 93A
DREAMING AND EMOTION: A NEW THEORY

Ernest L. Hartmann, M.D., *Department of Psychiatry, Tufts Medical School, 27 Clark Street, Newton MA 02459*

SUMMARY:

I will summarize briefly the broad currents of thinking about dreams in the 20th century—Freud's and Jung's approaches, and various biological theories. The biological work has led to important knowledge about the biology of REM sleep. However, it is increasingly clear that REM sleep is not dreaming. Rather REM sleep is the most common, but by no means the only, facilitator of the complex state of the human cortex necessary for dreaming.

Research by Kramer, Foulkes, Cartwright, myself, and others, has led to a contemporary theory of dreaming. My work on dream series after trauma—as the trauma resolves—reveals consistent striking features. The traumatized person often dreams of being overwhelmed by a tidal wave, swept away by a whirlwind, or chased off a cliff. These dreams occur regardless of the nature of the experienced trauma. These dreams picture not the sensory experience, but the feeling, "I am overwhelmed." The powerful dream image *contextualizes* the emotion. This is paradigmatic: dreams contextualize (find a picture-context for) the dominant emotion or emotional concern. Based on blind ratings with good reliability, we find that such images are more frequent and more intense after trauma. They are also more frequent and more intense in dreams than in daydream material.

A contemporary theory, in outline: dreaming makes connections more broadly than waking in the nets of the mind (neural networks and connectionist nets will be discussed). The connections are not made randomly, but are guided by the dominant emotion or emotional concern. Dreaming contextualizes emotion. It does this in the form of picture-metaphor. The process may be functional—integrating or "weaving in" trauma or other new material.

No. 93B
THE DREAMING BRAIN RECONSIDERED

Mark L. Solms, Ph.D., *Neurosurgery, Royal London Hospital, Whitechapel, London E11BB, England*

SUMMARY:

This paper reviews recent neuroscientific findings about the dreaming brain. It summarizes the converging results of two major studies—one using the method of clinicoanatomical correlation (Solms, 1995, 1997) and the other, positron emission tomography (Braun et al., 1997, 1998). These studies cast serious doubt on the prevailing view that the brainstem control of REM sleep completely eliminates any possible "contribution of ideas (or their neural substrate) to the primary driving force of the dream process" (Hobson & McCarley, 1977, p. 1338). On the contrary, dreaming involves a highly specific pattern of activation and inhibition in those parts of the brain that subserve some of the highest motivational and symbolic mechanisms of the mind.

No. 93C
NEW METHODS FOR STUDYING DREAM CONTENT

G. William Domhoff, Ph.D., *Department of Psychology, University of CA-Santa Cruz, Psychology Department, USSC, Santa Cruz CA 95064*

SUMMARY:

This paper presents new methodologies for dream collection and for systematic content analysis of dreams. Research is presented showing that 100–125 "most recent dreams" from different subjects, or 75–100 dream journal reports from an individual are necessary to produce a representative sample.

The paper discusses widely accepted findings from content analysis studies demonstrating the consistency of dream content over years and even decades in an individual, the continuity between dream content and waking emotional concerns, and the frequent repetition of specific dream themes. The implications of these findings for theories of dream meaning, such as those of Freud, Jung, Hobson, and Crick/Mitchison, are discussed. The data are not consistent with any of these theories. It appears that a new theory of dream meaning may be necessary if these laboratory and content studies are accepted.

No. 93D
THE ROLE OF DREAMS IN MOOD REGULATION

Rosalind Cartwright, Ph.D., *Department of Psychology, Rush-Presbyterian, 1653 West Congress Parkway, Chicago IL 60612*

SUMMARY:

Dream content has been noted to relate to the dreamer's emotional issues, although often these are experienced with neutral affect. One explanation for this anomaly is the loss of muscle tone during REM sleep, making this a physiologically relaxed state. This may work to "desensitize" the dreamer to their "upsetting" emotions. If dreams have such an "internal therapist" role, it is hypothesized that: 1.) When pre-sleep affect is moderately high, unpleasant content will be progressively reduced across the night ("working through" effect), 2.) When pre-sleep affect is very high it may exceed ability for these to be defused within one night (i.e., depression, post trauma), 3.) When normals are in periods of good functioning, there may be no regularity to dream content successively, 4.) Improved morning mood will follow the "working through" from unpleasant to pleasant dreams within a night, 5.) Negative morning mood follows the reverse pattern of neutral dreams at the beginning and negative dreams at the end of night.

All of these proposals have been tested in samples of 60 normals and in 75 with untreated major depression. All hypotheses were confirmed in this research.

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2. Solms M: The Neuropsychology of Dreams: A Clinico-Anatomical Study. Mahwah, NJ, Lawrence Erlbaum Associates, 1997
3. Domhoff G: Finding Meaning in Dreams: A Quantitative Approach. New York, Plenum Press, 1996
4. Cartwright R, Lamberg L: Crisis Dreaming. New York, Harper Collins Publishers, Inc., 1992

SYMPOSIUM 94—DRUG-INDUCED DISEASE: WHAT EVERY PSYCHIATRIST NEEDS TO KNOW
The Food and Drug Administration

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: understand the diagnostic/management process utilized in the case of a patient with possible drug-induced psychiatric or non-psychiatric disease; describe how FDA reviews individual medication clinical investigational databases for adverse drug events (ADEs) and their impact on drug approval and labeling; explain clinical pharmacologic considerations (pharmacokinetic/pharmacodynamic) which underlie new drug approval and ADE management; list clinically significant psychiatric symptomatology associated with the use of certain non-psychiatric drugs; recognize special populations and risk factors (age, gender, race, genetic) for ADEs; describe how the FDA MEDWATCH program facilitates reporting of serious ADEs and

product problems, and enables psychiatrists to be important contributors to postmarketing surveillance.

No. 94A
PREMARKETING DRUG SAFETY EVALUATION: WHAT GOES INTO THE LABEL?

Thomas P. Laughren, M.D., *HFD-120, Food & Drug Administration, 5600 Fishers Lane, Rockville MD 20857-0001*

SUMMARY:

Demonstrating that a drug is reasonably safe under the conditions of its proposed use is one of the requirements for drug approval and also the basis for safety information included in the drug's initial approved labeling. Evaluating the safety of a new drug on the basis of premarketing studies is a challenge, since this database is generally relatively small and premarketing studies are focused mostly on showing effectiveness rather than safety. In fact, the approach to analyzing for safety is more a process of estimation and exploration than the hypothesis testing that characterizes the analysis of effectiveness data.

This talk will focus on the approach used at FDA to evaluate the premarketing safety database for a new drug, beginning with a characterization of that database. The general goals of this process are to (1) identify causally related adverse events, (2) estimate the risk for those events, and (3) identify risk factors for those events, including patient factors such as age and gender, and drug factors such as dose and duration of use. If successful, this process will reveal the more common adverse events associated with a drug's use, but will likely not identify the rare events that often emerge only after marketing.

No. 94B
DRUG-INDUCED DISEASE: PHARMACOKINETIC AND PHARMACODYNAMIC CONSIDERATIONS

Charles J. Ganley, M.D., *HFD-110, Food & Drug Administration, 5600 Fishers Lane, Rockville MD 20852*

SUMMARY:

Clinical pharmacology involves the study of pharmacokinetic and pharmacodynamic relationships. The understanding of the pharmacokinetic and pharmacodynamic attributes of a drug product are important for the determination of a proper therapeutic dose range. They are also important in evaluating and explaining causality for a possible drug-related adverse event (i.e., whether the event is an exaggerated response to a known pharmacodynamic effect).

This presentation will discuss the use of clinical pharmacology principles in the assessment of drug-induced adverse events. There will be an emphasis on cytochrome P450 metabolism, identification of sensitive subgroups in the population and drug-drug interactions. Drugs approved for noncardiac indications that can prolong the QTc interval under certain conditions will be used as examples.

No. 94C
CLINICAL ASSESSMENT, WORK-UP, AND REPORTING OF ADVERSE DRUG EVENTS

Stephen A. Goldman, M.D., *Medwatch, Food and Drug Administration, 5600 Fishers Ln/HF-2/Rm 17-65, Rockville MD 20857*

SUMMARY:

The clinical assessment of adverse drug events (ADEs) is an important and complex task for psychiatrists and other health professionals to master. ADE recognition is impacted by its acknowledged subjectivity, and distinguishing between an ADE and normal disease can be difficult and sometimes impossible, as both may act through the same physiological and pathological pathways. As a result, it is often hard to reach a firm conclusion that a particular adverse event's occurrence is linked to drug exposure.

These considerations emphasize the need for a systematic approach to diagnosing drug-induced disease. Various structured strategies, and understanding such concepts as dechallenge and rechallenge, can be of great utility in ADE assessment. Of tantamount importance is the use of clinical experience and judgment and knowing how to augment one's pharmacological knowledge base.

A drug's safety profile is an evolving, ongoing process deriving from postmarketing clinical experience. Including a possible ADE or drug-drug interaction in the differential diagnosis of a patient's disease or clinical symptoms should become part of the regular evaluative thought process. Further, by reporting serious adverse events/product problems to FDA's MEDWATCH program, psychiatrists and other health professionals can play a major role in improving the public health.

REFERENCES:

1. Goldman SA, Kennedy DL, Lieberman R, editors: Clinical therapeutics and the recognition of drug-induced disease. MEDWATCH Continuing Education Article. Rockville, Md, Food and Drug Administration, June 1995
2. Rawlins MD, Thompson JW: Mechanisms of adverse drug reactions, in Textbook of Adverse Drug Reactions, ed. 4. Edited by Davies DM. Oxford, Oxford University Press, 1991, pp. 18–45
3. Park PK, Pirmohamed M, Kitteringham NR: Idiosyncratic drug reactions: a mechanistic evaluation of risk factors. Br J Clin Pharmacol 1992; 34:377–395
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6. Irey NS: Tissue reactions to drugs. Am J Pathol 1976; 82:617–647
7. Stephens MDB: The diagnosis of adverse medical events associated with drug treatment. Adv Drug React Ac Pois Rev 1987; 1:1–35
8. Goldman SA: The clinical impact of adverse event reporting. MEDWATCH Continuing Education Article. Rockville, Md, Food and Drug Administration, October 1996

Component Workshop 1
POLITICAL VIOLENCE AND TERRORISM AT THE MILLENNIUM
APA Corresponding Task Force on National and International Terrorism and Violence

Chairperson: Jerrold M. Post, M.D., *Political Psychology, George Washington University, 2013 G Street, NW, Ste 202A, Washington DC 20052*
Participants: David A. Rothstein, M.D., Kenneth Deklava, M.D., Stevan M. Weine, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the psychopolitical forces contributing to ethnic-nationalist violence, the political consequences of persistent traumatic wounds in the collective national psyche, and the psychopolitical forces associated with the changing face of international terrorism.

SUMMARY:

As we approach the new millennium, the international security environment is increasingly unstable. With the end of the cold war, the relative stability of the superpower rivalry has been replaced by a series of dangerous regional conflicts, a rise in ethnic-nationalist violence, and a change in the pattern of international terrorism. This workshop will explore the psychopolitical forces associated with these patterns, considering national identity formation and the need for enemies. Consideration will be given to the impact of the collective trauma in Bosnia; the political consequences of persistent wounds in the collective psyche; the influence of leadership on the ethnic cleansing in Bosnia and Kosovo; the underlying dynamics of ethnic-nationalist conflict and violence; and the changing face of terrorism. We will consider the amorphous nature of transnational terrorism, given tragic emphasis by the embassy bombings in Kenya and Tanzania, and prospects for weapons of mass destruction terrorism.

REFERENCES:

1. Robins R, Post J: Political Paranoia: The Psychopolitics of Hatred. Yale University Press, 1997.
2. Weine S: When History Becomes a Nightmare. Rutgers Univ. Press, 1999.

Component Workshop 2
WHAT'S NEXT? ISSUES IN MID-CAREER DEVELOPMENT
APA Committee on Women and the Association of Women Psychiatrists

Chairperson: Deborah Spitz, M.D., *New England Medical Center, Box 1007/750 Washington Street, Boston MA 02111-1526*
Participants: Diana Chapa, M.D., Samantha E. Meltzer-Brody, M.D., Leah J. Dickstein, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: identify adult developmental issues at midlife, describe changes in career trajectories at midlife for men and women, and discuss the interaction of midlife developmental issues and career options.

SUMMARY:

Adult development at midlife is marked by deepening involvement in meaningful activities, a realistic assessment of areas of mastery, the acknowledgment of limitations and roads not taken, and the movement toward generativity. Midlife career development reflects similar issues: the need to reassess and redefine career goals, how to select among a plethora of demands to best realize those goals and objectives, how to handle the transition to a more intense or a less demanding career path, and ultimately how to define retirement. This workshop will provide a forum for the discussion of mid-career issues in the context of midlife adult development. Presenters will share data about choices of mid-career professionals and identify critical decision points at mid-career, applicable to psychiatrists in academia, clinical practice, and administration.

REFERENCES:

1. Gilligan C: The vulnerable and invulnerable physician in Gilligan, Ward, Taylor Bardige, Eds, Mapping the Moral Domain: A Contribution of Women's Thinking to Psychological Theory and Education, Cambridge, Harvard Univ. Press, 1988.
2. Neugarten BL: The Meanings of Age, Chicago, Univ. of Chicago Press, 1996.

Component Workshop 3
RISK MANAGEMENT ISSUES IN PSYCHIATRIC PRACTICE
Psychiatrists' Purchasing Group, Inc.

Chairperson: Alan I. Levenson, M.D., *75 North Calle Resplendor, Tucson AZ 85716*
Participants: Ellen R. Fischbein, M.D., Martin G. Tracy, J.D., Frank G. Feeley, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize diagnostic categories that reflect the highest risk for suit; to be familiar with risks presented by organized systems of care as well as common risk management issues that arise out of supervisory relationships; to gain insight into general methods of protecting against risks inherent in these relationships; to 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, academia, 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. 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, as well as the risks associated with new forms of telecommunication. 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, residents, educators, and administrators will be discussed.

Component Workshop 4
QUALITY OF MENTAL HEALTH IN PUERTO RICO
APA Puerto Rico Psychiatric Society

Chairperson: Nestor J. Galarza, M.D., *Puerto Rico Psych Society, 33113 Veterans Plaza, San Juan PR 00933*
Participants: Sarah Huertas-Goldman, M.D., Lloyd I. Sederer, M.D., Ramon H. Parrilla, M.D., Eric D. Lister, M.D., Victor J. Llado, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop participants will have a better understanding of the recent mobilization of the health care movement

in a specific Hispanic community of the United States. They will appreciate the positive and negative effects of the local government-sponsored managed health reform on the quality of mental health care.

SUMMARY:

Over 40 psychiatrists, health care consultants, patient advocates, researchers, psychologists, nurses, social workers, government officials, hospital administrators, and insurance and managed behavioral health care personnel held an invitational Quality Summit in San Juan.

Several years ago the Puerto Rico Psychiatric Society (PRPS) requested consultation from the American Psychiatric Association (APA), its parent organization, to analyze and influence radical changes that were occurring in the delivery of mental health services in Puerto Rico as a consequence of government health reform (reforma). In October of 1997, two APA consultants, briefed by leadership of the PRPS, met with a representative group of psychiatrists, researchers, and leaders from governmental and private health and mental health care agencies and organizations. One conclusion from that meeting was that mental health service delivery in Puerto Rico was lacking in consensus policy development, particularly regarding quality performance standards for patient care. Consequently, a principal recommendation from the initial APA consultation was to convene a Quality Summit in 1998. This Quality Summit was held on April 17, 1998 in San Juan, Puerto Rico. Participants in this component workshop will be encouraged to give their own views on the issues based on their particular experiences.

REFERENCES:

1. Proceedings from the Quality Summit on Mental Health Care in Puerto Rico, San Juan, P.R., April 1998.
2. Sederer LI, Dickey B: Outcomes Assessment in Clinical Practice, Baltimore, William and Wilkins, 1996.

Component Workshop 5
THE CHANGING FACE OF PSYCHIATRY
APA Committee of Early Career Psychiatrists

Chairperson: James M. Slayton, M.D., *Cambridge Hospital, 90 Forest Hill Street, #1, Jamaica Plain MA 02130-2935*
Participants: Gabriela Cora-Locatelli, M.D., Anand Pandya, M.D., Joseph I. Sison, M.D., Emily A. McCort, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize how diversity of personal background and interest informs the career choice of new psychiatrists. Participants will discuss part-time careers, getting an extra degree (MPH versus MBA), working within an HMO, and how to integrate basic science or clinical research into one's career.

SUMMARY:

Five early career psychiatrists from diverse backgrounds will discuss their choices as they began "life after residency," and where they stand in their career plans at the present time. Participants will have the opportunity to pose questions and hear from senior APA leadership as discussants on how career choice has changed along with the demographic characteristics of the psychiatric workforce. Balancing personal and family interests with one's professional career will be emphasized. Reference will be made to more traditional psychiatric careers and their practitioners in the emerging mental health workforce. Groups with increasing numbers of psychiatrists, such as international medical graduates and women, will be recognized in their role of expanding traditional career expectations. At the conclusion, participants will be more cognizant of the spectrum of careers, ranging from administrative psychiatry to basic science research, from full- to part-time, and from academic to industry-based careers.

REFERENCES:

1. Menninger EW: The impact of the family on careers in psychiatry. Bulletin of the Menninger Clinic 1994; 58:497-501.
2. Sharfstein SS: Economics redefining the practice of psychiatry. Bulletin of the Menninger Clinic 1994; 58:447-453.

Component Workshop 6
PSYCHIATRY'S FUTURE: MEETING BUSINESS'S UNMET NEEDS
APA Committee on Occupational Psychiatry

Co-Chairperson: Leonard T. Sperry, M.D., *Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee WI 53226*, Rodrigo A. Munoz, M.D., *University of CA at San Diego, 3130 5th Avenue, San Diego CA 92103*
Participants: Stephen H. Heidel, M.D., William Wilkerson, Edgardo L. Perez, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize several misperceptions business executives have of psychiatry and psychiatric services; to indicate some of business's unmet needs that psychiatry could meet; to describe how business roundtables can foster dialogue between business and psychiatry; and to describe ways in which psychiatry can turn these needs into practice opportunities.

SUMMARY:

The current APA president will convene this program to highlight the importance for psychiatry's future of psychiatry's involvement in the workplace. A recent survey of business executives sponsored by the American Psychiatric Foundation found that executives harbor several misperceptions of mental illness in the workplace (i.e., "that ignoring mental illness is more cost-effective than treating it"; "the belief that cost related to mental illness is increasing" when, in fact, it is decreasing), and that these executives have several unmet needs that psychiatrists could meet. This workshop will describe how psychiatrists can and have entered into dialogue with business executives to clarify perceptions of mental health needs and services in the workplace and ways in which psychiatry can meet many of these unmet needs. An example of this kind of dialogue between a psychiatrist and the former president of a major corporation will be demonstrated. Several action plans will be offered for both individual psychiatrists and APA district branches. This program is meant to be as interactive as possible: besides the demonstration, sufficient time will be scheduled so that both panel and audience can interact with a prominent business executive and each other about psychiatry's opportunities in the workplace.

REFERENCES:

1. Dauphinais W, Price C: Straight from the CEO. New York, Simon & Shuster, 1998.
2. Sperry L: Psychiatric Consultation in the Workplace. Washington, DC, American Psychiatric Press, Inc., 1993.

Component Workshop 7
PARTNERS IN PRACTICE
APA Auxiliary

Co-Chairpersons: Harold I. Eist, M.D., *5705 Rossmore Drive, Bethesda MD 20814-2227*, Ann M. Eist, B.A., *5705 Rossmore Drive, Bethesda MD 20814-2227*
Participants: Arnold D. Goldman, M.D., Marilyn Goldman, J. Alfred Le Blanc, M.D., Jacquelyn M. Le Blanc

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to advise practitioners of regularly occurring problems and stresses

not ordinarily touched upon in training programs. The focus will be on day-to-day management of practice with spouse involvement combined with clinical issues. Young practitioners as well as the more experienced will learn how spouses can work together successfully.

SUMMARY:

The workshop will encourage lively discussion and information exchange between practitioners and spouses, practitioners' spouses, and spouses who are both residents. Issues to be examined include defining and dealing with psychiatric emergencies (e.g., What does a spouse do when a suicidal patient calls?); business aspects of medicine, including scheduling of appointments, billing, insurance, medical-legal issues, managed care, confidentiality, transference and countertransference issues, the non-paying patient (how many can a practice/family tolerate?). Also, the multiple dynamic implications of a home-office will be discussed. The workshop will examine the largely positive and some of the negative aspects of spouses working together as partners in practice. Spouses working together can foster better care and enhance mutual understanding, support, and empathy.

Participants will be asked to bring vignettes for discussion. For instance, how does a spouse deal with a patient calling late at night demanding, "Is Dr. _____ (your husband/wife) in bed with *you?*

REFERENCES:

1. American Medical Association Alliance: What every physician's spouse should know ... working in your spouse's office, 1993.
2. O'Connell L: Full-time mergers, Washington Post, 9/3/92, page D5.

Component Workshop 8
ADDICTION TRAINING STRATEGIES FOR PSYCHIATRIC RESIDENTS
APA Committee on Training and Education in Addiction Psychiatry

Chairperson: David R. McDuff, M.D., *Department of Psychiatry, University of Maryland, 701 West Pratt Street, Baltimore MD 21201*
Participants: Richard Belitsky, M.D., Jeremy A. Herschler, M.D., Jeffrey A. Berman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe and discuss the core topics and essential practice skills to be learned over four years in a model, general residency, addiction-training program; to apply addiction-training strategies endorsed by a group of general residents and/or used in academic psychiatry departments with accredited addiction psychiatry residency programs.

SUMMARY:

Alcohol and other drug-related disorders are common in the general population and even more common among medically and psychiatrically ill persons. Over the last decade, addictions faculty have developed suggested lists of core didactic topics and essential clinical experiences and descriptions of innovative educational strategies to train general psychiatrists to be competent in addictions diagnosis and treatment. Using published descriptions of model programs, survey data about addictions training during general residency, and satisfaction survey data from general psychiatry residents, a four-person panel of training directors and trainees will suggest minimal training standards, describe effective program design, and discuss innovative training strategies. First, an addiction training director will describe the didactic topics and clinical rotations of three model programs. Second, a general residency program director will discuss strategies for balancing the competing priorities of addiction, consultation-liaison, child, community, emergency, forensic, and geriatric psychiatry during general training. Third, a senior addictions fellow will report on survey results about addictions training in the 25 general residency programs that also have an addiction residency program. Finally, a senior psychiatry resident will discuss survey results from a sample of general residents on their views of the adequacy of their addiction training. Audience participation will be solicited after each presentation and at the end of the workshop to arrive at consensus description about acceptable and ideal addictions training during general residency.

REFERENCES:

1. Westreich L, Galanter M: Training psychiatric residents in addiction. Substance Abuse 1997; 18:13-25.
2. Halikas JA: Model curriculum for alcohol and drug abuse training and experience during the adult psychiatry residency. Am J Addictions 1992; 1:222-229.

Component Workshop 9
CULTURAL PERSPECTIVES ON COMING OUT IN PSYCHIATRY
APA Southern California Psychiatric Society's Committee on Gay, Lesbian and Bisexual Issues

Chairperson: Nick M. Gutierrez, M.D., *Department of Psychiatry, UCLA-NPI, 7510 West Sunset Blvd. #556, Los Angeles CA 90046*
Participants: William Arroyo, M.D. Clayton L. Chau, M.D., Robert T. Saray, M.D., Kevin P. Hayes, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize that several important factors impact on an individual's experience of coming out as a gay psychiatrist. This workshop aims to expose members, both straight and gay, to some of the different cultural, ethnic, and personal variables that may affect one's experience of coming out in training and in the workplace.

SUMMARY:

Cultural and ethnic factors may add to the complexity of the often difficult experience of coming out as a gay psychiatrist. Panel members will discuss how their own cultural backgrounds impacted on their experience of coming out in the field of psychiatry. The audience will have the chance to participate by asking questions of each panel member.

Dr. Chau will share his experiences and the difficulties he has encountered as a gay, Asian-Pacific American psychiatrist and how he is able to deal with these on a daily basis. Dr. Gutierrez will discuss how his Latino culture and its prevalent "machismo" attitude affected his ultimate decision to come out during training. Dr. Saray believes that many of the issues he has faced being a gay, Jewish-American psychiatrist can be dealt with in creative ways and will share his ideas about these. Dr. Hayes will lend his perspective on being a gay, African-American psychiatrist and how the cultural and ethnic barriers he encountered strengthened his own personal and professional identity. Dr. Arroyo will conclude the workshop with his perspective as a gay, Mexican-American psychiatrist and will discuss the issue of cultural variables and their impact on gay mental health trainees.

REFERENCES:

1. Cabaj RP: Gay, lesbian, and bisexual mental health professionals and their colleagues, in Textbook of Homosexuality and Mental Health. Edited by Cabaj RP, Stein TS. Washington, DC, American Psychiatric Press, 1996, pp. 33–42

2. Atkins DL, Townsend MH: Issues for Gay Male, Lesbian, and Bisexual Mental Health Trainees. Edited by Cabaj RP, Stein TS. Washington, DC, American Psychiatric Press, 1996, pp 645–658

Component Workshop 10
UNIQUE ROLE OF INDIVIDUAL SUPERVISION IN PSYCHIATRIC EDUCATION
APA Committee on Graduate Education

Chairperson: James W. Lomax II, M.D., *Department of Psychiatry, Baylor University, One Baylor Plaza, Ste 619D, Houston TX 77030*
Participants: Carol A. Bernstein, M.D., Jacqueline C. McGregor, M.D., Marjorie E. Waldbaum, M.D.

EDUCATIONAL OBJECTIVES:

Participants should be able to define what is learned from individual supervision that is not learned in lectures, seminars, or clinical supervision. Participants should also be able to understand the importance of obtaining an educational history of the supervisee and to initiate behaviors correlated with successful supervisory outcomes.

SUMMARY:

Drs. Lomax and Bernstein will review the defining elements of supervision that distinguish it as an educational process unique to psychiatric education. Videotape stimuli will show predictable problems encountered in individual supervision, and the audience will have the opportunity to discuss potential supervisory responses that facilitate learning by a supervisee. Structuring of supervisory interventions ranging from didactic instruction and modeling to clarification, confrontation, and interpretation will be demonstrated.

REFERENCES:

1. Jacobs D, David P, Meyer DJ: The Supervisory Encounter. New Haven, Yale University Press.
2. Binder JL, Strupp HH: Supervision of psychodynamic psychotherapies in Handbook of Psychotherapy Supervision, edited by Watkins CE, New York, Wiley, 1997.

Component Workshop 11
SILDENAFIL CITRATE, SEXUAL FUNCTION, AND HIV PREVENTION
APA Commission on AIDS

Chairperson: Marshall Forstein, M.D., *Department of Psychiatry, The Cambridge Hospital, 24 Olmstead Street, Jamaica Plain MA 02130*
Participants: Stephen J. Ferrando, M.D., Francisco Fernandez, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to examine the clinical, psychological, and ethical issues surrounding the advent of pharmacologic agents used to treat sexual dysfunction.

SUMMARY:

Clinical experience shows that sexual dysfunction is a common problem in both men and women affected by or infected with HIV. Metabolic, endocrine, psychiatric, and psychological factors, as well as pharmacological treatment all contribute to the emergence of disorders of sexual desire, arousal, and orgasm. Concerns have emerged in the context of being able to now treat erectile dysfunction in HIV+ men and the implications for primary and secondary HIV prevention. This workshop will explore the moral, social, political, and psychological dimensions as well as medical issues related to sexual function and HIV transmission.

REFERENCES:

1. Brown G, Kendall S, Ledsky R: Sexual dysfunction in HIV-seropositive women without AIDS. Journal of Psychology and Human Sexuality 1995; 7:73-97.
2. Fisher W: Do no harm: on the ethics of testosterone replacement therapy for HIV+ persons. Journal of Sex Research 1977; 34:35-36.

Component Workshop 12
WHAT SPECIALTY IS FOR ME? RESEARCH, FORENSICS, CHILD AND ADOLESCENT, OR GERIATRICS?
APA Assembly Committee of Area Member-in-Training Representatives

Chairperson: Judythe S. McKay, M.D., *Department of Psychiatry, WS Hall Psychiatric Institute, 1800 Colonial Drive, Box 202, Columbia SC 29202*
Participants: Gabriela Cora-Locatelli, M.D., Patrice A. Harris, M.D., Gregory J. Brown, M.D., Daniel Weintraub, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop the participant should be able to recognize two pros and cons of going into research, geriatrics, C&A, or forensics psychiatry, to describe two questions psychiatry residents should ask themselves when deciding about a specialty, to describe how choosing a fellowship in one of these areas could change the course of their career.

SUMMARY:

As the 21st century approaches, more and more specialty areas are available to residents. Questions often asked by residents are: Should I specialize? How do I decide? How would doing a specialty fellowship change the course of my career? This workshop will focus on helping residents learn more about four specialty areas in psychiatry: forensics, child and adolescents, geriatrics, and research; help them formulate questions they should answer before deciding on a specialty; and give them suggestions on what they can do now to help decide.

The workshop will begin with early career psychiatrists who specialized telling their story: The struggles they had making their choice; why they chose the field they did; what training they had to have; and what they like and dislike about their field. Next will be an interactive exchange where the participants can ask questions regarding any of these fields. For the final half hour the group will be divided into four groups: research, forensics, geriatrics, and child and adolescent. The participants can join the group they are most interested in or they can rotate between groups to get more information about each.

REFERENCES:

1. Borus JF, Sledge WH: The American Psychiatric Press Synopsis of Psychiatry. Washington, D.C. American Psychiatric Press, Inc., 1996, pp. 1357-1370.
2. Dorwart R: A national study of psychiatrist's professional activities. Am J Psychiatry 1992; 149:1499-1505.

Component Workshop 13
PEARLS AND PITFALLS OF WORKING WITH ETHNIC CAREGIVERS
APA Committee on Ethnic Minority Elderly

Chairperson: Rita R. Hargrave, M.D., *University of CA at Davis, 4338 Leach Street, Oakland CA 94602-1336*
Participants: Dolores Gallagher-Thompson, Ph.D., Gwen Yeo

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants will be able to 1) recognize demographic, sociocultural, and psychological factors

that influence the working relationship between family caregivers of ethnic minority elders and 2) develop strategies that improve communication and effective collaboration with ethnic minority elders and their caregivers.

SUMMARY:

Ethnic minority patients represent the fastest growing segment of the elder population in the U.S. Earlier studies have reported the underutilization of formal care services by ethnic minorities and suggest that networks of family and friends provide the bulk of the needed care. Due to economic and social changes and the decreased availability of family caregivers, ethnic minority elders are increasingly using nursing homes, home care, and other formal care services. This workshop is designed to highlight cultural factors (e.g., health beliefs, knowledge of services, trust, and density of social network) that influence the perception and use of health care services by ethnic elderly and their caregivers. The workshop can assist with the development of culturally sensitive treatment planning that accommodates the special needs and concerns of this population. The workshop will outline practical guidelines for working effectively with ethnic minority elders and their caregivers. The workshop will be valuable to mental health professionals, physicians, nurses, social workers, and health care administrators who participate in the care of ethnic minority elders.

REFERENCES:

1. Yeo G, Gallagher-Thompson D: Ethnicity and the Dementias, Washington DC, Taylor and Francis, 1996.
2. Cox C, Monk A: Minority caregivers of dementia victims: a comparison of Black and Hispanic families. Journal of Applied Gerontology 1990; 9:340-350.

Component Workshop 14
SPECIAL POPULATIONS IN RURAL PSYCHIATRY
APA Corresponding Task Force on Rural Psychiatry

Chairperson: Stuart A. Copans, M.D., *Brattleboro Retreat, 75 Linden Street, Brattleboro VT 05302*
Participants: Diane K. Fast, M.D., Stephen A. Cole, M.D., Ben Coplan, B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should have learned the characteristics of rural native Americans and first nations peoples, rural immigrants, and rural homeless. They should be able to help plan primary and secondary prevention programs for these populations and to provide assessment and treatment.

SUMMARY:

This workshop will focus on skills and knowledge involved in meeting the clinical needs of rural patients coming from three different populations, rural Native Americans or First Nations Peoples, rural immigrants, and the rural homeless. For each group the speaker will outline the barriers that make delivering optimal care difficult in rural areas, discuss some of the clinical characteristics of the population, and address approaches that have been used to overcome barriers to the provision of good clinical care.

In working with rural Native Americans and First Nations Peoples, it is crucial to learn the differences between the belief systems of different tribes and to learn to work with indigenous healers.

In working with immigrants it is important to understand the stresses all immigrants face, but also to understand the differences between different immigrant populations.

The rural homeless are often invisible and in small towns have few psychiatric services available to them. Providing treatment and support services may be discouraged by small-town governments because of fears that such services may attract mentally ill persons.

Each presentation will be followed by a discussion session in which workshop attendees can share their own experiences and knowledge.

REFERENCES:

1. Manson SM., Walker RD., Kivlahan DR: Psychiatric assessment and treatment of American Indians and Alaska Natives. Hospital and Community Psychiatry 1987; 38:165-173.
2. Copans SA: Immigrant and refugee children, in Handbook of Child and Adolescent Psychiatry, Vol. 4: Varieties of Development, edited by Alessi NE, New York, J. Wiley and Sons, pp. 619-631.

Component Workshop 15
HELP FOR HIGH-RISK SCHOOLS: MENTORING PROGRAMS THAT WORK
APA Committee on Psychiatry and Mental Health in the Schools

Co-Chairpersons: Lois T. Flaherty, M.D., *University of Pennsylvania, 770 Lantern Lane, Blue Bell PA 19422-1612,* Joan E. Kinlan, M.D., *3843 Massachusetts Avenue, NW, Washington DC 20016-5102*
Participants: Margaret Delorme, Trina B. Allen, M.D., John McCarthy

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to demonstrate an awareness of the role of of mentoring in adolescent development, recognize the essential qualities of effective mentoring programs, and learn how to help develop mentoring programs in urban schools.

SUMMARY:

The public awareness of the extent of the exposure to violence in inner city schools and the high dropout rates have fostered the idea that these schools offer little in the way of hope for their students and that these are violent and dangerous warrens. Studies on resiliency have shown the salutary effect of a significant adult outside the family for high risk youth. The adolescent period is a time of plasticity during which identity formation is a major task. Mentors can play an important role in adolescent development. Mentoring is an intervention that has implications for fostering healthy development as well as addressing psychopathology. Boys and girls have different developmental needs. Dr. Flaherty will present an overview of the research on the efficacy of mentoring programs and present a conceptualization of the role of the mentor in adolescent identity development. Margaret Delorme, from High Expectations, and John McCarthy, director of Elementary Baseball, will each describe a successful mentoring program in the Washington DC area. Dr. Kinlan will give a commentary based on her familiarity with these programs. Dr. Allen, an APA/CMHS Zeneca Minority Fellow and former teacher, will discuss the schools' perspectives. The audience will be encouraged to share experiences and consider how mental health professionals can contribute.

REFERENCES:

1. Freedman M: Kindness of Strangers: Adult Mentors, Urban Youth and the New Volunteerism, San Francisco, Jossey Bass, 1993.

2. Stiffman AR, Earls F, Dore P: Adolescent violence. In Handbook of Adolescent Health Risk Behavior, Edited by DiClemente R, Hansen WB, Ponton LE., New York, Plenum, 1996, pp. 289-312.

Component Workshop 16
INNOVATION IN VETERANS AFFAIRS RESEARCH: MENTAL ILLNESS RESEARCH EDUCATION AND CLINICAL CENTERS
APA Consortium on Special Delivery Settings

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, 4301 West Markham, Slot 554, Little Rock AR 72205-7101,*
Participants: Bruce J. Rounsaville, M.D., Murray A. Raskind, M.D., Stephen R. Marder, M.D., Thomas B. Horvath, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, participants should be able to describe the goals and areas of study of VA's Mental Illness Research Education and Clinical Centers, including basic science studies in genetics and molecular biology, pharmacological and psychosocial management, and services delivery research on major mental disorders.

SUMMARY:

This presentation describes the VA's innovative new Mental Illness Research Education and Clinical Centers (MIRECCs), each of which is dedicated to a range of scientific endeavors from basic science to services delivery research. Drs. Guggenheim and Lehmann will serve as co-chairs, introducing the other presenters. Connecticut/ Massachusetts MIRECC Director Bruce Rounsaville, M.D., will discuss studies on practice patterns and costs of dually diagnosed vs. homogeneous patient groups; clinical effectiveness research on pharmacotherapies and neurobiological studies of dually diagnosed patients. Northwest Network MIRECC Director Murray Raskind, M.D., will discuss projects ranging from molecular genetics to health services research affecting veterans with schizophrenia, post-traumatic stress disorder (PTSD) and psychosis in dementia. Southern California MIRECC Director Stephen Marder, M.D., will discuss projects directed towards improving long-term functional outcome of patients with chronic psychotic mental disorders, including schizophrenia, schizoaffective disorder, and psychotic mood disorders.

REFERENCES:

1. Lehman AF, Carpenter WTJ, Goldman HH, Steinwachs DM: Treatment outcomes in schizophrenia: implications for practice, policy, and research. Schizophr Bull 1995; 21:669-75.
2. Poorkaj P, Bird TD, Wijsman E, et al: Tau is a candidate gene for chromosome 17 frontotemporal dementia. Ann Neural 1998; 43:815-825.

Component Workshop 17
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 workshop, 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 workship will address difficult challenges commonly encountered by psychiatrists working in nursing home settings. These challenges 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 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. 1994; 78:895-909.
2. Reichman WE, Katz IR: Psychiatric Care in the Nursing Home. New York, Oxford University Press, 1996.

Component Workshop 18
GENDER EQUITY IN MEDICAL SCHOOL AND RESIDENCY
APA Rhode Island Psychiatric Society

Chairperson: Alison M. Heru, M.D., *Department of Psychiatry, Brown Univ./Butler Hospital, 345 Blackstone Boulevard, Providence RI 02906,*
Participants: Patricia R. Recupero, M.D., Andrea J. Mernan

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to introduce to those in leadership positions the importance of being proactive to prevent sexual harassment complaints and demonstrate a gender supportive environment; 2) to educate faculty, residents and medical students in the recognition of sexual harassment and to identify problem-solving options for resolution; 3) to introduce a curriculum to promote gender equity.

SUMMARY:

The Brown University Gender Equity Program, in conjunction with members of the Rhode Island Psychiatric Society Committee on Women, has formalized an educational program directed at medical students and residents to increase their sensitivity and awareness of sexual harassment and related issues. Videotapes will be shown of residents role playing, followed by a discussion by these residents of their participation in this educational activity. Participants in this workshop will be asked to give opinions and ask questions of the residents and presenters. The participants will describe a program of management of gender equity issues that has been used at the university. The goals of the program are to educate students and faculty about gender-related harassment issues, provide an advisory resource for students seeking guidance on these issues, and provide a confidential resource outside the formal university procedures to help students clarify their concerns and evaluate their options in reporting or otherwise dealing with these issues.

REFERENCES:

1. Baird CL, Bensko NL, Bell PA: Gender influence on perceptions of hostile environments and sexual harassment. Psychological Reports 1995; 77:79-82.
2. Sexual Harassment in the Workplace and Academia, edited by Shrier DK, American Psychiatric Press Clinical Practice Series (#38), Washington DC, APPI, 1996.

Component Workshop 19
LEGAL UPDATE: MANAGED CARE, PRIVACY, AND SEX OFFENDERS
APA Council on Psychiatry and Law and APA Commission on Judicial Action

Chairperson: Renee L. Binder, M.D., *Department of Psychiatry, Langley Porter Institute, 401 Parnassus Avenue, Box F, San Francisco CA 94143,*
Participants: J. Richard Ciccone, M.D., Paul S. Appelbaum, M.D., Howard V. Zonana, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to demonstrate an understanding about the work of the APA Council on Psychiatry and Law and the Commission on Judicial Action concerning topics of importance to psychiatric practice including managed care, confidentiality, and the treatment of sex offenders.

SUMMARY:

The APA Council on Psychiatry and Law and the APA Commission on Judicial Action have the responsibility of addressing psychiatric practice issues from legal, legislative, and judicial perspectives. This involves influencing and monitoring psychiatric issues in legislatures and the courts and developing position statements, resource documents, and task force reports, and filing amicus curiae briefs in court cases. The purpose of this presentation is to inform APA members about recent projects of the Council on Psychiatry and Law and Commission on Judicial Action.

Dr. Renée Binder, chair of the Council on Psychiatry and Law, will give a brief overview. Then Dr. Richard Ciccone, chair of the Commission on Judicial Action, will report on recent cases involving ERISA and managed care. Next, Dr. Paul Appelbaum will update the audience on privacy and confidentiality issues. Finally, Dr. Howard Zonana, chair of the Task Force on Sexually Dangerous Offenders, will discuss recent developments in this area. The audience will have the opportunity for an active interchange with the presenters and will be encouraged to give suggestions for future efforts in these areas.

REFERENCES:

1. American Psychiatric Association Task Force Report on Sexually Dangerous Offenders. Approved by Board of Trustees, July 1998, Washington DC, APPI, 1999.
2. Appelbaum PS: A "health information infrastructure" and the threat to confidentiality of health records. Psychiatric Services 1998; 49:27-28-33.

Component Workshop 20
MAKING ORDER OUT OF CHAOS: RESIDENTS AND INSTITUTIONS
APA Committee of Residents and Fellows

Chairperson: Derek G. Puddester, M.D., *Department of Psychiatry, McMaster University, 726 Spring Gardens Road, Burlington, ONT L7T 1J3, Canada*
Participants: Lori Simon, M.D., Geoffrey M. Gabriel, M.D., Tracey L. Irvin, M.D., Julie Holman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe the most significant regulatory bodies, organized medical institutions, and other agencies that have influence over the training and practice of psychiatry; to help participants understand how these agencies relate to their own training and development, as well as how to contact and interface with such agencies.

SUMMARY:

The shared goal of trainees is to complete their training and practice as independent consultants. While this process may appear to be one managed by program directors and departments of psychiatry, it is open to the regulatory and political forces of many agencies. Many residents are unaware of the diversity of agencies that have significant influence over their training and may not be aware of the supportive and advocacy role some of these agencies may offer. We will review agencies in the domains of education, licensure, discipline, and resource management. Ultimately, the speakers will describe a map of sorts, with a large red arrow flashing "You are here," and will make liberal use of the World Wide Web and other forms of popular communications and media to facilitate discussion and audience participation.

REFERENCES:

1. Kim MS, et al: Assisting residents with career decisions. Academic Medicine 1998; 73:225.
2. Macnab A, et al: Measurement of how well a training program prepares graduates for their chosen career paths. Medical Education 1998; 4:362-366.

Component Workshop 21
TASK FORCE ON QUALITY INDICATORS: STATUS REPORT
APA Task Force on Quality Indicators

Co-Chairpersons: John M. Oldham, M.D., *Department of Psychiatry, NY State Psychiatric Institute, 1051 Riverside Drive, Unit 4, New York NY 10032,* Deborah A. Zarin, M.D., *Office of Research, American Psychiatric Assoc., 1400 K Street, NW, Washington DC 20005*
Participants: Harold Alan Pincus, M.D., Lloyd I. Sederer, M.D., Charles E. Riordan, M.D.

EDUCATIONAL OBJECTIVES:

After this workshop, the participant should understand performance measurement; the definition of quality indicator, measure, and standard; and the dimensions of care (access, quality, perception of care, outcomes) being developed by the APA Task Force on Quality Indicators. The workshop will provide opportunity for input to this work in progress.

SUMMARY:

There is a groundswell of interest in the development of performance measures, so that health care systems can be held accountable for the care they provide. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has recently introduced an ambitious performance measurement program. Other organizations, such as the National Committee on Quality Assurance (NCQA) and the American Medical Accreditation Program (AMAP) are developing methods to evaluate health care, and JCAHO, NCQA, and AMAP have announced a collaboration on an initiative to coordinate performance measurement activities across the entire health care system. The American Psychiatric Association established a Task Force on Quality Indicators to develop a professionally driven, clinically based framework for performance measurement. After determining four key dimensions of care to be evaluated (access, quality, perception of care, and outcome), the task force identified priority areas of importance (populations [e.g., children, the elderly] and diagnoses [e.g. schizophrenia, substance abuse]), as well as a series of clinical recommendations/goals and sample quality indicators to be used in evaluating the provision of behavioral health care.

Participants in this workshop will receive copies of the task force report (either a late draft or the final report) and will be invited to provide input and suggestions for the development of additional quality indicators.

REFERENCES:

1. Eddy DM: Performance measurement: problems and solutions, Health Affairs 1998; 17:7-25.
2. Sederer L, Dickey B: Outcomes Assessment in Clinical Practice. Baltimore, Williams & Wilkins, 1996.

Component Workshop 22
FIRST IMPRESSIONS: ASSUMPTIONS EXPOSED
APA/Center for Mental Health Services Minority Fellowship and APA/Zeneca Minority Fellowships

Co-Chairpersons: Petros Levounis, M.D., *New York University, 740 West End Avenue, #135A, New York NY 10025*, Evaristo O. Akerele, M.D., 4C Bulger Ave., New Milford NJ 0764?
Participants: Yesh Dhaiber, M.D., Khanh-Trang T. Nguyen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize some assumptions that patients and psychiatrists make about each other based on first impressions—from the point of referral to the first few seconds of the first session. Specifically, she or he should be able to identify and discuss assumptions about ethnicity and sexual orientation that influence the therapeutic relationship.

SUMMARY:

In this workshop, we will explore the assumptions that the patient and the psychiatrist make about each other when they first meet, before the treatment actually begins. From the very first moment of the referral, both participants in the therapeutic dyad start developing "templates" of assumptions about the other person; on these "templates" they will built their respective expectations of the treatment. The spelling of a last name, the office address, a person's accent on the phone, age, gender, skin color, physical attractiveness, the presence or absence of a wedding ring, and so many other "initial data" are often registered as powerful mental objects. These first impressions trigger assumptions that have a long-lasting impact in the treatment and often define the relationship, even when later evidence proves them wrong.

During the workshop, we will focus our attention on contrasting the assumptions based on ethnicity versus sexual orientation. We will explore the different issues, as well as the common challenges, that overt and covert minorities face in today's psychiatric work, based on first impressions.

Participants will be encouraged to share their own experiences and generate discussion on race and sexual orientation.

REFERENCES:

1. Carter RT: The Influence of Race and Racial Identity in Psychotherapy. New York, John Wiley and Sons, Inc., 1995.
2. Cabaj RP, Stein TS, (eds.): Textbook of Homosexuality and Mental Health Washington, DC American Psychiatric Press, Inc., 1996.

Component Workshop 23
THE HEALING WAYS OF THE ANISHINAABE OJIBWE PEOPLE
APA Committee of American Indian, Alaska Native and Native Hawaiian Psychiatrists

Co-Chairpersons: Robert C. Palmer, M.D., *4501 Orcutt Road, San Luis Obispo CA 93401*, Blackwolf Jones, M.S., *PO Box 28291, Green Bay WI 54324*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop the participants should have new acquired skills from a culture that practices prevention by teaching its life principles. Participants' relationships with patients and each other will be enlivened and enriched by the traditional use of natural materials and practices.

SUMMARY:

The purpose of this workshop is to interactively teach Ojibwe healing traditions. Participants will learn to use the ancient healing methods of the Mishomis (grandfather stone), medicine wheel, medicine bundle, prayer stick, and fear bundle. The purpose of these methods is to help resolve fear, anger, shame, and pain. Questions will be answered after each healing method. The Ojibwe life principles of Mishkowsin (inner strength), Aindahing (inner heart), Bimadisiwin (full life), and Namaji (pride, honor, dignity, and respect) will be taught. These guiding principles foster healthy emotional and moral development by deflecting focus from "me" to "we". Many children are raised in an environment of violence and disrespect; Ojibwe teachings illustrate how what we do to each other, we do to ourselves. Ultimately, psychiatrists will be encouraged to view themselves not only as physicians but as "elders" practicing and teaching more caring and respectful ways.

REFERENCES:

1. Jones B, Jones G: Listen to the Drum. Salt Lake City, Commune-a-Key Publishing, 1995.
2. Jones B, Jones G: Earth Dance Drum Salt Lake City, Commune-a-Key Publishing, 1996.

Component Workshop 24
MEDICATIONS IN ADDICTION THERAPY
APA Council on Addiction Psychiatry and the American Academy of Addiction Psychiatry

Chairperson: Sheldon I. Miller, M.D., *Department of Psychiatry, Northwest Memorial Hospital, 303 East Superior, Room 561, Chicago IL 60611-3015*
Participants: Thomas R. Kosten, M.D., Richard T. Suchinsky, M.D., James A. Halikas, M.D.

EDUCATIONAL OBJECTIVES:

Workshop participants should become aware of which pharmacotherapies are and are not effective in the treatment of cocaine, opioid, and alcohol addictions. They should become aware of which experimental approaches are more accepted as clinically valid, the indications for use, and the limitations.

SUMMARY:

Over the last several years there has been an explosion of research into medication treatments of various addictive disorders. New medications have been developed to treat alcohol addiction. There has, in addition, been extensive research into medications that may be useful in the treatment of cocaine addiction and abuse. Finally, new agents have been developed that may be used in addition to methadone in the treatment of opioid addiction. Many of the drugs in all of these categories have been used by some without FDA approval, or for that matter, without solid evidence in the literature of lasting effectiveness or benefit. For may psychiatrists who see substance-abusing and substance-dependent patients, there is confusion about what if anything is appropriate to use in addition to the psychosocial approaches and long-established medications that have been available for years. This session will focus on discussing agents that have been proven to be effective in the treatment of alcoholism and opioid dependence. There will also be a discussion of agents that have been tried with varying levels of success in the treatment of cocaine

dependence, some of which having high public and professional visibility.

REFERENCES:

1. Frances RJ, Miller SI: (editors). The Clinical Textbook of Addictive Disorders, Second Edition. New York, The Guilford Press, 1998.
2. Lowinson JH, Ruiz P, Millman RB, Langrod JG. (editors): Substance Abuse: A Comprehensive Textbook, Third Edition. Baltimore, Williams & Wilkins, 1997.

Component Workshop 25
LOST IN DIVERSITY MAINSTREAM
APA Committee of Black Psychiatrists

Co-Chairpersons: Michelle O. Clark, M.D., *Department of Psychiatry, UCSF/SF General Hospital, 1001 Potrero Ave, Room 7B-21, San Francisco CA 94110,* Sheryl D. Jones, M.D., *3260 Abbeywood Drive, Decatur GA 30034-1736*
Participants: Chester M. Pierce, M.D., Patricia A. Newton, M.D., Mindy J. Fullilove, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop the participants will have had a review of the new challenges to the unique differences in culture impacting persons of African descent in the United States (U.S. Africans/blacks) and the significance of these for practicing psychiatrists. We will facilitate discussion on strategies to reverse the trend toward invisibility of the black community.

SUMMARY:

Thirty years ago during the fervor of the social revolution in the United States, black psychiatrists were acutely concerned that the unique cultural issues of their communities remained missed, ignored, or misunderstood. This led to confrontations and was the genesis of the movement toward multiculturalism in our field. Since that time, attention to these issues has flowed and ebbed. Recent legislation and other political attacks on affirmative action render the current milieu one that places all subcultures, ethnic or otherwise, in the pool of "diversity." Within such a pool, issues unique to blacks are so diluted as to be disappearing. This presentation seeks to clarify and define some cultural issues for blacks, particularly as they relate to clinical practice. It will also be a forum for active discussion on ways to ensure cultural competence in these areas.

REFERENCES:

1. Newton P: Post Traumatic Slave Disorder, Baltimore, NTI Publication, 1998.
2. Spurlock J, Canino E: Culturally diverse children and adolescents: assessment and treatment, New York, Guilford Press, 1994.

Component Workshop 26
SUBSTANCE ABUSE, VIOLENCE, AND THE HISPANIC FAMILY
APA Committee of Hispanic Psychiatrists

Chairperson: Silvia W. Olarte, M.D., *Department of Psychiatry, NY Medical College, 37 East 83rd Street, Apt 1, New York NY 10028*
Participants: Eugenio M. Rothe, M.D., Ana E. Campo-Bowen, M.D., Manuel Trujillo, M.D., Oscar E. Perez, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the sociocultural factors that particularly influence substance abuse in the Hispanic population and understand the interplay of substance abuse and the cycle of family violence in the Hispanic family.

SUMMARY:

Hispanics will constitute the largest majority in the U.S. by the year 2010. Already Hispanic children constitute the largest U.S. minority in this age range. Substance abuse among U.S. Hispanics has been identified as one of the most serious mental health problems affecting this population. Socioeconomic stresses and the struggles of acculturation contribute to substance abuse, which in turn contributes to HIV transmission, domestic violence, and other psychosocial problems. A culturally sensitive approach to the treatment of substance abuse in Hispanics is one of the challenges for U.S. psychiatrists in the next century.

Domestic violence has been regarded as the "silent epidemic." Predominantly affecting more than one million women a year, it is only in the past five years that these staggering statistics have come to light. Hispanic women are particularly vulnerable to being abused due to cultural, social, and economic variables that place them in a position of lack of power and mastery over their lives. Accurate statistics about domestic violence toward the Hispanic woman and her family are underreported and thus largely unknown. Presenters of this workshop will discuss substance abuse and domestic violence and their impact on the Hispanic family within an appropriate cultural frame that will facilitate prevention, diagnosis, and treatment.

REFERENCES:

1. Ruiz P, Langrod JG: Hispanic Americans, In: Substance Abuse: A Comprehensive Textbook. Edited by Lowison JH, Ruiz P, Millman RB, Langrod JG. Third Ed. Baltimore, Williams and Wilkins, 1997, pp 705-711.
2. Carmen EH: Overview: the "wife-beater's wife" reconsidered. In, The Gender Gap in Psychotherapy. edited by Perri-Rieker P, Carmen EH, New York, Plenium, 1984, pp 213-236.

Component Workshop 27
TREATING HOMOSEXUALS: DOs AND DON'Ts
APA New York County District Branch's Committee on Gay and Lesbian Issues

Co-Chairpersons: Kenneth B. Ashley, M.D., *NYU Medical Center, 85 East 10th Street, #1F, New York NY 10003-5407,* John A. Gosling, M.D., *158 8th Avenue, Suite #2, New York NY 1001*
Participants: Richard O. Hire, M.D., Anand Pandya, M.D., Steven T. Wozniak, M.D., Michael Schneider, Psy.D. Ariel Shidlo, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should be able to recognize some of the complex issues involved in treating lesbian, gay, and bisexual patients and have a working knowledge of how to address these issues in the clinical setting.

SUMMARY:

This workshop will focus on clinical issues pertaining to the treatment of lesbian, gay, and bisexual patients. The presentations will address the following topics: 1.) Aspects of "gay affirmative psychotherapy," using a case vignette of a patient with confusion regarding his sexual orientation. The presentation will address issues of transference and countertransference, as well as the question of self-disclosure by the therapist of his own sexual orientation. 2.) The controversy surrounding so-called "reparative (conversion) therapy" as a treatment modality, with a discussion of preliminary findings of outcome studies. 3.) A review and critique of the literature regarding the prevalence of psychiatric disorders reported to occur more frequently in the lesbian, gay, and bisexual population. 4.) Specific problems relevant to the assessment of lesbian, gay, and

bisexual youths and young adults, with a particular focus on the issue of suicide risk.

REFERENCES:

1. Cabaj RP, Stein TS, (eds.): Textbook of Homosexuality and Mental Health. Washington, DC, American Psychiatric Press, Inc., 1996.
2. Oldham J, Riba M, Tasman A, (eds.): Review of Psychiatry Vol. 12. Washington, DC, American Psychiatric Press, Inc., 1993.

Component Workshop 28
RECRUITMENT AND RETENTION: IT'S EVERYONE'S JOB!
APA Membership Committee

Chairperson: Bernard A. Katz, M.D., *22 Rosalie Road, Newton Centre MA 02159-3131*
Participants: Rodrigo A. Munoz, M.D., Donna M. Norris, M.D., Allan Tasman, M.D., Alfred Herzog, M.D.

EDUCATIONAL OBJECTIVES:

The recruitment and retention session will provide an opportunity for DB presidents-elect, DB executives, and others interested in membership to exchange ideas, share information, and discuss the joint efforts and plans of DBs and APA to increase and retain members.

SUMMARY:

The recruitment and retention session will offer DB presidents-elect, DB executives, and others interested in membership a forum with APA leadership to explore ways to work together to better meet the needs of members and develop effective joint recruitment campaigns. A panel of APA leaders will be available to discuss current and future strategies and plans for retaining and recruiting members. The audience will have ample opportunity to ask questions, raise issues, and make suggestions. Membership staff will be available to provide input.

Component Workshop 29
CULTURAL/ETHNIC IDENTITY: IMPACT ON SELF-ESTEEM AND SUCCESS
APA Committee of International Medical Graduates, APA Committee of Asian-American Psychiatrists and APA Committee of Hispanic Psychiatrists

Co-Chairpersons: Gopalakrishna K. Upadhya, M.D., *Bronx-Lebanon Hospital, 1276 Fulton Avenue, Bronx NY 10456,* Edmond H. Pi, M.D., *Department of Psychiatry, University of Southern CA, 1937 Hospital Place, Grad Hall, Los Angeles CA 90033*
Participants: Lilia C. Clemente, Karen A. Venegas-Samuels, M.D., Geetha Jayaram, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize how to use cultural and ethnic identity to strengthen one's self-esteem in a new environment and to use an inherent capacity for personal growth constructively, leading in turn to professional success and personal happiness.

SUMMARY:

In the United States today, three out of every 10 persons is a member of an ethnic minority group, and nearly 20 million Americans are foreign-born. Over 41% of residents in psychiatry are international medical graduates, with increasing diversification by country of birth and ethnicity. Traditional cross-cultural observations and discussions have centered around challenges, prejudices, and potential complications in adaptation. Little attention has been paid to the positive impact of cultural and ethnic identity as a tool for successful integration. This workshop will critically discuss the challenges faced by these immigrant minorities and the positive impact of cultural and ethnic identity on one's self-esteem, personal happiness, and professional success. The primary presenter is an award-winning, successful, immigrant businesswoman, and panelists who are accomplished psychiatrists have been chosen from diverse backgrounds. The plan is for this workshop to be as interactive as possible with plenty of time devoted to audience participation.

REFERENCES:

1. Carnevale AP, Stone SC: The American Mosaic. New York, McGraw-Hill, 1995.
2. Greer C: Divided Society: The Ethnic Experience in America. New York, Basic Books, 1974.

Component Workshop 30
MEDIA SKILLS FOR MEMBERS-IN-TRAINING AND EARLY CAREER PSYCHIATRISTS

Co-Chairpersons: Nada L. Stotland, M.D., *Illinois Masonic, 836 West Wellington, Chicago IL 60657,* Donna T. Chen, M.D., *2810 Schildford Farm, Charlottesville VA 22901*
Participants: Derek G. Puddester, M.D., Gabriela Cora-Locatelli, M.D., Diana L. Dell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify and present effective messages about psychiatric illnesses, treatments, and public policies that affect them, to the public, through the media.

SUMMARY:

The knowledge and attitudes of individuals drive personal and family decisions about mental health care and, through the legislative and executive branches of government, determine laws and regulations concerning health care education, funding, systems, priorities, requirements, and restrictions. Ignorance about psychiatric issues is rife, as is stigma against the diseases, those who suffer from them, and those who treat them. Psychiatrists in training and recently out of training are in close contact with scientific developments and with the realities of providing care in a variety of settings. With their careers ahead of them, they have much at stake in the court of public opinion. They are perceived by the public and members of the media as less self-interested than more senior psychiatrists, and they can deliver messages with sincerity and enthusiasm. This workshop, with a faculty made up mostly of MITs and ECPs with public affairs experience, offers MITs and ECPs hands-on learning of the skills necessary to identify newsworthy issues, craft messages about them, fit the messages to the appropriate media, and get the messages across to the public despite distraction and anxiety.

REFERENCES:

1. Kotler P, Andreasen A: Strategic Marketing for Non-Profit Organizations, 5th Edition, 1996.

2. Carey SC: The GSWAE Foundation Marketing the Non-Profit Association, 1996.

Component Workshop 31
HISTORY OF EMPOWERMENT BY THE MENTALLY ILL
APA Committee on History and Library

Chairperson: Janet E. Ordway, M.D., *33 Pine Ledge Road, Bangor ME 04401*
Participants: W. Walter Menninger, M.D., Laurie M. Flynn

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe why patient rights and empowerment has been slow but steady over the last two centuries.

SUMMARY:

Patient rights and empowerment and their uneven progress over the last two centuries will be summarized by Dr. Ordway. Major changes occurred both here and abroad in the early 1800's when small airy hospitals were developed with programs based on moral treatment. Over the next half century their size increased from around 250 to three to four times that number as the mentally ill were moved out of their squalor and jails and into the hospitals, which then became custodial, in the early 20th century.

In the second half of the 20th century, many of the patients' rights became legally defined—the right to treatment, the right to refuse treatment, and the right to the least restrictive treatment, as discussed by Dr. Menninger. These changes were occurring along with deinstitutionalization.

As this century draws to a close, patient rights have led to patient empowerment. Laurie Flynn, executive director of NAMI, will discuss patients' increasing involvement in the decision-making process. They have made their needs clear, worked with legislatures on issues such as parity, and educated their families, members of organizations, and the public about mental illness.

REFERENCES:

1. Carling P: Return to Community: Building Support Systems for People with Psychiatric Disabilities, New York, The Guilford Press, 1995.
2. Tomes N: The Art of Asylum-Keeping, Philadelphia, University of Pennsylvania Press, 1994.

Component Workshop 32
HOMOPHOBIA HURTS FAMILIES: HOW PARENTS, FAMILIES, AND FRIENDS OF LESBIANS AND GAYS CAN HELP
APA Washington Psychiatric Society's Gay and Lesbian Committee

Chairperson: Daniel W. Hicks, M.D., *1309 T Street, NW, Washington DC 20009*
Participants: Leslie G. Goransson, M.D., William W. Van Stone, M.D., Catherine Tuerk, R.N., Lanette Graves

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the unique psychological stresses in "coming out" for gay and lesbian peoples and their families, and the potential effect on the mental health of the whole family; to understand the contributions of the organization PFLAG: what it is, how to access it, and how it can help families of gays and lesbians come to acceptance and decrease distress.

SUMMARY:

Despite increased visibility and awareness of openly gay men and lesbians in sports, entertainment, politics, science, and art and music, there continues to be a great deal of prejudice and homophobia in our society. This is demonstrated by statements such as that Senator Trent Lott made about gay people, as well as the nationwide media campaign sponsored by the religious right, with advertisements suggesting that gay people could and should be changed. This misinterpretation of the scientific facts about homosexuality, facts that are supported by APA and all other mental health groups, fosters a continuation of societal prejudice and homophobia. This, in turn, causes gay men, lesbians, and their families needless pain and suffering and can lead to serious psychological sequelae, including depression, substance abuse, torn families, and even suicide.

Parents, Families, and Friends of Lesbians and Gays (PFLAG) is an international organization for support, education, and advocacy. Chapters can be found in most large towns and cities. It becomes a haven for family members (and some gay people) to help give them support while they are educating themselves and overcoming their own prejudices to work toward understanding and acceptance of their family member(s). In addition, PFLAG has become one of the strongest advocates in the battle for equal rights and nondiscrimination for gays and lesbians.

REFERENCES:

1. Cabaj R, Stein T: Textbook of Homosexuality and Mental Health. Washington DC, APPI Press, 1993.
2. Ryan C, Futterman D: Lesbian and Gay Youth: Care and Counselling University Press, 1998.

Component Workshop 33
HEALTH AWARENESS EDUCATION FOR MEDICAL STUDENTS
APA Committee on Medical Student Education

Chairperson: Michael J. Vergare, M.D., *Department of Psychiatry, Albert Einstein Med. School, 5501 Old York Road, Hirsch Bld, Philadelphia PA 19141*
Participants: Leah J. Dickstein, M.D., Carolyn B. Robinowitz, M.D., Steven G. Dickstein, B.A., Julie Holman, M.D.

EDUCATIONAL OBJECTIVES:

The workshop will introduce the audience to a program model for helping orient medical students to the stresses of medical school and the profession of medicine. It will highlight the role psychiatric faculty can play in developing such programs.

SUMMARY:

For almost two decades, there has been a welcome resurgence of interest in the health risks attendant upon becoming and being a physician. Medical school can be a stressful experience, and feeling overwhelmed is common. To address these stresses, some schools have established orientation programs that include psychiatry faculty.

This workshop will review a model introduced at the University of Louisville by one of the panel, Leah Dickstein, M.D. Evolving from a student hour support program started in 1977, it has become a prominent multiday part of the orientation of all medical students to Louisville. Covered are aspects of physical, mental, and social health. Panelists will share their experiences as participants in this model program. They will elaborate on their own involvement with helping other students through the stresses of initiation into the profession of medicine and highlight ways psychiatric faculty can be helpful in building a support program for medical students. The audience will have the opportunity to review the materials that are utilized in the University of Louisville School of Medicine "Steps to Good Health" program. They will also interact with faculty from

the program to learn more about how to establish programs in their own institutions.

Component Workshop 34
MANAGED CARE FUNDING FOR PSYCHIATRIC CONSULTS
APA Committee on Standards and Survey Procedures and APA Committee on Consultation-Liaison Psychiatry and Primary Care Education

Co-Chairpersons: Carol L. Alter, M.D., *Bristol-Myers Squibb, PO Box 4500, Princeton NJ 08543,* Francisco Fernandez, M.D., *Department of Psychiatry, Loyola University, 2160 S First Ave/Bldg 54, #154, Maywood IL 60153*
Participant: Steven I. Altchuler, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to improve familiarity with common problems in managed care reimbursement for psychiatric care to medically ill patients (C-L services) and provide information about existing standards, guidelines, and competencies related to C-L reimbursement.

SUMMARY:

The provision of and reimbursement for psychiatric evaluation and treatment services provided to medically ill patients has been a significant problem in the managed care setting. The numerous difficulties arise from the often separate reimbursement pools for payment of psychiatric (mental health carveout) and physical health care services. The committees on Standards and Survey Procedures and Consultation-Liaison and Primary Care Education will conduct a workshop that will focus on common problems encountered in assuring funding for consultation-liaison services in the managed care setting and offer potential solutions to such problems. Recent work completed as part of a project funded by the Center for Mental Health Services to evaluate existing managed care standards and guidelines for several special patient populations served by psychiatrists included a panel on the Psychiatric Treatment of Chronic Medically Ill Patients and will be discussed. Information about treatment provision guidelines, clinical competencies based on current literature, and accreditation standards, including NCQA, JCAHO, and HCFA obtained from this project, will be discussed. Written materials will be available summarizing common problems, resources available, and strategies to employ for improved outcomes. Participants at the workshop will be encouraged to share their experiences and participate in a discussion with the panel to review strategies and negotiating points to improve reimbursement in those settings.

REFERENCES:

1. Alter CL, Schindler BA, Hails K, et al: Funding for consultation-liaison services in public sector managed care plans: the experience of the Consultation-Liaison Association of Philadelphia. Psychosomatics 1997; 38:93-97.
2. Katon W, Von Korff M, Lin E, et al: Population-based care of depression: effective disease management strategies to decrease prevalence. Gen Hosp Psychiatry 1997; 19:169-178.

Component Workshop 35
CURRENT ISSUES IN ABUSE AND MISUSE OF PSYCHIATRY
APA Committee on International Abuse of Psychiatry and Psychiatrists, and APA Committee on Abuse and Misuse of Psychiatry in the United States

Chairperson: Jose E. De La Gandara, M.D., *2161 Palm Beach Laks Blvd #215, West Palm Beach FL 33409-6611*
Participants: Abraham L. Halpern, M.D., Houshang G. Hamadani, M.D., Rigoberto Rodriguez, M.D., Margaret F. Jensvold, M.D., Andrew Siegel, M.D.

EDUCATIONAL OBJECTIVES:

Upon conclusion of this workshop, the participant should be able to recognize acts and situations representing abuses or misuses of psychiatry. They will be able to learn about specific areas of concern, abroad and at home, to demonstrate increased awareness, and to apply the acquired knowledge in their clinical practice.

SUMMARY:

Detainees, prisoners, and the mentally ill are vulnerable subgroups in society. While society cannot ignore these individuals, it often neglects or mistreats them directly or indirectly. Many societies with different traditions and religious, philosophical, or political beliefs, have different approaches in judging what constitutes reasonable behavior, insanity, reprehensible acts, and appropriate methods of punishment. In countries with totalitarian governments, religiously fanatic regimes, and in some "democracies." political detainees and prisoners find themselves in forensic and regular psychiatric wards where psychiatric methods may be used as a form of persuasion, intimidation, or punishment.

In western democracies, authorities in penal institutions are increasingly seeking psychiatric assistance to help them validate the "competence" of inmates in order to justify application of their sentences, particularly in the case of capital punishment. Financial considerations have lead to reduction of budgets, resulting in closure of facilities and reduction of psychiatric services to the mentally ill throughout the world. This workshop will address controversial ethical issues of psychiatric concern regarding different aspects of the evaluation and treatment of this population in the United States and abroad. Upon completion of their presentation, the speakers will join in a discussion with the audience.

REFERENCES:

1. Universal Declaration of Human Rights 1948: Office of the United Nations High Commissioner for Human Rights, Geneva, Switzerland.
2. Human Rights and the American Psychiatric Association. APA Council of International Affairs, 1994.
3. The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry 1998.
4. APA: Position Statement Committee on Abuse and Misuse of Psychiatry in the U.S., Am J Psych 1994; 151:1399.

Component Workshop 36
EXECUTIVE ROLES FOR PSYCHIATRISTS IN THE 21ST CENTURY
APA Committee on Psychiatric Administration and Management

Chairperson: Philip E. Veenhuis, M.D., *Medical Director, Division of MH/DD/SAS, 325 North Salisbury, Raleigh NC 27615*
Participants: Dave M. Davis, M.D., W. Walter Menninger, M.D., Gary E. Miller, M.D., Stuart B. Silver, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop participant should be familiar with the multiple emerging roles available and likely to become available in administration management.

SUMMARY:

The traditional practice of psychiatry has changed as a function of managed care and is likely to change further in the future. The Committee on Psychiatric Administration and Management will present and discuss several of these roles. Members of the committee on the panel represent diverse roles: state public mental health system; not-for-profit mental health organization and private practice;

mixed specialty group practice; mixed discipline practice and partnership. Audience participation will be invited.

REFERENCES:

1. New Roles for Psychiatris, in Organized Psychiatry Systems of Care ed. by Lazarus, JA, Sharfstein SS, Wash DC, Amer Psych Press, Inc., 1998.
2. Textbook of Administrative Psychiatry, edited by Talbott JA, Hales RE, Keil SL; Wash. DC, Amer Psych. Press, Inc., 1992.

Component Workshop 37
FUNDING MANAGED CARE AND PUBLIC PSYCHIATRIC SERVICE TODAY
APA Consortium on Funding for Services

Chairperson: Arthur T. Meyerson, M.D., *Department of Psychiatry, UMDNJ New Jersey Med School, 215 South Orange Avenue, D20, Newark NJ 07103*
Participants: Richard C. Lippincott, M.D., Michael English, Ph.D., Steven M. Katz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants will develop a competent and comprehensive understanding of funding issues and concerns in public psychiatry. Participants will develop innovative concepts for enhancing the resources and quality of psychiatric services.

SUMMARY:

Health and mental health are in rapid transition driven by managed care concepts, health insurance reform, shifting relationships between state, federal, and local government control, as well as significant shifts in values. A panel representing the various aspects, including managed care and insurance, has been assembled. The panel plans to rise to the challenges, constrictions, and changes by promoting a dialogue leading to understanding the social and health care changes and what "innovative means of financing" may be considered.

An overall picture of funding will be reviewed from within and without public managed care, emphasizing the critical changes experienced and those we may expect. A national review of state mental health authority funding patterns and variations therein will include data from the states regarding managed care for Medicaid populations. Issues of access, quality of services, and concerns for cost shifts (dumping the persistently mentally ill) will be explored. The role of federal block grant and other federal supports will be explored with special emphasis on knowledge, development, and exchange. The impact of CHIP will be included. Funding concerns relevant to health insurance parity for the mentally ill and the contribution of managed care also will be explored.

REFERENCES:

1. Lillie-Blauten M, Lyons B: Managed care and low-income populations: recent state experience, Health Affairs, 1998; 17.

Component Workshop 38
OUTPATIENT DETOXIFICATION TREATMENT SERVICES
APA Committee on Treatment Services for Addicted Patients

Chairperson: Joseph A. Virzi, M.D., *8160 Baymeadows Way W., Suite 250, Jacksonville FL 32256*
Participants: George K. Kolodner, M.D., Charles P. O'Brien, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify which patients are most appropriate for outpatient detoxification, gain knowledge concerning transferring the traditional detoxification protocols to accommodate the setting and to know how to provide newer detoxification protocols in this setting, priority about the types of logistical support that must be provided with this treatment modality, and a clear understanding of the signs and symptoms of the withdrawal state and when the patient must be transferred from the outpatient to inpatient setting.

SUMMARY:

The safety and effectiveness of an outpatient setting for alcohol detoxification was established 25 years ago. Moreover, familiarity with this setting has only recently become important as changes in inpatient detoxification for addiction treatment has shifted an increasing proportion of detoxification services from the traditional inpatient setting to the outpatient one. The loss of the individual patient referral to a closed, inpatient setting in the past has limited the referring physicians in following and providing these services; although they have been trained and experienced in dealing with the skill of detoxification, they are not allowed to provide this service themselves due to third party reimbursement restrictions for inpatient addiction treatment. More importantly, not all patients need alcohol detoxification on an inpatient basis and are more appropriately treated on an outpatient level.

Establishing the need for the detoxification and ruling out the necessity of inpatient hospitalization will be the first step discussed in our workshop. Protocols for understanding the withdrawal symptom process and the emergence of psychiatric and medical problems will be discussed in detail. Indeed, not all patients in alcohol detoxification need withdrawal medications, but for those who do, the appropriate doses and monitoring of the doses and the foundation for safe and comfortable detoxification with family support will be discussed as will anticonvulsant medications treatment detoxification protocol.

REFERENCES:

1. Feldman, et al: Am J Psychiatry, 1975; 132:407-12.
2. Hayashida M, Alterman AI, McLellan AT, et al: Comparative effectiveness and costs of inpatient and outpatient detoxification of patients with mild-to-moderate alcohol withdrawal syndrome. NEJM 1989; 320:358-365.

Component Workshop 39
CULTURALLY COMPETENT CARE OF LESBIAN, GAY, BISEXUAL, AND TRANSGENDERED PATIENTS
APA Northern California Psychiatric Society's Committee on Lesbian, Gay, Bisexual, and Transgender Issues

Chairperson: Dan H. Karasic, M.D., *Department of Psychiatry, San Francisco General Hospital, 1001 Potrero Avenue, Suite 7E, San Francisco CA 94110*
Participants: Karin L. Hastik, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize cultural and social factors that affect symptom presentation and care needs of lesbian, gay, bisexual, and transgendered patients.

SUMMARY:

Psychiatric diagnosis and treatment reflect a set of social and cultural assumptions that may affect the treatment of lesbian, gay, bisexual, and transgendered (LGBT) patients. Behavior, orientation, and identity of sexual and gender minorities may be unnecessarily pathologized. Assumptions of gender-specific behaviors in DSM-IV diagnoses do not account for the range of gender expression in these patients. Confounding factors in determining psychiatric diagnosis based on impairment in social or occupational functioning in socially

stigmatized groups will be discussed. The meaning of "therapeutic neutrality" in the context of majority social and cultural assumptions will be examined. Considerations for culturally competent care of LGBT ethnic minorities will be presented. Audience input concerning principles of cultural competence in the care of LGBT patients will be elicited.

REFERENCES:

1. Polansky JS, Karasic DH, Speier PL, et al: Homophobia: therapeutic and training considerations for psychiatry. Journal of the Gay and Lesbian Medical Association. 1997; 1:41-47.
2. Greene B: Ethnic minority lesbians and gay men: mental health and treatment issues. In: Ethnic and Cultural Diversity among Lesbians and Gay Men, edited by Greene B, Thousand Oaks, CA, Sage Publications, 1997, pp. 216-239.

Component Workshop 40
EXAMINING GLOBAL PSYCHIATRISTS' TRAINING CURRICULA
APA Committee on International Education

Co-Chairpersons: Winston W. Shen, M.D., *Department of Psychiatry, St. Louis University, 1221 South Grand Boulevard, St. Louis MO 63104-1016,* Michael J. Napoliello, M.D., *27 Richard Court, Princeton NJ 08540*
Participants: David G. Fort, M.D., F. Moises Gaviria, M.D., Suzane M. Renaud, M.D., Miguel A. Leibovich, M.D., John B. Sikorski, M.D., Eugenio M. Rothe, M.D., Pedro Ruiz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to be familiar with the trainings for psychiatrists all over the world and to improve our training programs by learning from others' experiences.

SUMMARY:

This workshop will provide a forum to discuss the medical student teaching, psychiatric residency training, and continuing medical education of practicing psychiatrists and those in psychiatric subspecialty training. The members of the APA Committee on International Education and interested APA members will have dialogue with international APA members and guests in this workshop. Ideas will be exchanged about teaching medical students and other medical colleagues and training psychiatrists in general psychiatry and psychiatric subspecialties. As in previous years, three committee members will first present and highlight some key aspects of psychiatric education in North America to set the stage for informal discussion. The open discussion will address questions from the audience and learn from the audience their experience in psychiatric training curricula outside North America. At the end of the workshop, participants should have greater insight and understanding of psychiatric education in different countries and cultures. Some ideas from this workshop may be adopted for use in psychiatric education programs in North America.

Component Workshop 41
CURRENT AND FUTURE TRENDS IN THE ASSESSMENT AND DIAGNOSIS OF INFANTS, TODDLERS, AND PRE-SCHOOLERS
APA Committee on Pre-School Children

Co-Chairpersons: Harry H. Wright, M.D., *Neuropsychiatry, University of South Carolina, 3555 Harden St Ext, Ste #104, Columbia SC 29203,* Kyle D. Pruett, M.D., *34 York, Suite 3, Guilford CT 06437*
Participants: Robert N. Emde, M.D., Michael S. Scheeringa, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize important issues in the assessment of young children and their families.

SUMMARY:

The historical strategy in mental health assessment and diagnosis of children has been to focus on specific symptoms and issues that are easy to identify and measure. Because of the complex nature and less-specific symptoms that occur with young children, the strategies used for older children and adolescents have not worked well with younger children (i.e., few diagnoses in DSM that are available for young children). In this workshop, we will highlight some important issues in the mental health assessment and diagnosis of young children. We will focus on the clinical aspects of the use of specific instruments for making diagnoses, assessing functional impairment, assessing developmental domains, and measuring the quality of parent-child interaction. A summary of the measures that have been developed for young children will be presented and the benefits and liability of their clinical use will be discussed. We will outline the critical importance of including a relationship focus in the assessment and diagnosis processes with young children. Understanding the quality of the parent-infant/toddler relationship is an important part of an assessment and diagnostic profile of a young child. The goal of the workshop is to provide take-home information on assessment and diagnosis of young children.

REFERENCES:

1. Thomas JM, et al: Practice parameters for the psychiatric assessment of infants and toddlers (0–36 months). J American Academy of Child and Adolescent Psychiatry 1997; 36(Supplement):215-365.
2. Zero to Three Diagnostic classification: 0–3: Diagnostic classification of mental health disorders of infancy and early childhood. Arlington, VA, Zero To Three, National Center for Infants, Toddlers and Families.

Component Workshop 42
ETHICAL CHALLENGES IN RISK-BASED CONTRACTING
APA Committee on Managed Care

Co-Chairpersons: Barry F. Chaitin, M.D., *UCI Medical Center, 100 The City Drive, Orange CA 92868,* Joanne H. Ritvo, M.D., *Department of Psychiatry, University of Colorado, 501 S Cherry Street, Ste 650, Denver CO 80246*
Participants: Anthony M. D'Agostino, M.D., Edward Gordon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the historical perspective for risk-based contracting including case rates and capitation; to recognize their application in public/university settings as well as in private practice; to recognize the potential ethical challenges for the provider groups as they struggle to meet patient needs in this setting; and to discuss recommendations for providers in this new contracting arena.

SUMMARY:

Almost no literature exists on the ethical dilemmas encountered by psychiatric providers as they enter the arena of risk-based contracting for the psychiatric care of given populations. We know only that case management rates are a mechanism for shifting risk to providers for the cost of treating that population and that as such they present potential problems affecting the welfare of patients, their families, and providers. Case rates differ from capitation in several ways. These differences will be discussed as will the risks to

the provider of risk-contracting. Ethical challenges will be discussed including how to inform a patient about payment arrangements and incentives as well as possible mechanisms for grievances. Presenters will address these challenges in both a larger "quasi-public" (university) system and a physician-owned private group of contractors. At least 20 minutes will be allocated for audience questions and comments.

Component Workshop 43
DISABILITY IN MENTAL DISORDERS FOR PSYCHIATRISTS
APA Committee on Psychiatric Diagnosis and Assessment

Co-Chairpersons: Frederick G. Guggenheim, M.D., *UAMS, 4301 West Markham, Slot 554, Little Rock AR 72205-7101,* Bedirhan Ustun, M.D., *World Health Organization, 20 Avenue Appia, CH-1211 Geneva, Switzerland*
Participants: Cille Kennedy, Ph.D., Shekhar Saxena, M.D., Harold Alan Pincus, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to discuss disability assessment for psychiatric disorders in an upcoming World Health Organization classification revision.

SUMMARY:

This workshop will present the assessment methodology for disabilities associated with alcohol, drug and mental disorders used in the field trials of the WHO's draft revision International Classification of Impairments, Activities, and Participation (ICIDH-2). These clinical assessments follow the general methods used in the ICD-10 and DSM-IV field trials. Disability assessment by psychiatrists, based on ICIDH-2, can be used for SSDI and SSI benefit evidence, claims for worker compensation, and program referral under managed care. The clinical field trials will be used to refine and/or verify the clinical validity and utility of ICIDH-2 structure, coding, and assessment. Clinical field trials of ICIDH-2 will be conducted through mid-year 2000. At the end of the workshop, participants will be familiar with the classification system and clinical field trial method. Workshop participants will be encouraged to partake in the WHO field trials under the auspices of the APA Office of Research.

REFERENCES:

1. Sartorius N, Kaelber CT, Cooper JE, et al: Progress toward achieving a common language in psychiatry: results from the field trial of the clinical guidelines accompanying the WHO classification of mental and behavioral disorders in ICD-10. Archives of General Psychiatry, 50:115-124.
2. World Health Organization: International Classification of Impairments, Activities, & Participation: A Manual of Dimensions of Disablement and Functioning. Beta-1 Draft. Geneva, June, 1997.

Component Workshop 44
THE FALLOUT FROM HOSPITAL MERGERS AND CLOSINGS
APA Committee on Physician Health, Illness, and Impairment

Co-Chairpersons: Linda Logsdon, M.D., *26111 West Fourteen Mile Road, Franklin Village MI 48025-1949,* Richard F. Limoges, M.D., *111 North 49th Street, Philadelphia PA 19139-2718*
Participants: Malkah T. Notman, M.D., Carmen T. Webb, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify the psychological stresses that are resulting from the mergers and closures of hospitals, to express frustrations, anger, anxiety, and sorrow over these losses, to make contact with other psychiatrists experiencing the same trauma, and to learn what support systems can be mobilized to help in these situations.

SUMMARY:

When hospitals close or merge with other hospitals, the psychological consequences to the physicians can be severe. Struggling to cope with change, the uncertainty of the new situation, and perhaps a loss of a job can leave the physician feeling isolated, angry, depressed, and hopeless. A discussion of the experiences of three of our committee members in two such environments may help the attendees express their own concerns and stresses. The Detroit Medical Center has merged four psychiatric residency programs in the last few years. Depression, anxiety, and severe dissatisfaction has resulted for the attendings, faculty, residents, and medical students.

The Allegheny Health Care System recently suffered a failure that has resulted in as many as 1500 personnel left with total instability of their professional future. Two of our members are caught in the midst of this situation. Between now and May, 1999, committee members will explore what support systems are available to help these physicians. What role can the state psychiatric society, the state and county medical societies, or the medical center/hospital administrations play in recovery? Currently, we do not find these groups providing any services that attend to the psychological consequences of mergers and closings. Nor does the literature provide directions in intervention. The committee's work through this year, and the workshop discussion will provide us with suggestions for meaningful intervention with those in need.

REFERENCES:

1. Canadian Medical Association Policy Summary on Physician Health and Well-Being: Can Med Assoc J 1998; 158:1191-1195.
2. Tighe P: Stress on the physician in managed care. American Medical Association, Seminar on Physician Health, Proceedings. April 1998, Vancouver, British Columbia.

Component Workshop 45
BEYOND SEX: GAY ISSUES AND THE GENERAL PSYCHIATRIST
APA Committee on Gay, Lesbian, and Bisexual Issues

Co-Chairpersons: Diana C. Miller, M.D., *12011 San Vicente Blvd. #250, Los Angeles CA 90049,* Leslie G. Goransson, M.D., *1629 K Street, NW, Washington DC 20006*
Participants: Mark H. Townsend, M.D., Steven J. Lee, M.D., Petros Levounis, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand many of the complex biopsychosocial issues that gay and lesbian patients face today and therefore to be able to treat this population more effectively.

SUMMARY:

More general psychiatrists are encountering gay, lesbian, and bisexual men and women in their practices. To treat this population successfully, psychiatrists must have a broad understanding of the unique issues in the lives of these patients. During the course of this workshop, there will be presentations, with clinical vignettes, on how to respond to a patient who wishes to change sexual orientation, the impact of the media on psychiatrists' and patients' perceptions of homosexuality, unique countertransference and transference issues with this population, and special considerations in the pharmacologic evaluation and management of this population. Following these presentations, there will be a discussion and the audience will be encour-

aged to present further clinical material from their own caseloads and experience.

REFERENCES:

1. Magee M, Miller DC: Lesbian Lives: Psychoanalytic Narratives Old and New, Hillsdale, N.J., Analytic Press, 1997.
2. Cabaj R, Stein T, editors: Textbook of Homosexuality and Mental Health, Washington, American Psychiatric Press Inc., 1996.

Component Workshop 46
SYSTEMS OF CARE FOR SERIOUS EMOTIONALLY DISORDERED CHILDREN AND ADOLESCENTS
APA Committee on Children with Mental or Developmental Disorders

Chairperson: Carl B. Feinstein, M.D., *Department of Psychiatry, Stanford University, Stanford CA 94305-5719, Participants:* Robert L. Hendren, D.O., Andres J. Pumariega, M.D. Roxanne Dryden-Edwards, M.D. Sukhmani K. Gill, M.D., Patrick Willard, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should have improved knowledge of comprehensive models of care, major government programs, and managed care restraints impacting the care of children with the most serious emotional disorders.

SUMMARY:

This workshop addresses the challenge to psychiatrists in advocating for the treatment of children with serious emotional disorder (SED). Children with SED (approximately 5% of all children) have a severe psychiatric disorder that results in significant functional impairment, compromising their capacity to adapt to home, school, or community. In addition to direct treatment of the psychiatric disorder, these children require extensive rehabilitative, educational, and family support services. Such treatment conflicts with the short-term, "episode of illness" model of managed care. As states turn over mental health management for the medically indigent to private companies, new barriers to treatment have arisen. After a brief introduction (Dr. Feinstein), there will be three 15-minute presentations outlining neurodevelopmental (Dr. Hendren) and community-oriented care models (Dr. Pumariega), and providing one example of a successful program (Dr.s Roxanne Dryden-Edwards and Patrick Millard). These presentations will provide the stimulus for an extended discussion between panelists and workshop attendees. Dr. Sukhmani Gill (APA/Glaxo Wellcome fellow) will represent training concerns in the discussion. The discussion will include advances in clinical programming, recent federal, state, and local initiatives, the role of the public educational system, and the challenges of managed care.

REFERENCES:

1. Pumariega AJ, Glover S: New concepts in service delivery for children, adolescents, and their families. In, Advances in Clinical Child Psychology, Volume 20, New York, Plenum Press 1998.
2. England MJ, Cole RF: Building systems of care for youth with serious mental illness. Edited by Ollendick T, Priniz R, Hospital and Community Psychiatry 1992; 43:630-633.

Component Workshop 47
HIV PREVENTION: STIGMA AND NAMES-BASED REPORTING
APA New York County District Branch's AIDS Committee

Chairperson: Elizabeth V. Getter, M.D., *Village AIDS Day TX, 1133 West 20th Street, New York NY 10011, Participants:* John A.R. Grimaldi, Jr. M.D., Kenneth B. Ashley, M.D., Daniel B. Bauman, M.D., Chloe Nims, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be more informed about the complex issues related to self-disclosure of HIV status, risk behaviors, and the new New York State Partner Notification Law.

SUMMARY:

Significant advances have been made to combat the AIDS epidemic. Combination therapy has slowed the progression of AIDS for many people. However, an alarming number of people continue to become infected. The number of infected persons in the U.S. is estimated to be from 650,000 to 900,000, with at least 40,000 new infections each year. Despite years of HIV prevention education, both HIV+ and HIV− persons still engage in high-risk behaviors. Stigma and the fear of rejection continue to affect self-disclosure of HIV status as well as the decision to be tested for the virus. The Partner Notification Law, recently passed in New York State and expected to go into effect in 1999 requires physicians and laboratories to report newly diagnosed cases of HIV infection, HIV-related illnesses, and AIDS to the State Department of Health. The report would include the names, if available, of any contacts known to the physician or provided to the physician by the patient. People living with HIV/AIDS, AIDS organizations, health care providers, and others are deeply concerned that the new law runs the risk of driving people away from HIV testing and treatment for fear of loss of confidentiality. The panel will present data from literature and personal clinical experience. Participants will be encouraged to share questions and concerns regarding these issues.

REFERENCES:

1. Bayer R: AIDS prevention-sexual ethics and responsibility. N Engl J Med 1996; 334:1540-1542.
2. Centers for Disease Control and Prevention: AIDS Information Statistical Projections/Trends, Atlanta, Ga., 6/1/98.

Component Workshop 48
TO TELL OR NOT TO TELL: THE IMPAIRED SUPERVISOR
APA/Glaxo Wellcome Fellowship

Co-Chairpersons: Clifford A. McNaughton, M.D., *Univ of SD Med Sch, 1700 South Shafer Drive, Sioux Falls SD 57110-3914,* Karine J. Igartua, M.D., *3457 St Andre, Montreal, PQ H2L 3V4, Canada,*
Participants: Christopher M. Palmer, M.D., Michael F. Myers, M.D., Trevor I. Prior, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: understand that the definition of impairment includes physical and other mental illnesses in addition substance dependence, better recognize situations of impaired supervisor activity, and better understand the psychosocial impact of the impaired supervisor/resident relationship on residents, including their coping mechanisms, and the unique power position of the impaired supervisor.

SUMMARY:

Recently, there has been increased focus on the impaired physician. Commonly when the term impaired physician is used, images of, drug- or alcohol-impaired individuals come to mind. Physicians are at higher risk for alcohol or drug addiction (up to 15%). The broader definition of impairment, which includes physical and/or mental illness, may be more appropriate. The impaired psychiatrist is not an uncommon situation. One published study reported the response of residents to hypothetical vignettes (Rueben, 1990). The psychosocial impact on residents who work with an impaired supervisor has not been well studied. The resident-supervisor relationship is unique in

the medical community with respect to authority and power issues. Defense mechanisms employed by the resident in dealing with an impaired supervisor may be different from those employed by a physician dealing with an impaired co-equal.

This workshop will present the results of a survey of residents in U.S. and Canadian psychiatric residency programs concerning the impact of working with a physically or mentally impaired supervisor. The psychosocial experience and career-development issues will be explored. Vignettes of resident–impaired supervisor interactions will be discussed. Guidelines for dealing with impaired supervisors will be outlined.

REFERENCES:

1. Reuben DB, Noble S: House officer responses to impaired physicians. JAMA 1990; 263:958.
2. Doyle B: The impaired psychiatrist. Contemporary Psychiatry, Psych Annals 1987; 17:760.

Component Workshop 49
NATIONAL HEALTH INSURANCE: A DISTRICT BRANCH VIEW
APA Psychiatric Society of Westchester County, Inc.

Chairperson: Timothy B. Sullivan, M.D., *Department of Psychiatry, New York Medical College, 275 North Street, Harrison NY 10528*
Participants: Steffie Woolhandler, M.D. Tyrone S. Turner, M.D., Captane P. Thomson, M.D.

EDUCATIONAL OBJECTIVES:

This workshop will provide participants the opportunity to discuss with distinguished experts crucial issues in the national health care debate, especially pertaining to the means by which we may achieve universal access to health care for our patients.

SUMMARY:

The workshop will begin with each of the panelists discussing their work in the area of health care policy. Participants will hear the case for single-payer national health insurance (Dr. Woolhandler), proposing this option as the only fair and manageable way to achieve universal access and affordability. A Canadian psychiatrist who has lectured widely on health care policy and its effects on mental health practices (Dr. Turner) will review Canada's experience under Medicare, and what the U.S. may learn from it. Finally, participants will hear a discussion from the chair of APA's Committee on Universal Access to Health Care (Dr. Thomson) about a proposal that was referred, with the support of APA president Dr. Munoz, to the APA Council on Economic Affairs for sponsorship by the APA. This proposal advocates a health insurance model combining elements of MSAs and a catastrophic illness national health insurance program.

Workshop participants will have substantial opportunity for interaction with all three experts and for discussion and debate about facts and analytic methods. In addition, the chair will review the experience of the district branch sponsoring the workshop in surveying and educating DB members about health care policy over the course of the academic year (98–99).

REFERENCES:

1. Woolhandler S, Himmelstein D: Costs of care and administration at for-profit and other hospitals in the United States. NEJM 1997; 336:769-774.
2. Woolhandler S, Himmelstein D: Clinton's health plan: Prudential's Choice. Int J Health Serv 1994; 24:583-592.

Component Workshop 50
GETTING YOUR PATIENT ON SOCIAL SECURITY INCOME: AN INSIDER'S GUIDE
APA Committee on Poverty, Homelessness and Psychiatric Disorders

Chairperson: Stephen M. Goldfinger, M.D., *Department of Psychiatry, SUNY, Health Science Campus, 450 Clarkson Avenue/Box 1203, Brooklyn NY 11203,*
Participants: Ramanbhai C. Patel, M.D., Manoj R. Shah, M.D., Harvey Bluestone, M.D., Albert A. Hyman, M.D.

EDUCATIONAL OBJECTIVES:

To learn more about how to evaluate the most critical dimensions of a patient's functioning using SSI disability criteria and to record the results of their knowledge of patients in a way that most effectively ensures SSI eligibility.

SUMMARY:

For many of the most seriously psychiatrically disordered, access to entitlements (income support and Medicaid) serves as their "life preserver." The Committee on Poverty, Homelessness and Psychiatric Disorders has spent a great deal of time over its last several meetings examining the critical role of income and health care supports in maintaining the stability of impoverished psychiatric patients in the community. Often, those who might be eligible for SSI have their applications denied because of incomplete or poorly filled out evaluations by their treating physicians. In order to help address this issue, our 1999 workshop will provide a hands-on, multimedia, interactive workshop on filling out SSI and disability evaluations. Panel discussants will include members of the committee, Dr. Harvey Bluestone and a staff person from the SSI program whose job is to review and evaluate applications.

The session will consist of a videotaped interview with a patient who is about to apply for SSI and a "pre-test" during which participants will be asked to fill in an evaluation form. The workshop will focus on helping participants to understand the structure and language that SSI looks for in evaluating applications. Finally, a second attempt at writing up an evaluation form for the videotaped patient will take place, with responses critiqued by the three SSI reviewers on the panel. Ample opportunity will be made available for discussion with the panel. Printed materials will be distributed to take back to participants' offices.

REFERENCES:

1. Pincus HA, Kennedy C, et al: Determining disability due to mental impairment: APA's evaluation of Social Security Administration guidelines, Am J Psychiatry 1991; 148:1037-43.
2. Kennedy C, Simmens SJ, et al: The Social Security Disability Evaluation Study, New Dir Ment Health Serv 1990; 45:29-36.

Component Workshop 51
INTERNISTS OF THE MIND OR DOCTORS OF THE SOUL?
APA Committee on Religion and Psychiatry and APA Council on National Affairs

Chairperson: William N. Grosch, M.D., *Department of Psychiatry, Albany Medical College, 47 New Scotland Avenue, A-20, Albany NY 12203*
Participants: Allen R. Dyer, M.D. J. Philip Wogaman, Ph.D. Herbert Pardes, M.D. Allan Tasman, M.D. Don S. Browning, Ph.D. Reverend Clark S. Aist, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the advantages of a public philosophy for psychiatry,

to appreciate the diversity of opinions about what such a philosophy might entail, and to better understand the relationship between religion and psychiatry.

SUMMARY:

In order for psychiatry to be clear about the nature of its practice, it must develop a philosophy that articulates its work in a publicly intelligible way. Should psychiatry lead society in developing a positive view of the good society and the good person (or "healthy" society and person), or should it confine itself to the more cautious role of caring for the mentally ill? Who are we, internists of the mind or doctors of the soul? How are we to characterize the value commitments of psychiatry? How far should psychiatry go in trying to influence the values of the wider society? How does psychiatry relate to religion in the clinic, both to the religious commitments and experiences of the patient and to those of the therapist?

This component workshop organized by the Committee on Religion and Psychiatry, will begin with 10-minute responses from the panelists to Dr. Don Browning's Oskar Pfister Award lecture. Dr. Browning will then have an opportunity to address the remarks of the discussants. The format will allow ample opportunity for audience participation. Interaction between Dr. Browning, panelists, and members of the audience will be encouraged.

Following Dr. Browning's lead, the workshop will develop and explore his view of the relationship between religion and psychiatry.

REFERENCES:

1. Religious and Ethical Factors in Psychiatric Practice, edited by Browning DS, Jobe T, Evison IS, Chicago, Nelson-Hall, 1991.
2. Does Psychiatry Need a Public Philosophy?, edited by Browning DS, Evison IS, Chicago, Nelson-Hall, 1991.

Component Workshop 52
DOCUMENTATION REQUIREMENTS AND CODING UPDATE
APA Work Group on Codes and Reimbursements and APA Work Group on Harvard Resource-Based Relative Value Scale Study

Co-Chairpersons: Chester W. Schmidt, Jr., M.D., *Johns Hopkins Bayview Med Ctr, 4940 Eastern Avenue A4C, Baltimore MD 21224-2735,* Donald J. Scherl, M.D., *149 Corbett Avenue, San Francisco CA 78731*
Participants: Tracy R. Gordy, M.D. Melodie Morgan-Minott, M.D. Ronald A. Shellow, M.D. Frank T. Rafferty, Jr., M.D. Shelley Stewart, Eugene Cassel, Jay B. Cutler, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participant will be knowledgeable about the 1994–1995 Documentation Guidelines for E/M services, the current revisions in those Guidelines, and the Commission on Psychotherapy's suggestions for documenting psychotherapy.

SUMMARY:

In 1994–1995, the Health Care Financing Administration and the American Medical Association published guidelines for documenting evaluation and management services. The entire medical community raised so many concerns about these guidelines, which became requirements for documentation during subsequent audits of physician billing, that the AMA and HCFA were forced to consider major revisions of the guidelines now working their way through all medical societies. The goals of the combined APA work groups (RBRVS Study and Codes/Reimbursements) are to familiarize practitioners with the basic elements of these evolving guidelines as well as with the documentation developments sponsored by APA. Presentations and handouts will provide the details of the various sets of guidelines.

REFERENCES:

1. CPT, American Medical Assn, Chicago, 1998.
2. CPT Advisor American Medical Assn. Chicago, 1997.
3. Schmidt CW Jr: CPT Handbook for Psychiatrists, Second Edition. Washington, DC, American Psychiatric Press, Inc., 1998.

Component Workshop 53
DECRIMINALIZING SEVERELY MENTALLY ILL PERSONS
APA Council on Psychiatric Services

Chairperson: H. Richard Lamb, M.D., *Department of Psychiatry, University of Southern CA, 1934 Hospital Place, Los Angeles CA 90033-1071*
Participants: Roger Peele, M.D., Cassandra F. Newkirk, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should have a better understanding of the problem of criminalization of severely mentally ill persons and know a number of ways of preventing and alleviating this urgent problem.

SUMMARY:

The presence of severely mentally ill persons in jails and prisons is an urgent problem. This workshop examines this problem and makes recommendations for preventing and alleviating it. Clinical studies suggest that 6 percent to 15 percent of persons in city and county jails and 10 percent to 15 percent of persons in state prisons have a severe mental illness. Offenders with severe mental illnesses generally have acute and chronic mental illness and poor functioning. The factors most commonly cited for the mentally ill being placed in the criminal justice system include deinstitutionalization and a shortage of long-term hospital beds; more restrictive criteria for civil commitment; a lack of access to appropriate community treatment; and the attitudes of police officers and society toward mentally ill offenders. Recommendations include mental health consultation to police in the field; formal training of police officers; careful screening of incoming jail detainees; diversion to the mental health system of mentally ill persons who have committed minor offenses; assertive case management and various social control interventions such as outpatient commitment, court-ordered treatment, psychiatric conservatorship, and 24-hour structured care when indicated; involvement of and support for families; and provision of mental health treatment appropriate for this population.

REFERENCES:

1. Lamb HR, Weinberger LE: Persons with severe mental illness in jails and prisons: a review. Psychiatric Services 1998; 49:483-492.
2. Laberge D, Morin D: The overuse of criminal justice dispositions: failure of diversionary policies in the management of mental health problems. Int J Law & Psychiatry 1995; 18:389-414.

Component Workshop 54
HUMAN FACTORS IN TELEPSYCHIATRY
APA Committee on Telemedical Services

Chairperson: David F. McMahon, M.D., *Northeast Health, 100 Powers Street, Beverly MA 01915*
Participants: Norman E. Alessi, M.D., Zebulon C. Taintor, M.D., Charles L. Zaylor, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the effectiveness and limitations of current applications of telemedicine from the perspective of the psychiatrist and the patient. Participants identify the elements favoring more efficacious

telepsychiatry encounters in forensic and disability evaluations and observe what changes can occur in the doctor-patient relationship.

SUMMARY:

Telepsychiatry has come of age, offering a panoply of opportunities and the possibilities of misuse. But what is it like for the *patient* in a telemedicine encounter? In this workshop's lively, interactive discussions, the audience will learn about several current applications of telemedicine from viewpoints of the patient and psychiatrist. Although state-of-the-art technology may be described, our focus will be on the human experience. Audience involvement is strongly encouraged, since resistance to adoption of telemedicine by physicians due to their concerns about this new patient-care delivery system are central to the workshop's theme.

REFERENCES:

1. Telemedicine: A Guide to Assessing Telecommunications in Health Care. Marilyn J. Field, ed. Washington DC, National Academy Press, 1996, pp. 73-82.
2. AMA Policy 225.962 Medical staff membership category for physicians providing telemedicine: http://www.ama-assn.org/mem-data/special/omss/omssadv/policy. htm.

Component Workshop 55

PSYCHIATRIC DIMENSIONS OF DISASTERS

APA Committee on Psychiatric Dimensions of Disasters

Chairperson: Robert J. Ursano, M.D., *USUHS, 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 as illustrated by discussions of recent disasters.

SUMMARY:

Disasters, natural and man-made, have inflicted significant losses worldwide. Recent examples include the Asian floods and the bombing of the U.S. embassies in East Africa. Mental health issues relating to a disaster range from preparedness to care for those who become chronically ill. The psychiatrist needs to be responsive to the shifting needs of the affected populations over time. This workshop will continue to elaborate on the roles that a psychiatrist is well suited to assume in disaster planning and response.

Psychiatrists who have worked on recent disasters will be invited to attend and share their experiences. Historically, many workshop attendees have a wide range of experiences in both national and international disasters. The workshop provides a forum for sharing expertise and raising issues of concern for further exploration by the Committee on Psychiatric Dimensions of Disasters.

REFERENCES:

1. Ursano RJ, Fullerton CS, Norwood AE: Psychiatric dimensions of disaster: patient care, community consultation, and preventive medicine. Harvard Review of Psychiatry 1995; 3:196-209.
2. Ursano RJ, McCaughey B, Fullerton CS (eds): Individual and Community Responses to Trauma and Disaster: The Structure of Human Chaos. Cambridge, England, Cambridge University Press, 1994.

Component Workshop 56

NEW APA PRACTICE RECOMMENDATIONS ON ECT

APA Task Force on Electroconvulsive Therapy

Chairperson: Richard D. Weiner, M.D., *Department of Psychiatry, Duke University Medical Center, PO Box 3309, Durham NC 27713*
Participants: Laura J. Fochtmann, M.D., Charles H. Kellner, M.D., Harold A. Sackeim, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, the participant should be able to understand the most important aspects of contemporary ECT utilization, including referral for treatment, evaluation of patients' prior ECT, administration of treatments, post-ECT management, and training and privileging of practitioners.

SUMMARY:

In 1990, APA published comprehensive recommendations on treatment, training, and privileging in electroconvulsive therapy (ECT). This report has had a significant impact on the practice of ECT within the U.S. and has influenced the development of similar efforts in other countries.

Given the continued growth of research and clinical knowledge in this area, it became clear that a revision of the 1990 APA recommendations was indicated. Following a comprehensive review of the literature, as well as opportunities for ECT practitioners, experts in ECT and other relevant disciplines, other APA components, and major consumer organizations to provide input, a revised set of recommendations has been developed.

The workshop will provide an overview of these recommendations, with a particular focus on areas where they differ from those made in 1990. Substantial time will be allocated to maximize the opportunity for attendees to comment and have questions answered. It is our belief that these recommendations reflect state-of-the-art, yet practically realizable, practice of this valuable treatment modality and, as such, will further ensure the delivery of safe and effective ECT treatment in the years to come.

REFERENCES:

1. American Psychiatric Association: The Practice of Electroconvulsive Therapy: Recommendation for Treatment, Training, and Privileging. Washington, D.C., American Psychiatric Association, 1990.
2. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition. Washington, D.C., American Psychiatric Association, 1994.

Issue Workshop 1

CAREER STRATEGIES: STAY GENERATIVE AND STIMULATED

Chairperson: Joel Yager, M.D., *Department of Psychiatry, University of NM School of Med, 2400 Tucker, NE, Albuquerque NM 87131*
Participants: Jerald Kay, M.D. Carol C. Nadelson, M.D. Carolyn B. Robinowitz, M.D. Zebulon C. Taintor, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe strategies used by psychiatrists to maintain generative and stimulating careers by the following methods: 1) becoming expert in specific aspects of routine activities; 2) cultivating supplementary

activities in parallel with ongoing routines, and 3) developing sequential careers.

SUMMARY:

Clinical practice and academic medicine are being pummeled by changes that challenge the nature of traditional physician-patient relationships, reduce physician autonomy and resources, and increase administrative burdens. These changes are increasing physician distress in many fields of medicine, including psychiatry, and contribute to a crescendo of complaints about professional burnout. Each of the panelists has successfully negotiated mid-career renewal, based on developing new career and personal interests to supplement and enrich their initial professional roles and/or by means of quasi career switches. In addition, the panelists have mentored, supervised, and advised thousands of psychiatrists who have struggled successfully (and in some instances unsuccessfully) to maintain themselves as generative and stimulated professionals. This workshop will explore the strategies utilized by the presenters and their professional acquaintances and will engage participants in further discussion and exploration of these issues.

REFERENCES:

1. Career Pathways in Psychiatry: Transition in Changing Times. Hillsdale, N.J., Analytic Press, Inc., 1996.
2. Csikszentmihalyi M: Creativity: Flow and the Psychology of Discovery and Invention. Harper Perennial, New York 1997.

Issue Workshop 2
SCHIZOPHRENIA GUIDELINES: ADMINISTRATIVE CHALLENGES
The American Association of Psychiatric Administrators

Chairperson: Thomas W. Hester, M.D., *Division MHMRSA, DHR, 2 Peachtree Street, 22nd Flr., Atlanta GA 30303*
Participants: James W. Mimbs, M.D. Steven P. Shon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify and describe the two primary models used for formulation of Schizophrenia Practice Guidelines and to recognize the advantages and disadvantages of implementing the Schizophrenia Practice Guidelines.

SUMMARY:

Since 1996, three major clinical practice guidelines for the treatment of schizophrenia have been published. These guidelines utilize two primary models: detailed treatment algorithms and general treatment recommendations. These models are based on published research that is sometimes augmented by expert consensus. Many administrative psychiatrists have been asked to implement practice guidelines in response to managed care contracts, performance improvement systems, and advocacy groups (e.g., NAMI Consumer and Family Guide to Schizophrenia Treatment). The presenters are experienced in statewide efforts to implement both models of treatment guidelines. They will present their experiences regarding the pros and cons of implementing guidelines and their use in physician privileging, recredentialing, peer review, and performance improvement. Each brief presentation will be followed by a question-and-answer session, and the final 30 minutes will be dedicated to an interactive discussion with the audience.

REFERENCES:

1. Lehman AF, Steinwachs DM: At issue: translating research into practice: the Schizophrenia Patient Outcomes Research Team (PORT) treatment recommendations. Schizophrenia Bulletin 1998; 24:1-10.
2. American Psychiatric Association: Practice Guideline for the Treatment of Patients with Schizophrenia. Am J Psychiatry 1997; 154(Suppl. 4): 1-63.

Issue Workshop 3
PROBLEMATIC EXCESSIVE SEXUAL BEHAVIOR

Chairperson: Reid Finlayson, M.D., *The Homeward Health Center, 1500 Delphi Street, Guelph ON N1E 6K9, Canada,*
Participants: Patrick J. Carnes, Ph.D. Jennifer P. Schneider, M.D. John R. Sealy, M.D. Richard R. Irons, M.D. Stephen S. Brockway, M.D. James C. Montgomery, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this workshop, the participants should be aware of the differences and similarities between sexual addiction and compulsion. Participants will be able to diagnose problematic sexual behavior, recognize sexual misconduct by professionals, understand treatment approaches and family interventions, and understand implications for addictions medicine.

SUMMARY:

Much public attention is currently paid to sexual issues involving public figures. This intensifies the debate about sexual addiction and compulsion. This workshop focuses on diagnosing problematic sexual behavior. Current research and model development on addictive/compulsive behavior will be reviewed. Core examples of sexual misconduct by professionals will be used to illustrate issues of model adequacy. An overview to treatment approaches and family interventions will be discussed along with implications for addictions medicine.

REFERENCES:

1. Carnes PJ: The presidential diagnosis: sexual addiction and compulsivity. treatment and prevention, to be published.
2. Schneider J: How to recognize the signs of sexual addiction. Postgraduate Medicine 1991; 90:171-182.

Issue Workshop 4
PAIN SUBSPECIALTY: OPPORTUNITIES AND OBSTACLES

Chairperson: Rollin M. Gallagher III, M.D., *Allegheny Univ of Hlth Sc, MCP Hahnemann Sch of Med, Broad and Vine St M/S 403, Philadelphia PA 19102*
Participants: Beverly J. Fauman, M.D. Linda Logsdon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: present the rationale for psychiatrists practicing pain medicine; discuss opportunities for entering pain practice from residency, early career, and mid-to-late psychiatric career; describe access to pain training and examination certification and its consequences; and discuss opportunities in academic psychiatry, including teaching, practice, and research.

SUMMARY:

This workshop discusses opportunities and obstacles in pain management. Some believe subspecialties create hierarchies, precluding practice opportunities, others believe subspecialties expand career options, accessing new markets. This latter sentiment prevailed when considering the growing practice of pain medicine, heretofore ceded to other medical specialties and psychology. The American Board of Psychiatry and Neurology and American Board of Physical Medicine and Rehabilitation will offer an American Board of Medical Specialties (ABMS) Certificate of Subspecialization in Pain Management (CSPM) after examination by the American Board of Anesthesi-

ology. For board-certified psychiatrists in pain practice, the American Board of Pain Medicine now offers certification examination, not recognized by ABMS but by others. These credentials suggest that psychiatrists will be recognized as medical pain specialists by institutions and third parties, avoiding behavioral carveouts. A medical practice with humanistic, biopsychosocial underpinnings and medical specialists' reimbursement may attract new trainees.

The promise of pain practice is fraught with unanswered questions: What are credentials for examination? With so few psychiatrists presently practicing pain medicine, who will choose and teach fellows and direct fellowships? When can institutions apply for program approval?

After brief presentations, a workshop panel will encourage audience participation and discussion of these and other salient issues facing psychiatry.

REFERENCES:

1. Lippe PM: Pain medicine: a conceptual and operational construct. In M. Cohen, J. Campbell (Eds.), Pain Treatment at a Crossroads: A Practical and Conceptual Reappraisal. Progress in Pain Research and Management, Vol. 7. Seattle, IASP Press, 1996, pp. 307-314.
2. Clark MR: The Role of Psychiatry in the Treatment of Chronic Pain. In Cohen, Campbell JN (Eds.), Pain Treatment Centers at a Crossroads: A Practical and Conceptual Reappraisal, Progress in Pain Research and Management, Vol. 7. Seattle, IASP Press, 1996, pp. 59-68.

Issue Workshop 5

AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY UPDATE: A GUIDE PARTICULARLY FOR RESIDENTS TO UNDERSTAND THE REQUIREMENTS TO SIT FOR THE ABPN EXAMINATION

The American Board of Psychiatry and Neurology, Inc.

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. Michael H. Ebert, M.D. Larry R. Faulkner, M.D. Sheldon I. Miller, M.D. Pedro Ruiz, M.D. John E. Schowalter, M.D. James H. Scully, Jr., M.D. Elizabeth B. Weller, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to assist resident APA members, young career psychiatrist members, and other members in learning the policies and procedures of the ABPN for certification, recertification and subspecialization.

SUMMARY:

An overview of the policies and procedure of the American Board of Psychiatry and Neurology will be presented followed by an active dialogue about the necessary conditions for admission to the certification examination, the examination process, and the current status of recertification and subspecialization. Material will focus on the resident members and early career psychiatrists. Resident and early career psychiatrists will be encouraged to attend and ask questions about certification, recertification, and subspecialization, in addition to the specifics of the Part I and Part II written and oral examinations for certification. Participants will be urged to discuss child and adolescent psychiatry, addiction psychiatry, forensic psychiatry, geriatric psychiatry, clinical neurophysiology, and pain management.

REFERENCES:

1. Shore J, Scheiber S: Certification, Recertification and Lifetime Learning, Washington, D.C., APPI, 1994.
2. American Board of Medical Specialties: Recertification for Medical Specialists, Evanston, IL ABMS, 1987.

Issue Workshop 6

HOMEOPATHIC MEDICINE AND PSYCHIATRY

Chairperson: Edward B. Gogek, M.D., *PO Box 3967, Prescott AZ 86302*
Participants: Sandra N. Kamiak, M.D. Arlin E. Brown, M.D.

EDUCATIONAL OBJECTIVES:

After this workshop, participants will understand the principles of homeopathy, the basic science explaining its mechanism of action and the most important clinical research validating its efficacy. They should know how homeopathy differs from other forms of alternative medicine and the psychiatric conditions for which it is useful.

SUMMARY:

As homeopathic treatment becomes more widespread and more mainstream, even clinicians with no interest in alternative medicine will have to talk to their patients about homeopathy and sometimes communicate with alternative practitioners.

Psychiatrists who are open to alternatives often find homeopathy fits in very well with psychiatric practice. This workshop will present an overview of classical homeopathy. The first half of the workshop will cover homeopathic basic science, the scientific research explaining and validating homeopathy, and the homeopathic treatment of psychiatric disorders. The second half will be question and answer and discussion. Homeopathy is a controversial topic, and open dialogue is the best way to approach many of the issues important to physicians. The presenters are psychiatrists who use homeopathy in their practices. Besides their traditional medical and psychiatric training, all studied at the Hahnemann College of Homeopathy. Drs. Brown and Kamiak use homeopathy in private psychiatric practice, and Dr. Gogek integrates homeopathy into a community mental health center practice with both children and adults.

REFERENCES:

1. Bellavite P, Signorini A: Homeopathy: A Frontier in Medical Science. Berkeley, CA, North Atlantic Books, 1995.
2. Kleijnen J, Knipschild P, ter Riet G: Clinical trials of homeopathy. British Medical Journal 1991; 302:316-323.
3. Reilly D, Taylor MA, Beattie N, et al: Is evidence for homeopathy reproducible? The Lancet 1994; 344:1601-6.

Issue Workshop 7

PATTERNS OF BEHAVIOR IN POPULATIONS OF TRAUMA SURVIVORS: BIOLOGICAL AND CLINICAL ASPECTS

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. Susan Mirow, M.D. Rachel Yehuda, Ph.D. Robert D. Levitan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participants should: 1) become familiar with a more integrated psychosocial model of traumatic stress, 2) become familiar with the latest concept in the field of trauma: intergenerational aspects of trauma, cumulative effects, impact of trauma on biorhythms, 3) understand the complexity of the field of traumatic stress and its social implications.

SUMMARY:

Worldwide expansion of communication, mass media, and transportation in the past decade has enhanced awareness of the ubiquitous nature of trauma. As a consequence, renewed interest in the psychological sequelae of trauma survivors and their families among mental health professionals has triggered recent research into both overt and covert biological, psychological, and sociohistorical aspects of traumatic stress. Furthermore, the impact of trauma on families and offspring of victims has emerged as a new subject with the publication of the textbook edited by Dr. Yael Danieli on the intergenerational aspects of trauma.

The panelists of this workshop are members of the Intergenerational Aspects of Trauma interest area group of the International Society of Traumatic Stress Studies. Their experience is drawn from a wide range of populations—survivors of the Holocaust, their offspring, Vietnam veterans, victims of assault and civilian trauma, and work-related accidents. They will address basic biopsychosocial aspects of traumatic stress, the concept of "traumatic disorders" (a group of psychiatric disorders triggered by trauma), and the relationship between trauma and the onset of a wide variety of disorders, e.g., PTSD, other anxiety disorders, mood disorders, somatization disorders, and dissociative disorders. Newer concepts in the field of traumatic stress (i.e., the cumulative effect of trauma, intergenerational aspects of trauma, acquired vulnerability, social reenactment of trauma, and biorhythm/theory of chaos in traumatized individuals), and malevolence will be presented. Participation from the audience and discussion of specific clinical examples will be encouraged.

REFERENCES:

1. Novac A: Traumatic disorders—contemporary directions, Western Journal of Medicine, 1998; 169:40-41.
2. Yehuda R, Schmeidler J, Wainberg M: Vulnerability to post traumatic stress disorder in adult offspring of Holocaust survivors. Am J Psychiatry, 1998; 155:1163-1171.
3. Danieli Y: International Handbook of Multigenerational Legacies of Trauma, New York, Plenum Press, 1998.

Issue Workshop 8
BEYOND MEDICAL SCHOOL: THE MBA ADVANTAGE

Co-Chairpersons: Arthur L. Lazarus, M.D., *MBA, Prudential Health Care, 102 Rock Road, Horsham PA 19044,* Marie L. Zecca, *711 University Services, Philadelphia PA 19122*

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, especially 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, workshop participants will have a chance to learn about the physician-executive marketplace. The careers of physicians who recently graduated from one executive MBA program (Temple University) will be profiled. There will be ample time to ask questions and discuss personal experiences to help plan for a career in administrative psychiatry or medical management.

REFERENCES:

1. Lazarus A: The educational needs of physician executives: why an MBA? Physician Executive 1997; 23:41-44
2. MD/MBA: Physicians on the New Frontier of Medical Management, edited by Lazarus A, Tampa, Florida, The American College of Physician Executives, 1998

Issue Workshop 9
MANAGED CARE VERSUS FEE-FOR-SERVICE MEDICADE FOR ADOLESCENTS

Chairperson: Saul M. Levin, M.D., *Access Consulting, 1901 Penn Avenue NW, #705, Washington DC 20006*
Participants: Mady Chalk, Ph.D. Fran Cotter, Craigann Heflinger, Roy Gabriel

EDUCATIONAL OBJECTIVES:

To discuss various problems and methods of solutions for these problems, including recruitment and follow up interviews; to gain insight from audience participation based on their experience in adolescent studies.

SUMMARY:

Significant changes related to the organization and financing of behavioral health services are occurring throughout the USA. One of the most pronounced changes is the increasing use of managed care arrangements to control health care costs. The Substance Abuse and Mental Health Services Administration (SAMHSA) is sponsoring a multisite study to enhance knowledge about the effects of public-sector managed care on patterns of service use, service costs, outcomes, and satisfaction with care. The study will compare fee-for-service (FFS) Medicaid adolescent care versus managed care Medicaid adolescent services systems. The study is in two parts: 1) the prospective study of different services available to adolescents in the FFS vs. managed care systems in six states across the U.S.; 2) The Administrative Data Study, which will analyze service use and expenditure data for systems of care within each site. This workshop will describe some of the start-up issues (both successes and areas to be improved upon), as well as describe the overall study and six sites, namely, Oregon, Massachusetts, Tennessee/Mississippi, Pennsylvania, New York, and Puerto Rico.

REFERENCES:

1. Rahdert E, Czechowitz D: Adolescent Drug Abuse: Clinical Assessment and Therapeutic Interventions, 1995
2. Managing managed care: quality improvement in behavioral health, Edmunds M. et al, eds. Washington DC, National Academy Press, 1997

Issue Workshop 10
ANALYZING AND NEGOTIATING YOUR EMPLOYMENT CONTRACT

Co-Chairpersons: Thomas S. Jensen, M.D., *14 Golder Street, Lewiston ME 04240-6023,* Karen L. Boudreau, *Esq., RR 1 Box 545, Bailey Island ME 04003*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to read and understand employment contracts, recognize important

issues in employment contracts, recognize the risks in an employment contract, determine whether or not the contract represents the verbal understanding of the psychiatrist regarding the employment relationship.

SUMMARY:

The majority of psychiatrists will sign employment agreements during the course of their careers. These agreements directly impact the psychiatrist in many important ways: their ability to provide quality care, their degree of clinical autonomy, their financial remuneration, their hours and lifestyle, and the benefits that impact on practitioners and their families. Unfortunately, most psychiatrists are ill equipped for their employment contract negotiations. Many sign agreements without understanding what they are agreeing to. Some even sign agreements that do not represent the verbal agreement they thought they made.

This workshop is designed to equip psychiatrists to enter into employment agreements with a better understanding of the negotiation process, the risks of the contract, legal jargon that may appear superficially innocent, and how to get an agreement that sets up a mutually beneficial employment relationship.

REFERENCES:

1. Harty-Golder MD: Employee, contractor or agent? J Fla Med Assn 1996; 83(1):33-5
2. Lewis TB: Restrictive covenants in a physician's employment agreement. 1997; NJ Medicine
3. Stewart E: Drafting a sound physician employment agreement, Healthcare Financial Management, November 1996

Issue Workshop 11
LIFE-THREATENING ELDER PSYCHIATRIC EMERGENCIES

Chairperson: Michael J. Tueth, M.D., *Department of Psychiatry, University of Florida, PO Box 100256/College of Med, Gainesville FL 32610*
Participants: Nauphyll S. Zuberi, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand signs and symptoms of life-threatening psychiatric emergencies seen in elderly patients, to distinguish between functional and physical causes for psychiatric emergencies in the elderly, and to know management strategies for responding to life-threatening psychiatric emergencies in older persons.

SUMMARY:

While most elderly patients die from physical complications of disease, some have life-threatening behavioral disturbances that can be fatal to self or others if not recognized and adequately treated. Some life-threatening behaviors in the elderly are functional in nature including suicide, assault, and some psychoses. However, many elder behavioral emergencies result from physical illness. These include delirium, complications of dementia, as well as abuse and neglect. While the emergency department may be the most common setting where behavioral emergencies in the elderly are encountered, other venues are also represented including the outpatient clinic, the medical/surgical floor, and the nursing home.

The workshop format consists of an initial presentation of clinical details of life-threatening behavioral emergencies in the elderly, especially highlighting physical causes of these disturbances. This will be followed by a detailed presentation of the emergency management of elder behavioral emergencies, emphasizing both the least restrictive environment and patient safety. An audience discussion will be facilitated using hypothetical case presentations to maximize individual learning. The audience will be encouraged to take a vital role in arriving at the correct diagnosis and selecting the proper management strategy for each case presented.

REFERENCES:

1. Tueth MJ: Diagnosing psychiatric emergencies in the elderly. Am J Emerg Med 1994; 12:364-369.
2. Tueth MJ: Dementia: diagnosis and emergency behavioral complications. J Emerg Med 1995; 13:519-525.

Issue Workshop 12
BRIEF DYNAMIC THERAPY: WHEN LESS IS MORE

Co-Chairpersons: Carlos Blanco-Jerez, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, Box 81, New York NY 10032,* Donna T. Chen, M.D., *2810 Schildford Farm, Charlottesville VA 22901*
Participants: Lisa A. Mellman, M.D. Eve Caligor, M.D. Alan S. Barasch, M.D. Petros Levounis, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to compare the advantages of using a group supervisory process involving several supervisors and residents to teach brief dynamic psychotherapy; to see the difficulties involved in such process and have some ideas of how to solve them.

SUMMARY:

Increasingly, brief dynamic therapy (BDT) has become a popular form of treatment among patients and clinicians alike. However, learning and teaching BDT continue to be challenging tasks, especially in the context of residency training. Learning psychotherapy requires understanding different theoretical models and learning a variety of therapeutic techniques. It also requires exposure to enough treatment cases and significant amounts of protected time for supervision. These needs often conflict with the time demands that other obligations impose on residents. The psychotherapy skills learned may be influenced by the skill and style of the individual supervisor.

This workshop will demonstrate the didactic method used to teach residents BDT at the department of psychiatry of Columbia University. A trainee will present process notes from a session of one of his brief dynamic cases. Clinical material presented will be presented to a group composed of equal numbers of supervisors and trainees. In this group, supervision suggestions will be made regarding how to understand the dynamic process, alternative interventions, and future goals in the treatment. Ample time will be left for the audience to make contributions about the case, inquire about the didactic model, and discuss other ways of teaching brief dynamic therapy.

REFERENCES:

1. Messer SB, Warren CS: Models of brief psychodynamic therapy. New York, Guilford Press, 1995
2. Strupp HH, Binder JL: Psychotherapy in a New Key. New York, Basic Books, 1984.

Issue Workshop 13
TEACHING BOUNDARIES TO CLINICIANS

Chairperson: Samia Barakat, M.D., *University Manitoba, PZ433-771 Bannatyne Avenue, Winnipeg MB R3E 3N4, Canada*
Participants: Mark A. Prober, M.D. Mark S. Etkin, M.D. Teresa C.I. De Cloedt, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should understand: concepts of "boundary" and "boundary violation"; consequences of "boundary breach"; how to recognize risk factors and

prevent risk behaviors from developing. The participant will learn about the development of the Manitoba Boundary Education Program for clinicians; panelist observations and recommendations based on experience to date. The participants will engage in informal discussion with workshop faculty.

SUMMARY:

Dr. Etkin will begin by ensuring core knowledge in understanding the concepts of "boundary," "boundary violation," "exploitation," "fiduciary relationships," "power differentials," and "the slippery slope." Parameters of boundary (personal and professional) will be discussed. Vulnerability factors and dynamics (situational and personal) will be explored. He will also address the problematic role of inappropriate "projection," "transference," "counter-transference," and "role-reversal" in boundary breach. The potentially damaging consequences of boundary violation are explored. The importance of education and prevention is addressed.

Dr. De Cloedt will detail the development of the Manitoba Boundary Education Program. She will discuss the importance of formal investigation, "undertaking" and "mandatory disclosure understanding." She will also review intake (particularly in beginning to deal with learner anxiety and anger), program content and process, debriefing, monitoring, and reporting practices.

Dr. Prober will review program experience to date including demographic information, observations, and recommendations. The final 20 to 30 minutes will be spent in open discussion, sharing ideas and information.

REFERENCES:

1. Prober M: Boundaries. Prairie Medical Journal 1997; 67:11
2. Journal Articles
2. Donen N, Etkin M: Boundaries: smaller than you think. Prairie Medical Journal 1997; 67:13-14
3. De Cloedt T: The development of a Boundary Education Program. Prairie Medical Journal 1997; 67:17-18
4. Barakat S, De Cloedt T: Boundary violations within the student-educator relationship. Prairie Medical Journal: 67:19-20

Issue Workshop 14
MANAGEMENT OF COMORBID CONDITIONS IN SCHIZOPHRENIA

Co-Chairpersons: Michael Y. Hwang, M.D., *Department of Psychiatry, FDR VAMC, PO Box 100, Montrose NY 10548,* Lewis A. Opler, M.D., *Psychiatry, Columbia University, 5035 Arlington Avenue, Riverdale NY 10471*
Participants: Samuel G. Siris, M.D. Douglas M. Ziedonis, M.D. Leslie L. Citrome, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop the participant will be familiar with the current state of knowledge regarding some of the common comorbid conditions in schizophrenia and be better able to diagnose and treat these conditions.

SUMMARY:

Schizophrenic spectrum disorder has been known to encompass diverse clinical phenomena. Further, recent psychiatric research has also demonstrated varying neurobiological abnormalities in schizophrenic illness. These clinical and biological diversities continue to challenge practicing clinicians in terms of assessment and treatment of schizophrenic patients. Increasing research evidence suggests that schizophrenics with comorbid conditions including depression, OCD, substance abuse, and violent-aggressive behaviors may account for a considerable part of the schizophrenic heterogeneity and require specific pharmacological and behavioral treatment approaches for optimal outcome.

This workshop will review and discuss the clinical management of the following comorbid conditions: Dr. Siris will review the various depressive phenomena in schizophrenia and discuss their management. Dr. Hwang will discuss the diagnostic and treatment issues in obsessive-compulsive schizophrenics. Dr. Ziedonis will present recent findings and discuss treatment approaches in substance abusing schizophrenics. Dr. Citrome will review the clinical and treatment issues in aggressive and violent schizophrenics. Dr. Opler will review and discuss the clinical and biological perspectives of comorbidities in schizophrenia.

This presentation is part of the publication by the APPI Clinical Monograph Series on Management of Comorbid Conditions in Schizophrenia (in press).

REFERENCES:

1. Hwang MY, Opler LA (Guest Editors): Treatment and assessment of schizophrenic comorbidities. Psychiatric Annals 1994; 24:9 Sept.
2. Hwang MY, Bermanzohn PC (Editors): Management of schizophrenics with comorbid conditions. Clinical Monograph Series, Washington, DC, APPI (in press)

Issue Workshop 15
HIV/AIDS EDUCATION AND TRAINING OF PSYCHIATRISTS

Chairperson: Barbara Silver, Ph.D., *CMHS-HIV/AIDS Program, 5600 Fishers Lane, Suite 15-81, Rockville MD 20857*
Participants: Marshall Forstein, M.D. J. Stephen McDaniel, M.D. Francine Cournos, M.D.

EDUCATIONAL OBJECTIVES:

During this presentation, panelists will review HIV curriculum and discuss various methods for training. Panelists will share their clinical experiences and participants will learn about opportunities for participation in other local CMHS-sponsored education/training projects.

SUMMARY:

To address the complex mental health needs of people affected by HIV disease, the Center for Mental Health Services (CMHS) launched its Mental Health Care Provider Education in HIV/AIDS Program. With support from this program the American Psychiatric Association has been able to provide training, materials, and services for more than a decade to clinicians working in the AIDS arena. One of its program goals is to provide psychiatrists and residents with curricular materials on the spectrum of HIV-related neuropsychiatric disorders.

During this presentation, panelists will review corresponding curriculum and discuss various methods for training. Panelists will also share their clinical experiences. Participants will also learn about other CMHS-sponsored education/training projects that psychiatrists may participate in at the local level. Participants will receive complimentary copies of the curriculum and will have an opportunity to participate in a question and answer session covering the most important points. It is anticipated that the program will utilize an interactive audience response system to facilitate the immediate interaction between meeting participants and faculty. Participants will use handsets to respond to questions posed on screen by the speakers. Results will be automatically displayed for all the participants to see.

REFERENCES:

1. Forstein M, et al: HIV-Related Neuropsychiatric Complications and Their Treatments. Commission on AIDS, American Psychiatric Association, 1998

Issue Workshop 16
CHILDREN OF PSYCHIATRIST PARENTS: PART II

Co-Chairpersons: Leah J. Dickstein, M.D., *Department of Psychiatry, University of Louisville, 323 Chestnut Street, Louisville KY 40202,* Michelle Riba, M.D., *Department of Psychiatry, University of Michigan, 1500 EastMed Ctr Dr/Box 0704, Ann Arbor MI 48109-0704*
Participants: Ann Rosenthal, Pauline Langsley, M.D. Marcelo L. Olarte, Steven G. Dickstein, B.A. Erica Riba, Lawrence Hartmann, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the benefits derived from psychiatrist-parents, along with possible stigma.

SUMMARY:

This workshop, a repeat of last year's standing room only workshop, will offer different children of psychiatrists an opportunity to speak about having such parents. The women and men speakers will describe the benefits and hazards, if any, of such an experience. Stereotypes will be confronted, and positive, often unique, experiences will be described. This session is a useful and concrete way to assist young parents and those wishing to be parents.

REFERENCES:

1. Olsen RD, Sande JR, Olsen GP: Maternal parenting stress in physicians' families. Clinical Pediatrics 1991; 30(10):586-590
2. Lumley J: Patterns of life after graduation. Medical Journal of Australia 1979; 1(12):566-568

Issue Workshop 17
UNDERSTANDING THE DYNAMICS OF ABUSIVE RELATIONSHIPS

Chairperson: Gary J. Maier, M.D., *Mendota Mental Hlth Institute, 301 Troy Drive, Madison WI 53704-1521*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, 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." The importance of considering "relational" dynamics will be introduced (30 minutes).

The participants will then discuss three cases of abuse that involve "couples" at different stages of abusive relationships. Management/treatment issues will be discussed. These 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 abusive relationships in the context of the support system in their communities (30 minutes).

REFERENCES:

1. Maier GJ: Understanding the dynamics of abusive relationships. The Psychiatric Times, September 1996
2. Jones A, Schechter S: When Love Goes Wrong. New York, Harper Perennial, 1992

Issue Workshop 18
GAY AND LESBIAN SUBSTANCE ABUSE TREATMENT: CULTURAL COMPETENCY TRAINING

Chairperson: Saul M. Levin, M.D., *Access Consulting, 1901 Penn Avenue NW, #705, Washington DC 20006*
Participant: Edwin Craft, D.Sc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) Understand the issues of gay and lesbian cultural competancy for substance abuse treatment. (2) Know how to use relevant assessment tools for diagnosis and treatment.

SUMMARY:

Gay and lesbian substance abuse is reportedly higher than in the general population. Using culturally competent assessment tools is important in the diagnosis & treatment of the LGBT population.

Using federal treatment assistance protocols developed by the LGBT field (LGBT = Lesbian, Gay, Bisexual, & Transgender), participants will review and discuss relevant assessment tools and LGBT issues.

REFERENCES:

1. Cabaj RP: Substance abuse in the gay and lesbian community, in Substance Abuse: A Comprehensive Textbook, 2nd Edition. Williams & Wilkins, 1992
2. Hellman RE, Stanton M, Lee J, et al: Treatment of homosexual alcoholics in government-funded agencies: provider training and attitudes. Hospital Community Psychiatry 1989; 40(11):1163-1168

Issue Workshop 19
CLINICAL RESPONSES TO MANAGED HEALTH CARE

Chairperson: Harold J. Bursztajn, M.D., *Department of Psychiatry, Harvard Medial School, 96 Larchwood Drive, Cambridge MA 02138-4639*
Participants: Alan A. Stone, M.D. Bryant L. Welch, Ph.D. Patricia Illingworth, Ph.D. Rodney J.S. Deaton, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop participants will be able to recognize and treat the iatrogenic consequences of managed health care organization influence on clinical practice.

SUMMARY:

As managed health care reenters the center stage of the national legislative debate, the large moral and social implications of this phenomenon have become well articulated. Clinicians have rapidly become familiarized with the new ethical dilemmas posed by man-

aged health care for clinical practice. Even while public policy reforms are being slowly undertaken, there is a need to analyze and respond to managed health care influences on the clinicians' and patients' experience of care. We will explore constructive clinical responses to the denial of benefits, lack of trust, decrease of freedom of choice, and an increased loss of confidentiality, which the managed care revolution has amplified.

REFERENCES:

1. Appelbaum PS: Managed care's responsibility for decisions to deny benefits: the ERISA obstacle. Psychiatric Services 1998; 49:461n462, 472
2. Bursztajn HJ, Brodsky A. A new resource for managing malpractice risks in managed care. Archives of Internal Medicine 1996; 156:2057-2063

Issue Workshop 20
THE INTERNATIONAL WAR CRIMES TRIBUNAL: PSYCHIATRY'S ROLE

Chairperson: Landy F. Sparr, M.D., *Department of Psychiatry, Oregon Health Sciences Univ., PO Box 1034/ PVAMC P-7-MHDC, Portland OR 97006*
Participant: John F. Fergueson, M.Div.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the purpose and process of, and psychiatry's role in, the United Nations International War Crimes Tribunal for the former Yugoslavia.

SUMMARY:

In 1993, in response to the international community's demand for urgent action against the widespread violations of international humanitarian law in the former Yugoslavia, the International War Crimes Tribunal was established by the United Nations (UN) Security Council. The purposes of the tribunal were threefold: to do justice, to contribute to the restoration and maintenance of peace, and to deter further crimes. The traditional approaches of establishing a judicial body by treaty was discarded as being too slow. Instead, the Security Council proceeded to establish the tribunal by exercising its special powers under the UN's charter.

The tribunal began operating on November 17, 1993, when its 11 judges were sworn in at the Peace Palace in The Hague, Netherlands. An acting deputy prosecutor took office on February 21, 1994, and immediately began selecting and recruiting experienced staff. Six investigation teams were established and 14 investigations were undertaken, which represented the most extensive international criminal investigations ever conducted. Investigation teams work with senior trial attorneys to draft indictments (about 75 so far). There are currently approximately 25 defendants in captivity and multiple prosecutions are under way by multi-national teams.

Cases are extremely complex and are made more difficult by the lack of normal tools of criminal investigation (e.g., forensic laboratory reports, crime scene evidence). Prosecutions depend almost entirely on eyewitness testimony. As a result, witness protection is a major facet of the ongoing investigations. Those in the UN who worked to establish the tribunal believe that it is the only civilized alternative to a desire for revenge in the region; that if fair trials are not held, feelings of hatred and resentment will, sooner or later, erupt and lead to renewed violence. The tribunal has jurisdiction over war crimes and crimes against humanity, in particular, genocide. As the trials proceed, there has been a necessity for psychological evaluation of defendants. Initial evaluations are done by psychiatrists or psychologists who are "friends of the court"; however, the defense or prosecution teams can also solicit expert testimony. This panel will examine issues pursuant to evaluation and underlying dynamics of those who are alleged to have committed war crimes, and will address the issue of the use of psychiatric diagnoses to mitigate criminal responsibility. There will be ample time for audience participation.

REFERENCES:

1. Meron T: War crimes in Yugoslavia and the development of international law. Am J Int'l Law 1994; 88:78-87
2. Yearbook 1994. International Tribunal for the Prosecution of Persons Responsible for Serious Violations of International Humanitarian Law Committed in the Territory of the Former Yugoslavia Since 1991. United Nations ISSN: 1020-3907. The Netherlands, 1995

Issue Workshop 21
POEMS ON PSYCHIATRY

Chairperson: Charles R. Joy, M.D., *4406 Sunnydale Blvd, Erie PA 16509-1651*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) appreciate the extent to which poetry can succinctly express insights related to the practice of psychiatry, (2) recognize powerful emotional details related to his/her identifications with poems on psychiatry, (3) express personal experiences of practicing psychiatry in a highly refined fashion through the use of poetic technique.

SUMMARY:

The dynamic energies, the interpersonal relationships, and the sublimations and other distortions inherent in the practice of psychiatry provide a fertile substrate for the creation of poetry. Moreover, poems about psychiatry written by a psychiatrist and shared with an audience of psychiatrists provide a unique opportunity to identify and express powerful insights into the practice of psychiatry. In this workshop participants will have the opportunity to appreciate such original poetry, discuss in detail their associations to the content of the poems, and then begin to create their own poems in a highly structured workshop exercise.

The chair of this workshop has extensive experience writing and reading original poetry inspired by the practice of psychiatry. Selections will include "Something Different," which won first place at the APA Arts Association Exhibition in 1991, and "At The Preschool," which appeared in Mediphors in 1998. Themes addressed by the poems will include: the price of empathy, the risks of intervention, the persistence of borderline psychopathology, the nature of psychotherapy, the characteristics of assessment (including for wrap-around services), and more. Emotions will be engaged as participants experience psychiatry through the modality of poetry.

REFERENCES:

1. Joy CC: At the preschool. Mediphors 1998; 11:60
2. Joy CR: Psychotherapy. West Virginia Medical Journal 1988; 84:28

Issue Workshop 22
CLINICAL SKILLS ASSESSMENT AND PSYCHIATRY TRAINING

Chairperson: Nyapati R. Rao, M.D., *Department of Psychiatry, Brookdale Hospital, One Brookdale Plaza, Brooklyn NY 11212*
Participant: Sidney H. Weissman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the rationale for requiring a clinical skills assessment

as a necessary prerequisite for residency training; understand the implications of this requirement on the recruitment of U.S. and non-U.S. medical graduates into psychiatry residencies.

SUMMARY:

For a number of years, American medical education has focused on the use of standardized patients as a way of obtaining objective data on the clinical performance of medical students. The Liaison Committee for Medical Education has required that this evaluation methodology be used by U.S. medical schools to evaluate their students. In July 1998, the ECFMG required that all IMGs complete a clinical skills assessment using standardized patients. Because of the cost of this examination, it is possible that the number of IMGs in the potential resident pool will decrease and significant psychiatric residency positions will go unfilled. This could occur independent of a positive effect on residency assessment of applicants. The full implications of the new clinical skills assessment on psychiatric training will be discussed. The results of a survey of IMG residents in various specialties, as well as residency applicants, on their attitudes toward the CSA will be presented.

REFERENCES:

1. Sutnick A, Stillman P, Norcini J, Freedman M, Roegan M: ECFMG assessment of clinical competence of graduates of foreign medical schools. JAMA 1993; 270:1041-1045
2. Sutnick A, Stillman P, Norcini J, Freedman M, et al: Pilot study of the use of the ECFMG clinical competence assessment to provide profiles of clinical compentencies. Academic Medicine 1994; 69:65-67

Issue Workshop 23
CASE FORMULATION: THREE ALTERNATIVE VIEWPOINTS

Chairperson: Marcia J. Kaplan, M.D., *University of Cincinnati, 222 Piedmont, Suite 8500, Cincinnati OH 45219*
Participants: Lawson R. Wulsin, M.D. Toby D. Goldsmith, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, participants should be able to list the elements of case formulation; identify the biologic, psychodynamic, and cognitive aspects of a patient's presenting complaints; identify strengths and weaknesses of each approach to treatment; and should feel more confident about viewing patients from multiple theoretical viewpoints.

SUMMARY:

Case formulation depends on the psychiatrist's experience and theoretical orientation. Combining the psychodynamic, psychopharmacologic, and cognitive viewpoints is a challenge for the clinician. This workshop is designed to enable clinicians to understand and practice case formulation. The basic principles of case formulation will be applied to a variety of cases chosen from the workshop leaders' caseloads. The workshop leaders are experienced general adult psychiatrists with distinctive orientations, one psychodynamic/psychoanalytic, one cognitive/behavioral, and one psychopharmacologic/psychobiologic. After a brief introduction the chairperson will present a case (5-10 minutes) followed by presentation of three alternative formulations (5-10 minutes each). Audience discussion will follow (5-10 minutes). Case two and three will follow the same format. The distinctive approaches taken by psychiatrists of differing theoretical orientation will be contrasted for each case. The workshop is intended to help practitioners consider the strengths and weaknesses of each approach in the different types of patients presented, and determine which approach they would be most likely to use and why.

REFERENCES:

1. Nicholi AM: History and mental status, in New Harvard Guide to Psychiatry. Edited by Nicholi AM. Boston, Belknap press, 1988, pp43-44
2. MacKinnon RA, Michels R: General principles of psychodynamics, in The Psychiatric Interview in Clinical Practice. Philadelphia, W.B. Saunders Company, 1971, pp 65-84

Issue Workshop 24
LEADERSHIP IN ORGANIZATIONAL TRANSITIONS

Chairperson: Stewart Gabel, M.D., *Department of Psychiatry, Childrens Hospital, 1056 East 19th Avenue, Denver CO 80218*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) discuss specific objectives of leaders during their management of rapid organizational change, (2) discuss leadership-directed processes to facilitate successful organizational change, (3) discuss specific situations such as grief and mourning and resistance to change that may impede necessary organizational transitions.

SUMMARY:

This workshop will explore goals and essential tasks of leaders during rapid organizational transitions. A sequential, but overlapping, model emphasizing leadership-directed change will be discussed. Leaders should: (1) be perceived by the organization's members as having personally bonded with the organization, its members, goals, and purpose; (2) ensure the development of an inclusive process to evaluate internal and/or external problem areas that require change; (3) ensure the development of a plan that includes organizational members at all levels to effect transition to new models or approaches to care; (4) address the leader's own potential conflicts about required changes or new models that are anticipated; (5) facilitate the mourning process for those in the organization who are grieving the loss of programs that are no longer viable; (6) supervise the implementation of an integrated, comprehensive, and inclusive transitional plan for the organization; (7) supervise the revision of the transitional plan when this is necessary; and (8) supervise the development of procedures to solidify new programmatic structures while accepting the need for organizational change on a regular basis.

These areas will be discussed in an interactive manner with an emphasis on specific illustrations. Questions and answers will be encouraged throughout.

REFERENCES:

1. Bridges W: Managing Transitions. Making the Most of Change. New York, Addison-Wesley Publishing Co., Inc., 1991
2. Gabel S: Leadership in the Managed Care Era: Challenges, Conflict, Ambivalence. Administration and Policy in Mental Health, in press

Issue Workshop 25
INTERNATIONAL VIEWS ON PRACTICE GUIDELINES

Chairperson: Timothy B. Sullivan, M.D., *Department of Psychiatry, New York Medical College, 275 North Street, Harrison NY 10528*
Participants: Allen J. Frances, M.D. Christopher Thompson, M.D. Tyrone S. Turner, M.D.

EDUCATIONAL OBJECTIVES:

To recognize principles underlying the development of practice guidelines; how these principles are influenced by the treatment setting, including the nature of the health care system; demonstrate

familarity with the problems inherent in educating clinicians about practice guidelines, and in measuring the effects of such education on practice patterns.

SUMMARY:

As the literature on practice guidelines proliferates, there is increasing need for clinicians to understand the methodology through which these guidelines are formulated, and the impact guidelines can have on clinical practice patterns. This workshop will illuminate these issues, also comparing practice guideline efforts in the U.S., Canada, and the U.K. There will be three brief presentations on: (1) the different methodologies available to developers of practice guidelines (Frances); (2) a recent study of 21,000 individuals in the U.K. who were evaluated and treated by general practitioners for depression, in a randomized, controlled trial of the influence of practice guidelines and education on treatment outcome (Thompson); (3) efforts in Canada to develop similar educational programs following a national review of depression treatment experience (Turner). There will be extensive discussion with and among panelists about the contrasts between these efforts, and the implicit influence of the practice settings (i.e. the health care systems in the respective countries) on the development and implementation of practice guidelines for mental disorders.

REFERENCES:

1. Thompson C, et al: A randomized, controlled trial of clinical practice guidelines, and education, on the recognition and outcome of depression in primary care: The Hampshire Project. (submitted to The Lancet)
2. Kahn D, Carpenter D, Docherty J, Frances A: The Expert Consensus Guideline Series: Treatment of Bipolar Disorder Memphis, TN, Physician's Postgraduate Press, 1996

Issue Workshop 26
PSYCHIATRIC TRAINING OF INTERNATIONAL MEDICAL GRADUATES: RESIDENTS' PERSPECTIVES

Co-Chairpersons: Pedro Ruiz, M.D., *Department of Psychiatry, University of Texas, 1300 Moursund Street, Houston TX 77030,* Fuad J. Antuna, M.D., *P.O. Box 135098, Beirut, Lebanon*
Participants: Vinay Kapoor, M.D. Simrat S. Sethi, M.D. Crispin L. Juguilon, M.D. J. Francisco Vidal, M.D., Tarek A. Okasha, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should have increased awareness of problems encountered by IMGs during their psychiatry residency training. The workshop also provides a forum for exchange of ideas and solutions to hopefully mitigate some of the problems faced by IMG psychiatry residents.

SUMMARY:

This workshop will reflect on the experiences that international medical graduates (IMGs) in psychiatry residency training programs are exposed to during their training. Approximately 50% of available residency training positions for psychiatry are filled by IMGs. The presentations and discussion will focus on the difficulties encountered by IMGs during their psychiatry training resulting from issues relating to their differences in educational experience, language, training expectations, cultural differences, and adjustment to new environments.

The presenters will focus on their own experiences and how their training programs have reacted to these issues. During the discussion, focus will be given as to how residency programs in different regions of the country have addressed these problems.

It is felt that by paying special attention to the above concerns, the training programs can mitigate some of the problems faced by the IMG psychiatry residents in this regard. Hopefully, this will result in improved performance of IMGs and a more unique and valuable experience.

REFERENCES:

1. Lin T: Psychiatric training for foreign medical graduates: a symposium. Psychiatry. 1971; 34(3):233-257
2. Whitcomb ME, et al: Comparison of IMG-dependent and non-IMG-dependent residencies in the National Resident Matching Program. JAMA 1996; 276(9):700-703

Issue Workshop 27
PSYCHIATRY AND RELIGION: CONCEPTUAL CONSIDERATIONS

Chairperson: Avak A. Howsepain, M.D., *Veterans Administration, 2615 East Clinton Avenue, Fresno CA 93703*
Participants: Robert W. Hierholzer, M.D. John G. Donnelly, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) appreciate the degree to which psychiatrists' clinical encounters can be enriched by attending to the religious dimensions of their patients' lives, and (2) better understand the relationship between scientific theories and religious theories in the face of recent conceptual advances in the philosophy of science and philosophical theology.

SUMMARY:

Much has transpired in the history of ideas since Freud's influential reflections on the nature and origin of religious belief in The Future of an Illusion: the rise and fall of logical positivism, the dominance of historicist philosophy of science, the rise of theism in mainstream academic philosophy, and the deepening dialogue between religion and science. Sadly, many of these developments have escaped the notice of mainstream psychiatry where the relationship between religion and psychiatry is still looked upon with a fair amount of suspicion. There are, though, some hints that this state of affairs is changing. First, the DSM-IV now recognizes certain religious concerns as deserving of clinical attention. Second, the current popularity of biopsychosocial models in psychiatry has reminded the psychiatric community to attend more carefully to its patients' religious commitments. Third, the APA recently released guidelines governing psychiatrists' interactions with their patients that involve religious matters. Finally, important books and essays have recently appeared in mainstream publications that shed critical light on the relationship between psychiatry and religion.

This workshop is designed to promote rigorous and critical reflection on the relationship between psychiatry and religion. Key questions for discussion will include (1) What counts as religous (or more broadly ideological) influence in the context of clinical practice? (2) Must psychiatrists remain religously (or ideologically) neutral in the context of their clinical work? What are the therapeutic and ethical risks or benefits of doing so? (3) Must psychiatric theory eschew supernatural categories and, thereby, retain a thoroughgoing commitment to naturalism? (4) What, if anything, might psychiatry learn from religion and, conversely, what might religion learn from psychiatry? (5) Might psychiatry and religion best be viewed as mutually informing epistemological vehicles driven by complementary ways of knowing? Or is conflict between psychiatry and religion inevitable?

REFERENCES:

1. Meissner WW: Psychoanalysis and Religious Experience. New Haven and London, Yale University Press, 1984

2. Crossley D: Religious experience within mental illness: opening the door on research. British Journal of Psychiatry 1995; 166:284-286

Issue Workshop 28
SPIRITUAL AND ETHICAL ISSUES IN END-OF-LIFE CARE

Co-Chairpersons: Christina M. Puchalski, M.D., *National Inst of Hlth Research, 6110 Executive Boulevard, Rockville MD 20852,* Ellen Fox, M.D., *605 West Dickens Avenue, Chicago IL 60014*
Participants: William Breitbart, M.D. Francis G. Lu, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should have an increased understanding of death and be able to: (1) communicate more effectively with dying patients about spiritual issues, and (2) understand some of the ethical issues that come into play in decision making.

SUMMARY:

Spiritual and ethical concerns are of critical importance in end-of-life care. A 1997 Gallup Poll revealed that a majority of the public wants their spiritual beliefs addressed when they are near death. To address effectively patient's spiritual and ethical concerns, health care practitioners need to understand and support individual patient values, preferences, and spiritual beliefs. This workshop will include three interactive presentations. The first presentation will examine the dying patient's desire for comfort, rituals, a sense of peace, and feelings of closeness with God or a higher power. It will also argue that health care practitioners should be able to comfort patients in their search for transcendent meaning. The second presentation will use case examples to illustrate various factors at play in patient decisions to refuse life-sustaining treatment, including authenticity, suffering, and loss of control. The concept of decision-making capacity in this setting will also be explored. Finally, there will be an experiential exercise exploring the issues dying patients face. This group activity is designed to advance the health care practitioner's understanding of death and thereby improve communication with patients.

REFERENCES:

1. Puchalski CM: Facing death with true dignity. The World & I. July 1998; 34-39
2. Gould WB: Frankl: Life with Meaning. Pacific Grove, CA, Brooks/Cole Publishing Company, 1993

Issue Workshop 29
HOW TO WRITE AND PUBLISH IN PSYCHIATRY

Chairperson: Carol C. Nadelson, M.D., *1493 Cambridge Street, Cambridge MA 02139*
Participants: Sydney Bloch, M.D. Nancy C. Andreasen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the process of submission, peer review, and selection of articles for journals and books for publication in order to submit materials.

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

Issue Workshop 30
SEXUAL HARASSMENT IN SCHOOL: CONTEXT AND CURRICULA

Chairperson: Patricia R. Recupero, M.D., *Department of Psychiatry, Brown Univ/Butler Hospital, 345 Blackstone Boulevard, Providence RI 02906*
Participants: Anne T. Ryan, Ed.D. E. Kathleen Farrel, Ed.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop, participants will have a better understanding of the school environment facing children, the impact of aggression and harassment on their mental health, and the role of the school in addressing these issues. They will also be familiar with the relevant legal issues related to school-based sexual harassment.

SUMMARY:

Children between the ages of ten and 15 are at high risk for experiencing mental health problems, either in themselves or through contact with peers. Twenty percent of these children plan suicide and 80% of female students experience sexual harassment at school. Yet the curricula and health texts generally fail to address these problems as well as problems related to body image and eating disorders, depression, ADHD, and grief and loss issues.

This workshop will present data describing the middle school experience of aggression and sexual harassment. Discussion will focus on risk factor assessment, diagnosis, prognosis, and opportunities for community interventions. The relevant statutory and case law will also be reported.

Presenters will report on the implementation of I'm Not the Only One, a curriculum covering the above issues for sixth through eighth grades. The levels of understanding of the students both before and after the implementation of the curriculum will be presented. The pre and post data will be presented from both a quantitative and qualitative perspective. Discussion will focus on the need for proactive intervention and skills building both for and by the students.

REFERENCES:

1. Bryant AL: Hostile hallways: the AAUW survey on sexual harassment in America's schools. Journal of School Health 1993; 63(8):355-57
2. Gebser v LagoVista Independent School District. U.S. Supreme Court, No. 96-1866, June 22, 1998

Issue Workshop 31
FAMILY VALUES: LESBIAN AND GAY FAMILY CONSTELLATIONS

Chairperson: Ellen Haller, M.D., *Department of Psychiatry, University of CA at SF, Box F-0984/401 Parnassus Ave, San Francisco CA 94143*
Participants: Margery S. Sved, M.D., Victoria L. Harris, M.D. Mark H. Townsend, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) demonstrate an increased awareness of issues faced by lesbian

and gay parents, (2) summarize the multiple ways that lesbian and gay men may choose to create their families, (3) gain an appreciation of the legal complexities raised by creating families outside of traditional models.

SUMMARY:

Across the U.S. and internationally, gay men and lesbians are now raising children in a wide variety of family constellations. For centuries, homosexuals have been parents but nearly always in the context of a heterosexual marriage formed either before the individual was aware of his or her sexual orientation or despite such awareness. In recent years, the numbers of gay men and lesbians becoming parents after coming out as gay have increased dramatically. By choosing to become parents after coming out as homosexuals, gays and lesbians and their children face unique issues including the need for active decision making and the pain of homophobia. Options for parenting include either domestic or international adoption, foster parenting, or having a child biologically. Examples of further decisions include the use of known or unknown donor sperm and the level of involvement of each parent if using a known donor or a surrogate mother or choosing to co-parent. This workshop will involve presentations by gay and lesbian psychiatrists who have created families in a variety of ways. Each speaker will discuss his or her own decision-making process and will also address points helpful to any therapist treating gay or lesbian patients struggling with relevant issues. Clinical experiences of the audience will be elicited and discussed by the panel members.

REFERENCES:

1. Patterson CJ, Chan RW: Gay fathers and their children, in Textbook of Homosexuality and Mental Health. Edited by Cabaj RP, Stein TS. Washington DC, American Psychiatric Press, Inc, 1996
2. Kirkpatrick M: Lesbians as parents, in Textbook of Homosexuality and Mental Health. Edited by Cabaj RP, Stein TS. Washington DC, American Psychiatric Press, Inc, 1996

Issue Workshop 32
PERILS AND PROBLEMS IN SEXUAL HARASSMENT CASES

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. Annette J. Hollander, M.D. Arlene G. Sherer, M.D. Sharyn A. Lenhart, M.D. Karen Hopenwasser, M.D. Louise F. Fitzgerald, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to obtain a meaningful history, to recognize any existing pattern of sexual harassment, to document the significant symptoms as these relate to the history, and to provide appropriate treatment and support of their patients.

SUMMARY:

This workshop will allow recognition of early subtle sexual harassment/discrimination sequences at work, and the importance of relating present complaints to prior experiences and dealing with these systematically and appropriately in a therapeutic and legal framework. Sexual harassment charges are rising in the military, government, industry, and academia. Psychiatrists are increasingly called upon to evaluate or treat victims and perpetrators. The perils and problems in becoming involved in sexual harassment and employment discrimination cases are important to the forensic psychiatrist; also important is that the psychiatrist be available to both the plaintiff and the defense or else risk loss of credibility. The psychiatrist is in no position to state whether such discrimination occurred unless objective evidence exists.

The dynamics of the work setting, together with any childhood abuse or other preexisting psychopathology in plaintiffs alleging workplace sexual harassment, will be examined for issues of credibility, exaggeration, and malingering/lying/faking. While the focus of forensic evaluations is generally on the psychology of the victim and the behavior of the alleged perpetrator, a psychological profile of the alleged perpetrator will be offered here to guide extensive investigation into past offender behaviors. Just as profiles of victims of sexual discrimination have been emerging, literature review and interviews with victims and perpetrators reveal a working profile of harassers. This will be presented at the workshop.

REFERENCES:

1. Simon RI: The credible forensic psychiatric evaluation in sexual harassment litigation. Psychiatric Annals 1996; 26:3
2. Shrier D: Sexual Harassment in the Workplace and Academia-Psychiatric Issues. American Psychiatric Press, Inc., 1995

Issue Workshop 33
PRESCRIBING CONTROLLED SUBSTANCES: RISK MANAGEMENT

Chairperson: Lance P. Longo, M.D., *Sinai Samaritan, PO Box 342/2000 West Kilbourn, Milwaukee WI 53201*
Participants: Norman S. Miller, M.D. Brian J. Johnson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize clinical indications and contraindications for prescribing controlled substances. The participant should also demonstrate awareness of neurobiology of potentially addictive medications, understand important doctor-patient relationship dynamics, and become aware of risk management considerations.

SUMMARY:

Psychiatrists have a number of highly effective agents within their pharmacotherapeutic armamentarium that are considered controlled substances and thus bear unusual scrutiny. Benzodiazepines and other sedative hypnotics, psychostimulants, and opiates are medications with abuse potential whose prescription warrants careful consideration of risks, benefits, and doctor/patient relationship dynamics.

This workshop will review the epidemiology of controlled substance use and misuse in general populations, psychiatric populations, and substance abusing populations. The paradox of under-prescribing appropriate medications for indicated clinical conditions due to misunderstanding of misuse and addiction in non-addicted individuals will be contrasted with the problems of abuse in substance addicted individuals. Pharmacology of potentially addictive medications will be explored as it pertains to the concepts of abuse, dependence, addiction, and common brain reward pathways.

Components of the doctor/patient relationship including recognition of patient defense mechanisms, countertransference "warnings," co-dependence, and drug-seeking behaviors will be summarized. Recommendations for risk management include documentation of the decision-making process and informed consent, consultation, "writing (rx) right" and other medical/legal liability issues. Audience participation will be elicited in the discussion of dual-diagnosis assessment and management dilemmas, and recommendations will be made for use of alternative nonabusable pharmacotherapies for the treatment of anxiety disorders, insomnia, pain syndromes, and attention deficit disorder in substance abusing populations.

REFERENCES:

1. Johnson B, Longo L: The physician's decision to prescribe benzodiazepines to patients with addiction. Psychiatric Annals 1998; 28, 3

2. King AC, Miller NS: Medications of abuse and addiction: opiods, in Source Book of Substance Abuse: Etiology, Methodology Intervention. Edited by Harder RE, Ammerman RT, Ott PJ. Allyn Bacon, 1998

Issue Workshop 34
SILDENAFIL CITRATE: A SEX THERAPIST'S PERSPECTIVE

Chairperson: Richard Kogan, M.D., *30 East 81st Street, #9E, New York NY 10028*
Participants: Kenneth P. Rosenberg, M.D. Ellen L. Hollander, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) understand the principles of integrated psychosexual therapy, and (2) evaluate whether a patient is an appropriate candidate for treatment with sildenafil.

SUMMARY:

There are few medical conditions that are as potentially psychologically devastating as erectile dysfunction. Therefore, it is not surprising that when a remedy was introduced that was deemed to be effective, safe, and easy to use, it became the fastest selling medication in history. However, it is poor clinical practice to prescribe sildenafil (Viagra) without a thorough medical and psychiatric evaluation. This workshop will focus on the proper application of this potent medication.

Drs. Kogan and Rosenberg will describe the basic principles of integrated psychosexual therapy, which utilizes a combination of behavioral assignments, psychodynamic techniques, and pharmacologic intervention. The presenters will use case vignettes to explore such diverse issues as the following:

- Should sildenafil be used to enhance normal sexual functioning?
- Can sildenafil be effective in reversing SSRI-induced sexual side effects?
- Will sildenafil be as effective in women as in men?

Participants will be encouraged to share their own experiences in addressing these complex and vital issues.

REFERENCES:

1. Goldstein I, Lue TF, Padma-Nathan H, et al: Oral sildenafil in the treatment of erectile dysfunction, N Engl J Med 1998; 338:1397-1404
2. Kaplan HS: The New Sex Therapy: New York, Brunner/Mazel, 1974

Issue Workshop 35
THE U.S. HEALTH CARE FINANCING ADMINISTRATION REPORT: COMPLIANCE IN THE RESIDENT OUTPATIENT CLINIC

Chairperson: Sherri Hansen-Grant, M.D., *University of Wisconsin, 6001 Research Park Boulevard, Madison WI 53719*
Participants: Stephen J. Weiler, M.D. Nancy E. Barklage, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) demonstrate how to reorganize an outpatient delivery system to comply with HCFA guidelines, (2) demonstrate how to use the HCFA guidelines to enhance the educational experience of psychiatric trainees, and (3) compare this model with others that are being used in training institutions around the country.

SUMMARY:

In July 1996, the United States Health Care Financing Administration (HCFA) mandated that all Medicare services performed by resident physicians and other nonphysician mental health trainees require staff physician or psychologist attendance. The University of Wisconsin Department of Psychiatry extended the mandate to all outpatient services regardless of payer. This workshop describes the development and implementation of a model for reorganizing the outpatient delivery system. It will focus on how to enhance the educational experience of trainees, as well as ideas for avoiding problems that can occur during reorganization. Feedback from a survey of faculty, trainees, and patients will be discussed. Participants will have the opportunity to be interactive in applying the model to their institution and comparing it with strategies they have tried in complying with this mandate.

REFERENCES:

1. Code of the Federal Register. Vol 42. sect. 415.172 (a)
2. McMenamin SP, Scoggins GA: Developing & compliance program to identify and prevent inaccurate or improper medicare billing practices. Vo Med Q 1998; 125:12-14

Issue Workshop 36
THE MID-CAREER CLINICIAN: CHOICES AND CHALLENGES

Co-Chairpersons: Julie K. Pease, M.D., *171 Mays Road/ Papanui, Christchurch 8005, New Zealand*
Participants: Benjamin Crocker, M.D. John F. Zerner, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify mid-career issues pertinent to the psychiatrist, including the personal and professional influences on choices made in mid-career.

SUMMARY:

This workshop will address the issues and challenges faced by psychiatrists in mid career. The objective is to provide a forum for mid-career psychiatrists to contemplate and to discuss our choices and goals for the next phase of our careers. The first part of the workshop will consist of brief presentations on mid-life and mid-career issues in general, mid-career challenges specific to the psychiatrist, and choices facing psychiatrists who are working in varying areas of psychiatry, including private practice, public psychiatry, and academia. There will be time allotted for discussion between each of these short presentations, but the major part of the workshop will be a facilitated interactive discussion among members of the audience, focused on what we have accomplished thus far in our careers, and what challenges we face for the future, with emphasis on the personal and professional influences on our choices.

REFERENCES:

1. Erikson E: Eight ages of man, in Childhood and Society. W.W. Norton and Co., 1950
2. Corlett E, Millner N: Navigating Midlife. Palo Alto, Calif., CPP Books, 1993

Issue Workshop 37
RESIDENTS CONDUCTING PSYCHODYNAMIC PSYCHOTHERAPY

Chairperson: Leah J. Dickstein, M.D., *Department of Psychiatry, University of Louisville, 323 Chestnut Street, Louisville KY 40202*
Participants: William R. Hartman, M.D. Artie A. Bates, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize psychodynamic therapy techniques as demonstrated

through the experiences of two residents and the teacher of this 21-year-old model of teaching psychodynamic therapy.

SUMMARY:

This workshop will offer a third- and a fourth-year resident the opportunity to demonstrate their interest, experience, and learned knowledge and skills in conducting individual psychodynamic psychotherapy. At the University of Louisville, Dr. Leah Dickstein developed and has led a seminar in learning psychodynamic psychotherapy since 1978, by conducting ongoing psychotherapy with a patient with second-year residents present. After the 50-minute patient treatment hour, she leads a 40-minute discussion based on her monograph readings and the patient's sessions. These two residents have participated and now are following their own patients. They will each present their work with a selected patient, and Dr. Dickstein will serve as discussant.

REFERENCES:

1. Mohl PC, Martinez D, Matthews K, Ticknor C, et al: A psychotherapy service: preserving a place for psychodynamic teaching. Academic Psychiatry 1989; 13(1):48-51
2. Verhulst J: The psychotherapy curriculum in the age of biological psychiatry: mixing oil with water? Academic Psychiatry 1991; 15(3):120-131

Issue Workshop 38
CLINICAL ASPECTS OF HIV AND AIDS AMONG HISPANICS

Chairperson: Pedro Ruiz, M.D., *Department of Psychiatry, University of Texas, 1300 Moursund Street, Houston TX 77030*
Participants: Lourdes M. Dominguez, M.D. Humberto L. Martinez, M.D. Francisco Fernandez, M.D. Ricardo Galbis, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to diagnose, treat, and prevent HIV infection and AIDS among Hispanic populations in the United States. Additionally, they should be able to treat their HIV/AIDS patients within a culturally sensitive framework.

SUMMARY:

Currently, the HIV/AIDS epidemic has shifted toward the ethnic minority populations of this country, particularly Hispanics. Today, Hispanics represent approximately 8.4% of the total U.S. population; however, as of December 1996, 18% of the adult/adolescent AIDS cases and 23% of the pediatric AIDS cases reported in this country have affected Hispanics. The intravenous use of drugs among Hispanics is greatly contributing to this new pattern of HIV infection. In this respect, Hispanic women have also been seriously affected. The "machismo," with its impact on the pattern of sexual behavior among "Latinos/Latinas," has much to do with the current trends of HIV/AIDS among Hispanic populations. In this workshop, we will address and discuss the most relevant sociocultural characteristics inherent among the Hispanic population in this country. Additionally, we will also focus on how to constructively use these sociocultural characteristics in the clinical management of HIV/AIDS Hispanic patients. Moreover, we will also focus on the appropriate preventive interventions against HIV/AIDS among Hispanics. Hopefully, our presentations will assist clinicians with respect to the diagnosis, treatment, and prevention of HIV/AIDS among Hispanic patients.

REFERENCES:

1. Ruiz P, Fernandez F: Human immunodeficiency virus and the substance abuser: public policy considerations. Texas Medicine 1994; 90(5):64-67
2. Garza-Trevino ES, Ruiz P, Venegas-Samuels K: A psychiatric curriculum directed to the care of the Hispanic patient. Academic Psychiatry 1997; 21(1):1-7

Issue Workshop 39
COPING WITH MALPRACTICE

Chairperson: Kenneth C. Olson, M.D., *Bridger Psychiatric, 931 Highland Blvd, Suite 3340, Bozeman MT 59715*
Participant: Larry Riley, J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant will be able to recognize the symptoms of malpractice stress syndrome. He or she will be aware of the avenues of support that are available. The process of "recovery" that typically follows being sued will be described.

SUMMARY:

The impact of the malpractice suit on the physician is described. The psychological impact of being sued on both the doctor and his family has been referred to as the malpractice stress syndrome. The nature of being sued and the personality traits of the physician will be characterized. Also discussed will be the impact on the family, how to prepare children, the impact on the spouse, and dealing with the media. Attitudes that might help minimize unnecessary stress while undergoing litigation will also be delineated.

Proposals discussed in regard to assisting those undergoing litigation include: developing a resource library, mentoring programs, support groups for the physician (as well their spouses), and provision of educational forums. It is hoped that by "normalizing" the emotional response to being sued and providing various avenues of recovery, it will somehow minimize the unnecessary suffering that can occur.

Discussion will be facilitated by a brief discussion of my individual reactions to being sued.

REFERENCES:

1. Martin A, Wilson JF, et al: Physician's psychologic reactions to malpractice litigation. Southern Medical Journal 1991; 84:1300-1304
2. Reading EG: The malpractice stress syndrome. New Jersey Medicine 1986; 83:289-290

Issue Workshop 40
TEACHING BRIEF THERAPY IN A MANAGED CARE CLINIC

Chairperson: Nancy B. Kaltreider, M.D., *125 Upland Road, Kentfield CA 94904-2737*
Participants: Ellen Haller, M.D. Jacquelyn B. Chang, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to plan a program for resident experience in dynamic psychotherapy in a managed care context with an understanding of the advantages and challenges offered by this teaching environment.

SUMMARY:

In the new health care delivery system, it is essential for residents to learn the effective use of brief dynamic therapy, often combined with psychopharmacology. Women Care Mental Health Clinic in the Department of Psychiatry at UCSF primarily serves managed care patients. We found our population offered motivated, employed patients with focal issues who were ideal candidates for brief dynamic therapy. Clinic faculty developed strategies to maximize the educational opportunities, including a faculty screening evaluation inter-

view and regular case conferences, which included discussion of gender issues and ethical dilemmas imposed by managed care. Early review of treatment options under "medical necessity" criteria encouraged patient willingness to convert to self-pay at sometime during the ten-session contract. We experience excellent patient flow, few dropouts, and a high level of satisfaction from patients, residents, and managed care contractors. Clinic faculty handle much of the paperwork and actively model how to enjoy the intellectual challenge of psychotherapy with motivated patients in a restrictive care environment. The clinic director, training director, and a current resident will discuss their approach, show a role-play of a patient evaluation, and then invite sharing of educational experiences within managed care from the audience. We will conclude with a strategic plan based on the problems presented.

REFERENCES:

1. Sabin JE: Is managed care ethical care? in Controversies in Managed Mental Health Care. Edited by Lazarus A. Washington, DC, American Psychiatric Press, 1996, pp 115-126
2. Hoyt, MF: Brief Therapy and Managed Care: Readings for Contemporary Practice. San Francisco, JosseyBass Publishers, 1998

Issue Workshop 41
SPECT IMAGING: CLINICAL APPLICATION FOR DIAGNOSIS

Co-Chairpersons: Malcolm D. Roberts, M.D., *Halifax Behavioral, 841 Jimmy Ann Drive, Daytona Beach FL 32117*
Thomas Yuschok, M.D., *303 North Clyde Morris, Daytona Beach FL 32114*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) demonstrate an understanding of SPECT imaging, (2) recognize clinical situations where SPECT would help with the differential diagnosis, and (3) use SPECT to aid accurate diagnosis of clinical presentations.

SUMMARY:

The workshop will begin with a comprehensive review of SPECT imaging in psychiatry. Image acquisition techniques and pharmaceuticals will be reviewed. Audience participation/interaction will be centered on use of large-screen projections of SPECT scans as seen on a nuclear medicine computer terminal. Actual cases will be displayed and the audience will interact with the presenters (a psychiatrist and nuclear radiologist) in assessing and diagnosing cases from clinical presentations. Later, audience members will be blinded to clinical presentation and learn to diagnose SDAT, CVA, schizophrenia, major depression, bipolar affective disorder, ADHD, and OCD. At the conclusion of this workshop, the participant should be able to demonstrate an understanding of the use of SPECT in psychiatric practice, apply this knowledge to help with diagnosis, and recognize specific disorders.

REFERENCES:

1. Gordon I: Cerebral blood flow imaging in pediatrics: a review. Nucl Med Comm 1996; 17:1021-1029
2. Schuckit, MA: An introduction and overview to clinical applications of neuroSPECT in psychiatry. J Clin Psychiatry 53(11 suppl):3-6, 1992.

Issue Workshop 42
ETHICAL BOUNDARIES IN ALTERNATIVE THERAPIES

Co-Chairpersons: Antoinette W. Jakobi, M.D., *Department of Psychiatry, Unity Health Systems, 1561 Long Pond Road, Ste 303, Rochester NY 14626*
Lisa M. Rosica, D.O., *Unity Health Systems, 1561 Long Pond Road, Ste 303, Rochester NY 14626*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the complexity of using integrative therapies that involve body contact with psychiatric patients. The participant will recognize how techniques involving touch can be utilized without violating the boundaries of the patient-clinician relationship.

SUMMARY:

Alternative medical practices are being used more frequently for the treatment of many disorders including those in psychiatric patients. Patients frequently choose to see therapists who incorporate various modalities of somatic treatment that include bodily contact—massage therapy, therapeutic touch, acupuncture, osteopathic manipulation, etc. These modalities are used as stand-alone treatments or in conjunction with other forms of therapy. They are used in patients with depression, anxiety, trauma history, chronic pain, and other diagnoses. There is an increasing awareness that the body is the repositor of psychological states and that memories and stress can be stored in the body as well as the psyche. The presenters have an interest and training in several types of therapies that involve bodily contact, and are concerned with the issues this brings up in terms of therapeutic boundaries. We will explore the extent to which boundaries may be flexible in terms of the work that is done in alternative therapy. Participants will be encouraged to discuss their own experiences in terms of therapeutic boundaries. Ethical concerns in this regard will be explored.

REFERENCES:

1. Gutheil TG, Gabbard GO: The concept of boundaries in clinical practice: theoretical and risk-management dimensions. Am J Psychiatry 1993; 150:188-196
2. Gutheil TG, Gabbard, GO: Misuses and misunderstandings of boundary theory in clinical and regulatory settings. Am J Psychiatry 1998; 155:409-414

Issue Workshop 43
THE USE OF SPIRITUALITY GROUPS IN PSYCHIATRIC TREATMENT

Chairperson: Nalini V. Juthani, M.D., *Department of Psychiatry, Bronx-Lebanon Hospital, 1276 Fulton Avenue, Bronx NY 10456*
Participants: David B. Marcotte, M.A. Ricardo Bernal, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to assess their patient's experience and coping expressed in spiritual beliefs and practices, and how to enhance treatment using spirituality groups.

SUMMARY:

The integration of spirituality in psychiatric care has received increasing attention in recent years. It is estimated that 95% of

psychiatric patients value religion highly and practice some form of spirituality. This workshop will present a model for the use of spiritual reflection groups in the treatment of psychiatric inpatients that has been used at an inner-city hospital in the South Bronx section of New York City. The workshop will be highly interactive and practical. It will demonstrate how these groups can be used to gain a richer understanding of the patient's subjective experience and to enhance treatment. The presenters will discuss their experiences from the perspective of a Hindu attending psychiatrist, a non-practicing Catholic, first-year psychiatric resident, and a Jesuit priest who is a doctoral student in clinical psychology. Case vignettes will be presented to illustrate the model and initiate discussion. Participants will be encouraged to introduce their own experiences and to discuss the implications of integrating spirituality and psychiatric care.

REFERENCES:

1. Gallup: Religion in America. Princeton, NJ, Princeton Religion and Research Center, 1993
2. Knoll J, Sheehan W: Religious beliefs and practices among 152 psychiatric inpatients in Minnesota. Am J Psychiatry 1989; 146:67-72

Issue Workshop 44
MODELS OF PSYCHIATRIC CARE FOR NATIVE COMMUNITIES

Co-Chairpersons: Cornelia Wieman, M.D., *Six Nations Mental Hlth Svcs, Box 609, Oshweken ON N0A 1M0, Canada,* Gary A. Chaimowitz, M.D., *Box 585, Hamilton ON L8N 3K7, Canada*
Participant: Andrew Hackett, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should have an increased awareness of Native mental health issues and an understanding of the complex issues in delivering psychiatric care to Native communities. The participant should also be familiar with different models of psychiatric care for these communities.

SUMMARY:

The mental health status of First Nations peoples in Canada is far from optimal. Suicide rates are at least three times higher than for non-Native individuals. There is a significant knowledge gap regarding prevalence and incidence rates of mental disorders as few rigorous studies of Native mental health exist in the peer-reviewed literature.

Our presenters will present diverse points of view around our central theme. We will present introductory information regarding the demographics and cultural features of Native peoples, experiences of a non-Native, fly-in psychiatrist to a remote community, and the unique perspective of an Aboriginal psychiatrist in a rural community. Service delivery issues including accessibility, mental health care utilization, and cultural relevance will be discussed. Approaches to establishing collaborative working relationships with Native mental health workers and traditional healers will be discussed.

It is hoped that the symposium will attract individuals with experience and/or interest in working with Native peoples in remote, rural, or urban communities. We will discuss the models of mental health care delivery presented, and have an opportunity to share ideas about future direction for psychiatric services, which may translate into improved mental health care for First Nations peoples.

REFERENCES:

1. Brant CC: Native ethics and rules of behavior. Canadian Journal of Psychiatry 1990; 358:530-539
2. Wadram JB, Herring DA, Young TK: Aboriginal Health in Canada: Historical, Cultural, and Epidemiological Perspective. University of Toronto Press, 1995

Issue Workshop 45
VIOLENCE DENIED BEGETS MORE VIOLENCE

Co-Chairpersons: Levon Z. Boyajian, M.D., *361 Cumberland Street, Englewood NJ 07631-4704,* Haikaz M. Grigorian, M.D., *50 Magnolia Avenue, Tenafly NJ 07670-2120*
Participants: Alice Kassabian, D.S.W. Diane Kupelian, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be cognizant of factors influencing the intergenerational transmission of violence, and to focus particularly on genocide and ethnic violence as a consequence of denial and the absence of punitive measures. Participant should consider means for interrupting this cycle.

SUMMARY:

Violence in general and ethnic violence in particular has increased markedly in this century. It is likely that punitive child rearing practices and denial of the pain inflicted contribute to this. The lack of punishment of guilty perpetrators of genocide and "ethnic cleansing" encourages continued mass ethnic violence—witness the Turks, the Nazis, the Serbs, and the Iraqis.

The children of the victims of the Armenian Genocide are beset by rage at the continued denial and by the systematic destruction of architectural monuments and cultural artifacts in the Turkish effort to blot out and rewrite Armenian history. But what has happened to the generations of Turks who have been reared on lies and denial in the face of irrefutable evidence and no punishment of the guilty? Now they are involved in the "ethnic cleansing" of the indigenous Kurds in Eastern Turkey despite decades of unsuccessful suppression. The impunity with which the perpetrators continue their violence strengthens the denial and rationalizations. Being raised on violence, lies, and denial is an invitation to savagery. We must insist on the truth and holding the guilty accountable.

Brief five- to ten-minute presentations will be followed by open general discussion by all present.

REFERENCES:

1. Chalk F, Johanssohn K: The History and Sociology of Genocide, Yale U Press, 1990
2. Milburn MA, Conrad SD: The Politics of Denial, MIT Press, 1996

Issue Workshop 46
MEDICAL SCHOOL RESPONSE TO STUDENT SUICIDE

Chairperson: Donald A. Misch, M.D., *Department of Psychiatry, Medical College of GA, 1515 Pope Avenue, Atlanta GA 30912*
Participants: Ruth-Marie Fincher, M.D. Mason Thompson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop the participant should be able to recognize the impact on classmates of medical student suicide, and design, facilitate, and implement effective institutional responses to such an event.

SUMMARY:

Medical student suicide, while uncommon, is nonetheless not a rare event; and it has profound repercussions for classmates, medical school faculty and officials, and the medical school itself. This is an experience that may result in lasting attitudes or beliefs, both

positive and negative, regarding mental illness, suicide, medical school, and the field of medicine. At such a key moment, it is crucial that medical schools respond appropriately so as to minimize the trauma and maximize the opportunity for healthy processing of the event by survivors, including not only classmates but also involved medical school faculty and administrative officials. This workshop will report the results of an extensive survey of medical student reactions regarding the suicide death of a classmate, including their reactions to a broad range of institutional interventions after the suicide. Medical school administrative officials will then give a brief overview of key issues and their personal experiences, in the institutional response to the suicide of a medical student. Following interactive discussion with workshop participants, recommendations will be generated for productive medical school responses to the suicide of a student, with suggestions as to particular pitfalls and how they might be avoided.

REFERENCES:

1. Kaltreider NB: The impact of a medical student's suicide. Suicide and Life-Threatening Behavior 1990; 20:195-205
2. Hays LT, Cheever T, Patel P: Medical student suicide: 1989-1994. Am J Psychiatry 1996; 153:553-555

Issue Workshop 47
CLINICAL AND FORENSIC ASPECTS OF SEXUAL HARASSMENT

Chairperson: Malkah T. Notman, M.D., *Department of Psychiatry, Cambridge Hospital, 54 Clark Road, Brookline MA 02146*
Participants: Linda M. Jorgenson, J.D., Elissa P. Benedek, M.D., Carl P. Malmquist, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop. The participant will have a better knowledge of the differences between the psychiatric criteria for sexual harassment and the forensic criteria and recognize the psychiatric sequellae.

SUMMARY:

Forensic evaluation of sexual harassment complaints is an area where complex personal and clinical data often must be reduced to black-and-white terms. The evidence involved in complaints of this type is sometimes subjective and can rely heavily on personal interpretations of words and actions.

As a legal issue, sexual harassment now receives considerable attention. It is, however, surrounded by confusion and ambiguity in a psychiatric setting. The potential for complications arises from the relationship, if any, of the harassment complaint to earlier experiences of trauma and abuse and the extent to which prior experiences affect the magnitude and importance of current events.

This workshop will explore the psychiatric and forensic issues involved in evaluating sexual harassment complaints by examining a series of actual cases and through the presentation of a detailed case on videotape. The audience will be invited to participate by bringing their own forensic and clinical cases as well as by discussion.

REFERENCES:

1. Charney DA, Russell RC: An overview of sexual harassment. Am J Psychiatry 1994; 151:10-17
2. Roberts BS, Vann RA: Sexual harassment in the workplace: a primer. Akron Law Review #29, Winter 1996

Issue Workshop 48
CLINICIAN-EDUCATOR TRACK IN RESIDENCY TRAINING

Chairperson: Michael D. Jibson, M.D., *Department of Psychiatry, University of Michigan Med Ctr, 1500 E Medical Center Dr, Ann Arbor MI 48109-0016*
Participants: Anita R. Kumar-Gill, M.D., Donna J. Champine, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants should be able to recognize the value of developing skills as a clinician educator during residency training and identify strategies for accomplishing this task.

SUMMARY:

The purpose of this workshop is to introduce the concept and development of a new model in residency education, known as the Clinician Educator Track. Traditionally, residency education programs have focused primarily on the development of clinical and research skills. This new Educator Track currently being implemented in the psychiatry residency program at the University of Michigan will provide an avenue of training with a focus on producing excellent teaching clinicians, education administrators, and education researchers.

This workshop will be divided into three segments: (1) overview of the Clinician Educator Track Program, as it will be implemented throughout each year in the University of Michigan residency training program; (2) overview of strategies to be utilized in developing a knowledge base and teaching skills in educating medical students, residents, nonpsychiatric professionals, and the community; (3) discussion groups of 6-10 participants each will function as "think tanks" to discuss the relevance of education as the focus of clinician training, and to expand upon the ideas presented. At the end of the discussion groups, the workshop participants will gather as a group again to share and further explore their ideas.

REFERENCES:

1. Borus JF: Teaching and learning psychiatry. Academic Psychiatry 1993; 17:3-11

Issue Workshop 49
SPIRITUAL/RELIGIOUS ASSESSMENT IN CLINICAL WORK

Co-Chairpersons: Francis G. Lu, M.D., *Department of Psychiatry, University of CA at SF, 1001 Potrero Avenue, San Francisco CA 94110,* Christina M. Puchalski, M.D., *National Inst of Hlth Research, 6110 Executive Boulevard, Rockville MD 20852*
Participant: David B. Larson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the importance of incorporating history taking and assessment of religious/spiritual issues in clinical work, and understand the practical methods of utilizing the assessment in treatment planning.

SUMMARY:

According to the APA Practice Guidelines on the Psychiatric Evaluation of Adults and the DSM-IV Outline for Cultural Formulation, cultural issues including religion/spirituality should be incorpo-

rated in history taking, assessment, and treatment planning. Yet, clinicians may be unfamiliar with actual methods of religious/spiritual assessment. This workshop will first demonstrate methods of interviewing, assessment, and treatment planning through a videotape. Participants will be invited to critique and comment on the videotape and use it as a stimulus for discussion of their own clinical work. Specific issues discussed will include the importance of respectful rapport, the use of the DSM-IV Outline for Cultural Formulation, the DSM-IV diagnosis of religious or spiritual problems, and the use of religious/spiritual consultations and interventions such as with chaplains.

REFERENCES:

1. Puchalski CM: Taking a spiritual history. Videotape produced by The George Washington University Medical Center, 1997
2. Model Curriculum for Psychiatric Residency Training Programs: Religion and Spirituality in Clinical Practice. Edited by Larson DR, Lu FG, Swyers JP. May 1996, revised, July 1997

Issue Workshop 50

WHEN PSYCHIATRISTS LIVE WITH MENTAL ILLNESS
The National Alliance for the Mentally Ill

Co-Chairpersons: Michael F. Myers, M.D., *St. Paul's Hospital, 1081 Burrard Street, Vancouver, BC V6Z 1Y6, Canada,* Leah J. Dickstein, M.D., *Department of Psychiatry, University of Louisville, 323 Chestnut Street, Louisville KY 40202*
Participants: Elizabeth A. Baxter, M.D. Mark L. Dembert, M.D. Suzanne E. Vogel-Scibilia, M.D. Laurie M. Flynn, M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) understand the challenges of being both a psychiatrist and a patient, (2) overcome internalized stigma toward colleagues who live with psychiatric illness.

SUMMARY:

It is estimated that at least 50% of mental health professionals or a first-degree relative have suffered from a psychiatric illness. However, many of these individuals live in secret conflict with this and/or fear the consequences of disclosure. In this workshop, the co-chairs (Drs. Myers and Dickstein) will introduce and discuss the subject with brief commentary. Drs. Baxter, Dembert, and Vogel-Scibilia will tell their stories of being diagnosed with mental illness and working as psychiatrists. Themes include identification with and empathy for one's patients; dealing with disparaging comments made by psychiatrist colleagues about psychiatric patients (i.e., internalized stigmatization); issues around "coming out" to training directors, co-workers, and patients; advanced directives regarding risk of relapse; role diffusion of being both a patient and physician; concerns about boundaries with patients; and advocacy challenges. Ms. Laurie Flynn, executive director of NAMI, will examine the ways in which NAMI can work collegially with psychiatrists who have been diagnosed with and treated for mental illness. Attendees will have 30 minutes to interact with presenters and to discuss ways of further diminishing the stigma of psychiatric illness in physicians.

REFERENCES:

1. Baxter EA: The turn of the tide. Psychiatric Services, in press
2. Dembert ML: A secret society. Submitted for publication

Issue Workshop 51

ETHICAL DILEMMAS IN TREATING THE HOMELESS MENTALLY ILL

Co-Chairpersons: David M. Band, M.D., *St. Elizabeth's Hospital, 2700 Martin L King, Jr Ave SE, Washington DC 20032,* Stephen M. Goldfinger, M.D., *Department of Psychiatry, SUNY, Health Science Campus, 450 Clarkson Avenue/Box 1203, Brooklyn NY 11203*
Participants: Marcella A. Maguire, Ph.D. Lien A. Hung, M.D. Donald C. Ohuoha, M.D., Michaela Boran, M.D., Alexander Meski, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop the participants should be familiar with some of the most common ethical challenges and dilemmas involved with and impeding the treatment of the homeless mentally ill, and appreciate recommendations for overcoming these barriers to treatment.

SUMMARY:

Many of the ethical principles that drive the provision of treatment to the severe and persistent mentally ill are based on the assumption that treatment is provided in hospitals or community mental health centers. For psychiatrists and other mental health providers working with homeless mentally ill in community settings, these assumptions do not often hold. Case managers are confronted with ethical dilemmas on a daily basis and are often forced to make "on the spot" decisions.

Issues ranging from medication management, using drug company resources, obtaining medications not on formulary, necessary transportation of "non-patient" family members in institutional vehicles, confidentiality of clinical records, collaboration between public and private community agencies working with the same individuals, rationing of resources, housing, and personal boundaries between providers and homeless clients during engagement and treatment are some of the day-to-day ethical dilemmas that the workshop will be addressing.

Participants will be encouraged to present some of their own clinical vignettes to both demonstrate successful ways to navigate through the ethical mine fields of providing care to the homeless mentally ill and to present challenging problems for the workshop participants to help solve.

REFERENCES:

1. American Psychiatric Association: The principles of medical ethics with annotations especially applicable to psychiatry. Washington, D.C., 1989
2. Lamb HR, Bachrach LL, Goldfinger, SM, Kass FI: Summary and recommendations, in Treating the Homeless Mentally Ill. Edited by Lamb HR, Bachrach LL, Kass FI. Washington, D.C., American Psychiatric Association, 1992, pp 1-10

Issue Workshop 52

THE PSYCHIATRIST AND PARKINSON'S DISEASE

Co-Chairpersons: David M. Roane, M.D., *Department of Psychiatry, Beth Israel, First Avenue at 16th Street, New York NY 10003*
John D. Rogers, M.D., *10 Union Square East, New York NY 10003,*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to distinguish idiopathic Parkinson's disease from the Parkinson's

plus syndromes and have detailed knowledge of the psychiatric complications of Parkinsonism and their treatment.

SUMMARY:

This workshop, with a psychiatrist and a neurologist acting as co-leaders, will emphasize the importance of treating the motor, behavioral, and cognitive disabilities of Parkinsonism in an integrated fashion. We will review the neuropsychiatric complications seen in Parkinson's disease (PD) and the Parkinson's plus syndromes. A major focus will be the use of a variety of therapeutic agents including new generation antipsychotics, antidepressants, ECT, cholinergic agonists, and new medications for PD.

Much time will be devoted to case vignettes in order to create a forum for audience participation. The vignettes will illustrate the rational sequencing of pharmacological interventions in complicated patients. They will also be used to address psychosocial aspects of treatment; in particular, the importance of involving family members and caretakers in treatment decisions. We plan to provide ample opportunity for participants to raise questions based on their own clinical experiences.

Finally, we seek to demonstrate the value of collaboration between neurology and psychiatry in the care of patients with PD and related disorders.

REFERENCES:

1. Weiner WJ, Lang AE (eds): Behavioral neurology of movement disorders. Adv Neurol 1995; 65
2. Papka M, Rubio A, Schiffer RB: A review of Lewy body disease, an emerging concept of cortical dementia. The Journal of Neuropsychiatry and Clinical Neurosciences 1998; 10:267-279

Issue Workshop 53
BIOBEHAVIORAL TREATMENT OF ADDICTIVE DISORDERS

Chairperson: Richard J. Frances, M.D., *Silver Hill Foundation, 208 Valley Road, New Canaan CT 06840*
Participants: Sheldon I. Miller, M.D. Sheila B. Blume, M.D. Frances R. Levin, M.D. Lionel Solursch, M.D. Robert B. Millman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion, the participant of this workshop should come away with a good knowledge of epidemiology, magnitude of the problem, and treatment of dual diagnosis patients. Participants should come away with knowledge and skills about how to build effective integrated treatment programs for a biobehavioral approach to working with patients with dual diagnosis. Working with dual diagnosis patients is both challenging and rewarding and special skills are needed to tailor treatment to this population.

SUMMARY:

This will be the 32nd year that a group originally started by John Ewing will hold a discussion format workshop at the American Psychiatric Association annual meeting with this year's focus being on biobehavioral treatment of dual diagnosis. Usually the term dual diagnosis is used to describe addiction plus an additional psychiatric problem. Approximately one-third of patients with addictive disorders have an additional psychiatric problem. Approximately 55% of schizophrenics, perhaps as high as 60% of bipolar patients, and approximately one-third of patients with anxiety disorders have an addictive disorder. Developing integrated treatment programs for patients with addictive disorders often poses a challenge to treatment systems. Managed care has emphasized cost effectiveness, and integrated treatment approaches are likely to be the most cost-effective way to treat both disorders. Our discussion will cover biological and behavioral approaches to treatment of both disorders. Self-medication hypothesis, staging of treatment, and new behavioral and psychopharmacological approaches will be emphasized. As usual, we expect a lively discussion from the floor with each presenter talking for no more than five minutes.

REFERENCES:

1. Frances RJ, Miller SI, (eds): Clinical Textbook of Addictive Disorders, New York, Guilford Press, 1991
2. Frances RJ, Miller SI (eds): Clinical Textbook of Addictive Disorders, 2nd Edition New York, Guilford Press, 1998

Issue Workshop 54
THE MEDIA AND REACHING OUT TO THE UNDERSERVED

Co-Chairpersons: Gabriela Cora-Locatelli, M.D., *LCS/NIMH/NIH, Building 10, Room 3D41, Bethesda MD 20892,*
Elmer E. Huerta, M.D., *3057 Fourth Street, NE, Washington DC 20017*
Participant: Pablo Sanchez

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize and pursue other means of addressing social, cultural, and mental health issues through the media.

SUMMARY:

Objective: The Latino population of the United States is growing at a rate five times faster than that of the general population. It is estimated that by the year 2005 Hispanics will become the largest minority group in the country. Due to multiple factors including lack of access to quality health care and information, Hispanics suffer a disproportionate burden of preventable conditions.

Methods: By developing, producing, and disseminating educational materials in Spanish on health promotion and disease prevention; by using Spanish-language media—radio, television, print, and electronic media—as its main vehicle to reach Latinos throughout the United States.

Results: By developing successful educational programs, through the radio, print and electronic media, as well as television. We have addressed mental health issues monthly, based on public interest.

Conclusions: The impact of Dr. Huerta's educational media work is demonstrated by the extraordinary public response to his radio campaigns: the State of Maryland Breast and Cervical Program in 1993; the Tamoxifen breast cancer prevention trial recruitment in 1994; the Cancer Information Service campaign to promote a cookbook of healthy recipes in Spanish; and the 1997 Latino Cardiovascular Disease Prevention and Outreach Initiative with the National Heart, Lung and Blood Institute. Similar educational campaigns should be thoroughly explored to address mental health issues.

REFERENCES:

1. "Hard to Reach" Hispanics Get Health News via Physicians' Radio, TV Shows. JAMA 1997; 278:4
2. The Washington Post, July 16, 1998 and January 26, 1995; El Tiempo Latino, several feature presentations; El Coloquio, and many other Spanish language publications

Issue Workshop 55
DEATH IN THE FAMILY: FAMILY TRADITION AND THE WILL

Chairperson: Gerald Schneiderman, M.D., *Department of Psychiatry, Hospital for Sick Children, 60 St Clair Ave East, Ste 202, Toronto ON M4T 1N5, Canada*
Participant: Felice Kirsh, L.L.B.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize, anticipate, or treat emotional disorders in individuals

arising out of the death of a family member, specifically, problems caused by the will of the deceased, such as unfairness, favoritism, revenge of punishment for perceived poor behavior while the deceased lived. Additionally, patients facing death can be helped to use the will as a constructive means of perpetuating family tradition.

SUMMARY:

The will is more than a codification of the disposition of worldly belongings after death; it can be a dynamic factor in the preservation of family tradition and family health—or, in the negative case, it can be a horribly destructive influence on the surviving family. The death of a family member is a traumatic event for all the survivors. If the family tradition is strong and healthy, however, the survivors will grieve but move ahead, and the will of the deceased, if properly constructed, can be a powerful instrument for effecting the healing process and maintaining the healthy family tradition. Conversely, the will can be a destructive instrument in perpetuating or exacerbating a "pathological" family tradition, especially when the testator uses the will as a means of continuing to "control" the family from the grave, or to punish or take revenge on certain surviving family members for perceived poor behavior during the testator's life. The author draws on extensive research and clinical experience in counseling family members on how to cope with the realities of death. Case studies are used to illustrate both the positive and negative potential of the will in aiding or destroying the surviving family.

REFERENCES:

1. Schneiderman G: Coping with death in the family, fourth edition. Toronto, NC Press Ltd, 1994
2. Condon GM, Condon JL: Protecting the inheritance while it's in the hands of your child, in Beyond the Grave, New York, Harper Collins, 1995

Issue Workshop 56
IS RETRAINING FOR CLINICIANS NECESSARY?

Co-Chairpersons: Daniel Castellanos, M.D., *Department of Psychiatry, University of Miami, 1150 NW 14th St, Ste 501 (M861), Miami FL 33136,* Sanford I. Cohen, M.D., *1400 NW 10th Avenue, #301, Miami FL 33136*
Participants: Michael J. Bennett, M.D. Paul Jay Fink, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) recognize factors that support the need to provide/obtain continuing education to meet the needs of today's managed care settings, and (2) recognize that comprehensive clinical training will allow psychiatrists to function diverse clinical realms.

SUMMARY:

Clinicians continue to face multiple challenges in today's health care environment. Training and education are essential to the growth and practice of all clinicians. Debate exists as to whether clinicians should be trained specifically in the principles of managed care. Should clinicians be trained specifically in managed care principles for treating patients insured by managed care plans? The counter argument is that clinicians should not be trained for a specific type of organizational structure or funding source: clinicians should obtain training in skills that can be utilized to provide care regardless of the funding sources. This debate will transcend a pro and con managed care debate and address fundamental issues of psychiatric education and ongoing training. Active participation and debate by the audience will be encouraged through the question and answer and panel discussion period.

REFERENCES:

1. Bennett MJ: The importance in teaching the principles of managed care. Behavioral Healthcare Tomorrow 1993; 2:28-32
2. Fink PJ: Adapting your practice to changes in the mental health field. Directions in Psychiatry 1994; 14(suppl 8):1-4

Issue Workshop 57
DSM-IV AND OLD-TIME ROCK AND ROLL

Chairperson: Henry B. Nelson III, M.D., *5965 South Woodland Drive, Ogden UT 84403-5473*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify DSM-IV diagnoses with rock and roll hit songs, hearing great music and having a good time in the process.

SUMMARY:

Music is the universal language, and old-time rock and roll is the classic music of the sixties, which maintains its popularity even today. DSM-IV is the universal language of psychiatric diagnostic classification. In this multimedia workshop, we will take a musical journey through DSM-IV with the Beatles, the Rolling Stones, Simon and Garfunkel, the Supremes, Carly Simon, and many others. I will present snippets of 60 different rock and roll hits that match 40 DSM-IV disorders in all major diagnostic categories. The audience will actively participate throughout as they try to identify the groups that perform the hits; dancing is optional. This light-hearted presentation will be an unforgettable "#1 hit" of rock and roll and diagnoses for all who attend.

REFERENCES:

1. Whitburn J: Top 40 Hits. New York, Billboard Publications, Inc., 1992
2. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, D.C., American Psychiatric Association, 1994

Issue Workshop 58
TO LIVE OR DIE: COMPLEXITIES AT LIFE'S END

Chairperson: James W. Lomax II, M.D., *Department of Psychiatry, Baylor University, One Baylor Plaza, Ste 619D, Houston TX 77030*
Participants: Sheila M. LoboPrabhu, M.D. John W. Burruss, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to consider a wider range of options and concepts as they confront the complex decisions that must be made at the end of life. The goal is to facilitate understanding of the clinical, spiritual, ethical, and forensic aspects of caring for terminal patients.

SUMMARY:

Decisions at the end of life are challenging and emotionally laden for all involved. Any psychiatrist, but particularly those involved in consult-liaison work, must be prepared to address the complex dilemmas that arise during these times. This workshop will attempt to identify and explore the clinical, spiritual, ethical, and forensic aspects of the decision to live or die. The panelists assert that the competent psychiatric consultant assures that the total situation, person and context, is assessed, and all of the salient factors considered in an appropriate manner. Special emphasis will be placed on the role of the consult-liaison psychiatrist when asked to participate in the management of terminal patients. Case examples from a large, teaching hospital will be used to illustrate specific problems encountered. These will be supplemented by brief, didactic presentations intended to familiarize attendees with some of the major religious and ethical themes at the end of our patients' lives. Audience partici-

pation will be encouraged, as clinical examples and presentations are used to elicit experiences from each practitioner's career and life.

REFERENCES:

1. Gostlin LO: Deciding life and death in the courtroom: from Quinlan to Cruzan, Glucksberg, and Vacco. JAMA 1997; 278:1523-1528
2. Nuland SB: How We Die: Reflections on Life's Final Chapter. New York, Vintage Books, 1995

Issue Workshop 59
TREATMENT RESISTANCE VERSUS RESISTANT TREATERS

Chairperson: Michael R. Fox, M.D., *University of South Florida, 100 West Davis Boulevard, Tampa FL 33606-3504*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) understand noncompliance from multiple perspectives: biological, behavioral, psychodynamic, sociopolitical, and family systems; (2) discuss the incidence, costs, consequences, theories of causality, and available solutions; (3) understand a systems theory solution that changes the treatment system in a manner that empowers patients and their family members, and decreases noncompliance.

SUMMARY:

The literature on treatment noncompliance suggests it is more complex than usually accepted. Noncompliance occurs at the interface of multiple systems: (1) patient-illness system, (2) family system, (3) sociopolitical system, and most importantly, (4) the treatment system, including its rules; medication effects; and the physician's personal style, treatment orientation, and countertransference. The participants will discuss their own assumptions, problems, and solutions for noncompliance. This will be supplemented with a review of the literature on incidence, cost, theories of causality, and available interventions. A systemic approach will be presented whose foundation is: **Treatment resistance does not cause noncompliance; resistant treaters do.** Changing the psychiatrist's interaction with the patient and his family is as important as changing the patient, his illness, or his family. Through role-play, specific methods of changing the process of treatment decision making in a manner that directly empowers patients and their families, and decreases resistance will be illustrated. The psychiatrist delegates all of his authority to make treatment decisions to the patient and family members, and functions only as a consultant, as long as the decisions are made according to an agreed on process and there is no risk of harm—even if it is against recommendations.

REFERENCES:

1. Demyttenaere K: Compliance during treatment with antidepressants. J Affect Disord 1997; 43(1):27-39
2. Fox MR: Turning powerlessness into opportunity: a case of bipolar affective disorder, in The Shared Experience of Illness. Edited by McDaniels SH, Hepworth J, Doherty WJ. New York, Basis Press, 1997, pp 251-273

Issue Workshop 60
TEACHING ASSESSMENT VIA ROLE PLAY: A DEMONSTRATION

Chairperson: Julia B. Frank, M.D., *George Washington University, 2150 Penn Ave, NW/AN8411, Washington DC 20037*

EDUCATIONAL OBJECTIVES:

After this workshop, participants will be able to implement role playing as a method of instruction for third-year clerks, adapting the offered curriculum for use in their own academic settings

SUMMARY:

The director of the George Washington University psychiatry clerkship and eight currently enrolled medical students will demonstrate an innovative, flexible method of teaching ambulatory assessment and treatment planning. Following a review of the principles of problem-based learning, two current third-year students will role play the assessment of a predetermined but unscripted primary care mental health problem known to the "patient" but not the interviewer. Other students participate in the interview, follow-up discussion, and presentation of treatment plan, guided by a student "consultant" with faculty support. Audience members will have the opportunity to participate in the roles normally taken by student-observers. Further time is allotted to discuss the method and how students have responded to it. A copy of the current GW curriculum and faculty guidelines will be provided for adaptation for use in other settings.

REFERENCES:

1. Lieberman SA, Stroup-Benham CA, Peel JL, Camp MG: Medical student perception of the academic environment: a prospective comparison of traditional and problem based curricula. Academic Med 1997; 72: suppl 13-15
2. Donner RS, Bickly H: Problem-based learning in American medical education: an overview. Bull Med Lib Asson 1993; 81 294-8

Issue Workshop 61
SWIMMING WITH THE SHARKS: ORGANIZATION POLITICS

Chairperson: Michelle Riba, M.D., *Department of Psychiatry, University of Michigan, 1500 East Med Ctr Dr/Box 0704, Ann Arbor MI 48109-0704*
Participants: John S. McIntyre, M.D. Elissa P. Benedek, M.D. Carol A. Bernstein, M.D. Jo-Ellyn M. Ryall, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) recognize systematic issues within organizations that promote or hinder advancement, (2) begin to understand personal goals versus organizational goals and how they may intersect or be at odds with one another, and (3) listen to examples from workshop participants about experiences within organizations and how to learn from the mistakes or successes.

SUMMARY:

The ability for 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. A great amount of time will be set aside to hear from the audience 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.

REFERENCES:

1. Barton WE, Barton GM: Mental Health Administration. New York, Human Sciences Press, 1983

2. Talbott JA, Kaplan SR: Psychiatric Administration. New York, Grune and Stratton, 1983.

Issue Workshop 62
DOCTOR, LEARN TO SET LIMITS AND REDUCE MALPRACTICE SUITS

Chairperson: Miguel A. Leibovich, M.D., *Harvard Medical School, 83 Cambridge Parkway, #609W, Cambridge MA 02142*
Participants: Sara C. Charles, M.D. Maureen Mondor, R.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: (1) demonstrate knowledge of the current litigation climate, (2) appreciate the sources of stress in litigation, (3) recognize how setting appropriate limits in clinical practice is important for the prevention of malpractice suits.

SUMMARY:

For most physicians, malpractice suits are a source of great anxiety, frustration, and confusion. During the workshop the panelists will explore the physician's personality traits, attitudes, and behaviors that may contribute to a patient's initiating malpractice litigation. More specifically, the discussion will focus around physicians' difficulties in appropriately setting limits in their professional interactions. Clinical examples will serve to illustrate malpractice events that resulted from physicians not responding with empathetic firmness to patients' unusual requests. Also the tendency of some physicians to see themselves as "super persons" (and thus not limit high patient volume or overly hectic schedules) will be explored. How these tendencies impinge on their leisure activities and produce unnecessary stress will be discussed as a potential contributor to malpractice incidents. Ample opportunities will be offered to the audience for discussion and interaction with the panelists about these issues. Also the participants will be invited to share their own difficulties in maintaining appropriate boundaries and in setting limits during their clinical interventions.

REFERENCES:

1. Charles SC, Wilbert JR, Franke KJ: Sued and non-sued physicians self-reported reactions to malpractice litigation. Am J Psychiatry 1985; 142:437-440
2. Leibovich MA: Peer support for the emotional consequences of malpractice litigation. Straight Forward, official publication of the Physician Rehabilitation Program of the Medical and Chirurgical Faculty of Maryland. Summer 1996; 7:3

Issue Workshop 63
VIDEO CASE STUDIES OF COUPLES IN TREATMENT

Chairperson: Ian E. Alger, M.D., *500 East 77th Street, #132, New York NY 10162*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: (1) identify critical stages of couples therapy, and (2) have developed an increased awareness and understanding of his/her style as a couples therapist.

SUMMARY:

Participants will have the opportunity to role play clinical examples of couples treatment with the leader, and through the use of video playback, and identify issues of impasse and stress during different stages of couples treatment, including engagement, problem identification, change facilitation, and termination.

Workshop participants will have the opportunity of comparing their own clinical experiences relating to problems of dual career couples; struggles during separation and divorce; issues in second marriages; sexuality and intimacy; and issues involving children as well as extended family members, and peer and friendship networks.

REFERENCES:

1. Alger I: Marital therapy with dual-career couples. Psychiatric Annals 1991; 21:8
2. Alger I: Marital Crises. Psychiatric Therapies, 20th Edition, Grune and Stratton, 1981

Issue Workshop 64
COGNITIVE THERAPY FOR PERSONALITY DISORDERS

Co-Chairpersons: Judith S. Beck, Ph.D., *Cognitive Therapy & Rsch, The Beck Institute, 1 Belmont Avenue, Suite 700, Bala Cynwyd PA 19004,* Jesse H. Wright, M.D., *Department of Psychiatry, University of Louisville, Norton Psy Clin. PO Box 35070, Louisville KY 40232*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) conceptualize personality disorder patients according to the cognitive model, (2) recognize therapeutic alliance issues in treatment of personality disorders, (3) set goals and plan treatment for patients with characterological disturbance, (4) combine pharmacotherapy and cognitive therapy for personality disorder patients, and (5) describe and implement cognitive techniques.

SUMMARY:

Cognitive therapy, a short-term, structured, problem-solving-oriented psychotherapy, has been shown in over 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 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 employed. Questions and clinical material from participants will be encouraged throughout and a final segment will instruct interested participants in the steps they can take to learn about this empirically validated approach for a difficult patient population.

REFERENCES:

1. Beck AT, Freeman A, et al: Cognitive Therapy of Personality Disorders. New York, Guilford, 1990
2. Beck JS: Cognitive approaches to personality disorders, in American Psychiatric Press Review of Psychiatry, Vol. 16. Edited by

Dickstein LJ, Riba MB, Oldham, JM. Washington, D.C., American Psychiatric Press, 1993

Issue Workshop 65
PSYCHIATRY AND POLITICS

Co-Chairpersons: Paul A. Kettl, M.D., *Department of Psychiatry, Penn State University, PO Box 850, Hershey PA 17033-0850,*
Jay B. Cutler, J.D., *Government Relations, American Psychiatric Assoc., 1400 K Street, NW, Washington DC 20005*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be better able to understand the effects of public policy on psychiatric practice, and ways to influence the political process.

SUMMARY:

As we meet in Washington, we are reminded that psychiatry is affected by a large array of political and public policy concerns. In this workshop, we will explore different ways we can influence the political process for our patients and our profession.

Dr. Paul Kettl, acting chair of psychiatry at Penn State, will discuss his experiences as a Democratic nominee for U.S. Congress in the 1996 elections. He will discuss ways that meeting participants can become directly involved in the political process. He will be joined by Mr. Jay Cutler, the director of government relations for the American Psychiatric Association. Mr. Cutler has been quite effective at representing the interests of psychiatry to the U.S. Congress throughout his career. We will discuss current political issues confronting psychiatry including parity of insurance coverage for psychiatric illness, and physician-assisted suicide.

REFERENCES:

1. Kettl PA: The politics of physician assisted suicide. American Journal of Forensic Psychiatry 1998; 19:49-56
2. Kettl PA: The psychiatry of politics. Abstract. 1997 Syllabus and Proceedings Summary, 49th Institute on Psychiatric Services, October 25, 1997, APPI, Washington, D.C.

Issue Workshop 66
PREVENTING SUICIDE: TEAM BUILDING AND MOBILIZING RESOURCES

Chairperson: Alex N. Sabo, M.D., *Berkshire Medical Center, 725 North Street, Pittsfield MA 01201-4109*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) name six factors from the empirical literature associated with risk of imminent suicide, (2) name three biological approaches to treating severe depression complicated by high suicide risk, (3) identify a cognitive-behavioral strategy for intervention, and (4) identify strategies for alliance building based on the use of risk assessment and solution-focused systemic interventions.

SUMMARY:

Suicide claims more than 30,000 lives per year in the U.S. and is the eighth leading cause of death. In the current era, psychiatrists treat highly lethal individuals with only modest use of hospital settings. This means that the psychiatrist must sharpen team building, assessment, and treatment skills to be used in largely outpatient settings. This workshop will explore the risk assessment and treatment over a three-year period of a 40-year-old mother of two who made several near-lethal suicide attempts in the context of a severe recurrent psychotic depression, triggered in part by the death in utero of a third child. Videotaped interviews of the patient, her spouse, and sister, as well as several different clinicians who worked with her in various settings contribute to build a complex perspective on her illness, the risks in treating her, and the opportunities to overcome what appeared, at one time, to be her almost certain demise. Participants in the workshop will develop a formulation of the problem and strategize regarding possible interventions. They will then become familiar with a risk-assessment tool, psychodynamic and biological formulations, and cognitive-behavioral and systemic interventions that were actually used in her care.

REFERENCES:

1. Fawcett J, Clark DC, Busch KA: Assessing and treating the patient at risk for suicide. Psychiatric Annals 1993; 23(5):244-255
2. Havens L: Anatomy of a suicide, in A Safe Place: Laying the Groundwork of Psychotherapy. Cambridge, MA & London, England, Harvard University Press, 1989, pp 79-90

Issue Workshop 67
CULTURE: PERCEPTION AND COMMUNICATION

Co-Chairpersons: Trevia F. Hayden, M.D., *Department of Psychiatry, University of Maryland, 701 West Pratt Street, Baltimore MD 21201-1542,* Raina T. Sullivan, M.D., *Department of Psychiatry, University of Maryland, 701 West Pratt Street, Baltimore MD 21201-1542*

EDUCATIONAL OBJECTIVES:

The program's major aims are to increase cultural awareness and appreciation, to promote and exhibit cultural competence, and to demonstrate enhanced communication skills.

SUMMARY:

More than a decade ago, Engel introduced the concept of the biopsychosocial model for understanding illness and disease. Recently, there has been a resurgence of interest in cultural diversity issues. This interest, fueled by the changes in the demographics in America, has led to some advances in our understanding of diversity issues. Most psychiatrists would agree that culture is important; however, practical applications and clinical impact is less clear to most psychiatrists. Our workshop will provide an educational forum for the discussion of the importance and impact of cultural diversity issues in residency education training programs, peer relationships, and doctor-patient relationships. Particularly germane issues in psychiatry such as the concepts of cultural sensitivity, cultural appropriateness, and cultural competence will be explored. Moreover, this workshop's major emphasis is the diversity training program that utilizes interactive activities in large and small group settings to explore the impact of perception and communication. Our program will utilize two forms of self-evaluation. First, will be verbal feedback during the wrap-up portion of the program and second will be a written questionnaire evaluating the participants' attitudes about diversity issues and the workshop itself.

REFERENCES:

1. Oldham JM, Riba MB (eds): Issues in the assessment and diagnosis of culturally diverse individuals, in Review of Psychiatry London, England, American Psychiatric Press, 1995

2. Gaw A (ed): Culture, Ethnicity and Mental Illness. Washington D.C., American Psychiatric Press, 1993

Issue Workshop 68
BRIDGING TRADITIONS IN PSYCHIATRIC EDUCATION

Co-Chairpersons: Todd S. Cox, M.D., Johns Hopkins, *600 North Wolfe St/Meyer 131, Baltimore MD 21287,* Irving M. Reti, M.D., *600 North Wolfe St/Meyer 131, Baltimore MD 21287*
Participants: Sarah A. Reading, M.D. Adam I. Kaplin, M.D. Jennifer L. Payne, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to describe how the traditions of psychiatry may be bridged to provide a coherent approach for the education of psychiatry residents. Additionally, participants will leave with an understanding of a useful approach to structuring the field of psychiatry.

SUMMARY:

The aim of this workshop is to describe a coherent structure for psychiatry that provides a rational approach to psychiatric evaluation, formulation, and treatment. This approach has been useful for our residency education at the Johns Hopkins Hospital.

The structure bridges the disparate approaches of traditional psychiatry. It is embodied in four different methods of reasoning, each of which assists in the understanding of the various mental disorders seen in our patients. These four methods or perspectives are based on the following models of reasoning: disease, dimension, behavior, and life story.

The workshop will run over 90 minutes. An introduction to our approach by one of our residents will be followed by four residents each describing the method of reasoning and treatment implications for each of the perspectives; case examples will be provided. The workshop will conclude with a presentation by a Johns Hopkins faculty member of a single case illustrating formulation and management using the four perspectives. Questions will then be fielded.

In summary, this workshop will describe how the traditions of psychiatry may be bridged to provide a coherent approach for the education of psychiatry residents, and we expect the audience will leave with an understanding of a useful approach to structuring the field of psychiatry.

REFERENCES:

1. McHugh P, Slavney P: The Perspectives of Psychiatry. Baltimore, The Johns Hopkins University Press, 1986
2. Shorter E: A History of Psychiatry. John Wiley & Sons, Inc., New York. 1997

Issue Workshop 69
UPDATE ON MENTAL HEALTH IN THE OREGON HEALTH PLAN

Co-Chairpersons: Bentson H. McFarland, M.D., *Department of Psychiatry, Oregon Health Science Univ, 3181 SW Sam Jackson Pk Rd, OPO2, Portland OR 97201,* David A. Pollack, M.D., *1021 Arlington Boulevard, E312, Arlington VA 22209*
Participants: Magnus Lakovics, M.D. Robert A. George, M.D. Richard H. Angell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop participants should be able to recognize political and economic issues that arise when mental health is integrated into a prioritized health care system that involves both public and private providers.

SUMMARY:

The Oregon Health Plan is a Medicaid Reform Demonstration Project designed to increase health care access by: (1) expanding enrollment; (2) replacing fee for service with managed care; and (3) integrating physical health, mental health, and chemical dependency services. Over the last year the mental health aspects of this program have been implemented statewide. There has now been a dramatic restructuring of publicly funded behavioral health services in Oregon. Under the new system, private sector managed care systems and public sector behavioral health agencies are forced to work with each other. At least in theory, linkages between primary medical care and behavioral health care have been strengthened. This workshop will stimulate discussion about the integration of public with private behavioral health sectors as well as the risks and benefits of managed care. There will be brief presentations summarizing the following: (1) national overview of Medicaid reform, (2) the interface between primary care and behavioral health specialty care, (3) private sector viewpoint, (4) children's issues, and (5) local government perspective. Participants will be asked to compare Oregon's experience with developments in their states. The discussion will address the roles of psychiatrists in mixed public/private managed health care systems that incorporate mental health and chemical dependency services.

REFERENCES:

1. Cutler DL, McFarland BH, Winthrop K: Mental health in the Oregon Health Plan: fragmentation or integration? Administration and Policy in Mental Health 1998; 25:361-386
2. Pollack DA, McFarland BH, George RA, Angell RH: Prioritization of mental health services in Oregon. Milbank Quarterly 1994; 72:515-550

Issue Workshop 70
SAFEGUARDING THE ELECTRONIC PSYCHIATRIC RECORD

Chairperson: David P. Olson, M.D., *Department of Psychiatry, Univ of MA Medical Center, 55 Lake Avenue North, Worcester MA 01655*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the essential structural, technological, and policy issues relating to the protection of the electronic psychiatric record.

SUMMARY:

The computerization of the psychiatric record has the potential to dramatically improve the quality of care we provide to our patients. Examples of benefits of these electronic patient records include the following: better coordination of care between physically separated providers, simultaneous access to patient records, linkages to drug interaction databases with automated alerts, and access to standards of care such as practice guidelines. In the most straightforward implementation, these electronic psychiatric records also create new opportunities for breaches of confidentiality on a scale that dwarfs potential abuses of the traditional paper record. In an unprotected system, thousands of patient records can be searched and copied in a matter of seconds or minutes. How do we ensure the protection of this highly sensitive data while preserving the advantages of an electronic record? Fortunately, there have been rapid advances in the area of data security over the past decade. Encryption, partitioned data, secure communication standards, virtual private networks, firewalls, access policies, and audit trails all play a role in the construction of a secure psychiatric information system. This workshop will review these essential security components and provide a forum

for discussion of institutional experiences with protecting electronic psychiatric data.

REFERENCES:

1. Dick RS, Steen EB (eds): The Computer-Based Patient Record: An Essential Technology for Health Care. Institute of Medicine, National Academy Press, Washington, D.C., 1994
2. For the record: protecting electronic health information. Computer Science and Telecommunications Board, National Research Council, 1997

Issue Workshop 71
TONING AND CHANTING AND MUSIC MEET MEMORIES

Chairperson: Leah J. Dickstein, M.D., *Department of Psychiatry, University of Louisville, 323 Chestnut Street, Louisville KY 40202*
Participants: Alice H. Cash, Ph.D. Joy Berger, M.C.M.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to demonstrate and explain the uses of toning (meditation) and chanting and music in general as forms of complementary medicine that can enable patients to cope better with life situations in general psychiatric treatment

SUMMARY:

This is a repeat of 1998's very successful (40+ attendees) experiential toning and chanting workshop. Dr. Cash, musician, social worker, and teacher of toning and chanting, and Dr. Dickstein have worked together for a number of years enabling psychiatric patients in psychodynamic psychotherapy to add toning and chanting exercises as an excellent technique to reduce anxiety symptoms. Attendees will learn the theory and then the techniques and have the opportunity to practice these easy and beneficial complementary medicine skills.

REFERENCES:

1. Keyes L: Toning: The Creative Power of the Voice. DeVorss Publishing, 1973
2. Cash A: Chanting and toning, in Health Awareness Workshop Reference Book: The Keys to Complete Constructive Self-Care. Edited by Dickstein LJ. Louisville, KY, Proactive Press, 1998

Issue Workshop 72
CLINICAL IMPLICATIONS OF THE CYTOCHROME P450

Chairperson: George M. Simpson, M.D., *Department of Psychiatry, USC School of Medicine, 1937 Hospital Place, Los Angeles CA 90033*
Participant: Jose de Leon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should have a basic understanding of the possible clinical significance of drug interactions mediated by the Cytochrome P450.

SUMMARY:

Many psychiatric drugs are metabolized by the Cytochrome P450 isoenzymes. Recently, there has been some discussion on the laboratory versus clinical meaning of them. The presenter has extensive expertise with the use of blood levels and the Cytochrome P450-2D6 in his research and clinical activities in a state hospital. In his experience, there are small numbers of patients who could significantly benefit from knowing their genotype, or being cognizant of drug interactions. These issues might have important implications for their treatment.

A small review of the Cytochrome P450 isoenzymes will be presented, followed by a discussion of patients personally treated by the presenter. The audience will be invited to decipher what the possible pharmacological mechanism involved was. Cases including patients taking clozapine, risperidone, quetiapine, olanzapine, various antidepressants, cabamazepine, and fluoxetine will be presented. A dialogue will then be established so that the audience can discuss their own experiences with this subject. Finally, a description of the future in this area will be presented by describing DNA chips and assays, ("biochips"), which may be used in clinical practices 10 to 15 years from now.

REFERENCES:

1. Ereshefsky L: Pharmacokinetics and drug interactions: update for new antipsychotics. J Clin Psychiatry 1996; 57(Suppl 11):12-25
2. de Leon J, et al: A pilot study of the Cytochrome P450-2D6 genotype in a psychiatric state hospital. Am J Psychiatry (in press)

Issue Workshop 73
TEACHING PSYCHIATRY IN AN AMBULATORY SETTING

Chairperson: Richard Balon, M.D., *Department of Psychiatry, University Psychiatric Center, 2751 East Jefferson, Suite 200, Detroit MI 48207*
Participants: Phillip S. Freeman, M.D. Michelle Riba, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize recent problems in teaching psychiatry in an ambulatory setting, and to improve his/her abilities to teach psychiatry in this setting.

SUMMARY:

The continuous demise of inpatient psychiatric units in medical centers and the closure of state hospitals around the country has led to a push to increase teaching in the ambulatory setting with recent requirements of 50% of medical student teaching to be spent in this setting. Residents are required to spend at least one year in an ambulatory setting. However, teaching of outpatient psychiatry has several disadvantages, such as the trainees' possible lack of primary responsibility for patient care, the possibility of inadequate supervision, and the impact of managed care on diversity and mix of patients.

This workshop will consist of the following three parts: (1) a brief overview of the advantages and disadvantages of teaching psychiatry to medical students and residents in an ambulatory setting, discussion of various models of outpatient teaching, and strategies for the improvement of outpatient teaching; (2) problems in teaching dynamic psychotherapy to students and residents in an ambulatory setting, and (3) teaching psychiatry in innovative ambulatory settings, such as an outpatient consultation-liaison situation, followed by a general discussion.

Workshop participants will have an opportunity to exchange experiences and ideas about teaching psychiatry in an ambulatory setting during the general discussion.

REFERENCES:

1. Rodenhauser R: Student ratings of outpatient learning favor rural community mental health centers. Academic Psychiatry 1997; 21:205-211

2. Frank SH, Stange KC, Langa D, Workings M: Direct observation of community-based ambulatory encounters involving medical students. JAMA 1997; 278:712-716

Issue Workshop 74
TREATING THE STRESSED PHYSICIAN

Chairperson: Roy W. Menninger, M.D., *Menninger Foundation, 5800 SW 6th Street, Topeka KS 66606*
Participants: Michael F. Myers, M.D. Stephen Saeks, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize and better understand the impediments to treatment of troubled or stressed physicians; use fresh ideas for improving treatment effectiveness.

SUMMARY:

The mounting pressures of contemporary medical practice may be evident in signs of increased stress among physicians. These indications include depression, irascibility, serious conflicts with colleagues and practice administrators, and tensions with and estrangements from the spouse. It is significant that these behavioral evidences of stress may not precisely correspond with traditional psychiatric diagnostic entities, and yet reflect treatable dysfunction. More and more of these physicians are seeking (or required to seek) help from psychiatrists, who therefore need a sophisticated understanding of some features of the psychology of physicians. Physicians, for example, are reluctant to consider themselves in need of help and find the role of patient unacceptable. Their professional effectiveness as problem solvers leaves many physicians unable to deal with emotional issues, either those of their patients or their own.

Many physicians have considerable difficulties dealing with intimacy—a major factor in an unsatisfactory marital relationship.

This workshop will identify and discuss these and other issues that complicate the physician's capacity to manage stress, and which frequently contribute to symptomatic dysfunction. The workshop presenters will offer some ideas about effective therapeutic strategies. It is expected that physicians in the workshop will also contribute their observations and experiences in their work with troubled and severely stressed physicians.

REFERENCES:

1. Gabbard GO, Menninger RW: Medical Marriages. Washington D.C., American Psychiatric Press, Inc., 1988
2. Myers MF: Doctors' Marriages: A Look at the Problems and Their Solutions, 2nd ed. New York, Plenum Publishing, 1994

Issue Workshop 75
HOW TO MAKE AN EFFECTIVE PSYCHIATRIC PRESENTATION

Chairperson: Phillip J. Resnick, M.D., *Department of Psychiatry, University Hospital, 11100 Euclid Avenue, Cleveland OH 44106*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to improve techniques for holding audience attention, involving the audience, and using slides effectively.

SUMMARY:

This workshop will provide practical advice on how to make a psychiatric presentation with pith, punch, and polish. Instruction will be given on planning a scientific paper presentation and a half-day APA course. The workshop leader will cover the selection of a title through to the choice of closing remarks. Teaching techniques to hold the audience's attention include the use of humor, anecdotes, and vivid images. Participants will be taught to involve the audience by breaking them into pairs to solve problems by applying recently acquired knowledge.

Participants will be told that they should never (1) read while lecturing; (2) display their esoteric vocabulary; or (3) rush through their talk, no matter what the time constraints. Tips will be given for making traditional word slides and innovative picture slides. Advice will be given on the effective use of videotape vignettes. Videotapes will actually be used to illustrate common errors made by lecturers. The workshop will also cover how to select material for handouts. Finally, participants will be encouraged to make a three-minute presentation with slides and receive feedback from workshop participants.

REFERENCES:

1. Sachdeva AK: Use of effective questioning to enhance the cognitive abilities of students. J Cancer Educ 1996; 11:17-24
2. Bloom BS (ed): Taxonomy of Educational Objectives: The Classification of Educational Goals. Handbook I: Cognitive Domain, New York, Longman, 1984

Issue Workshop 76
PHARMACOTHERAPY OF ADDICTIVE DISORDERS

Co-Chairpersons: Norman S. Miller, M.D., *Department of Psychiatry, Michigan State University, A227 East Fee Hall, East Lansing MI 48824,* Raye Litten, Ph.D., *6000 Executive Blvd., MSC7003, Bethesda MD 20892*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be up to date in 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 drugs addictions) can be classified according to these 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, Gold MS, Smith DE (eds): Manual of Therapeutics for Addictions. New York, Wiley-Liss, 1997

2. Miller NS (ed): The Integration of Pharmacological and Nonpharmacological Treatments in Drug/Alcohol Addictions. Binghamton, NY, The Haworth Medical Press, 1997

Issue Workshop 77
CLINICAL ISSUES IN GERIATRIC ALCOHOLISM

Co-Chairpersons: Roland M. Atkinson, M.D., *Oregon Health Sciences Univ, 3181 SW Sam Jackson Park Road, Portland OR 97201,* David W. Oslin, M.D., *3615 Chestnut Street, Philadelphia PA 19104*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) recognize and diagnose alcohol use disorders (AUDs) in older adults, (2) recommend individualized treatment for geriatric AUDs, (3) manage psychiatric comorbidities in older patients with AUDs, (4) differentiate dementia caused by AUDs from other types.

SUMMARY:

Alcohol use disorders (AUDs) are a significant problem in the aging population. A number of special features mark these disorders in older adults with regard to clinical presentation, comorbidities, and treatment. These features will be presented by theme, and the audience will be able to "vote" at the outset on which themes they wish to have emphasized. There will be up to 10 minutes of interactive discussion for each theme addressed, and a Q & A wrap-up. Themes that can be covered include:

- Screening, recognition, and diagnosis;
- A Major treatment approaches: brief intervention, case management, individual and group psychotherapies, cognitive-behavioral therapy, and pharmacotherapy;
- Psychiatric and substance comorbidities and their management;
- Dementia and cognitive loss; and
- Setting-specific issues including general psychiatric practice, substance abuse treatment programs, and long-term care.

REFERENCES:

1. Center for Substance Abuse Treatment. Substance Abuse Among Older Adults: Treatment Improvement Protocol #26. Rockville MD, USDHHS, PHS, Substance Abuse and Mental Health Administration, 1998. [DHHS Publication No. (SMA) 98-3179]
2. Oslin D, Atkinson RM, Smith DM, Hendrie H: Alcohol related dementia: proposed clinical criteria. International Journal of Geriatric Psychiatry 1998; 13:203-212

Issue Workshop 78
ASSESSMENT AND INTERVENTION OF MOVEMENT DISORDERS

Chairperson: Leonardo Cortese, M.D., *University of Western Ontario, 392 South Street, London ON 00054, Canada*
Participants: Richard Williams, M.D. Michael Caligiuri, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to (1) improve recognition of neuroleptic-induced movement disorders by demonstration and participation through physical exam, (2) know the benefits of using assessment scales, and (3) understand the advantages in tolerability of the atypical versus typical antipsychotics.

SUMMARY:

Presenters will review with the audience the recent knowledge concerning the four main types of neuroleptic-induced movement disorders. The presenters will then illustrate by video clips examples of various common movement difficulties, thus assisting in the recognition of these difficulties.

Exceptional to this workshop will be the presenters demonstrating on real patients the assessment of movement disorders using assessment scales. The presenters will encourage active participation by the audience in the physical examination and documentation using common movement disorders assessment scales.

REFERENCES:

1. Casey DE: Neuroleptic-induced acute extrapyramidal syndromes and tardive dyskinesia, in Schizophrenia. Edited by Hirsch S, Weinberger DR. Oxford, England, Blackwell, 1995, pp 546-565
2. Caligiuri MP, Lehr JB, Jeste DV: Parkinsonism in neuroleptic-naive schizophrenic patients. Am J psychiatr 1993; 150:1343-1348

Issue Workshop 79
THE WOMAN INTERNATIONAL MEDICAL GRADUATE IN PSYCHIATRY

Chairperson: Umadevi Naidoo, M.D., *Brigham & Women's Hospital, 330 Brookline Avenue, RABB 2, Boston MA 02115*
Participants: Carola Eisenberg, M.D., Maria T. Lymberis, M.D., Esther R. Knight, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant will understand the diverse perspectives of the four women International Medical Graduate (IMG) presenters, and how they have each overcome adversity to become highly successful psychiatrists. Advice for handling dilemmas, and an emphasis on problem solving that would be useful to all women IMGs, will be the focus.

SUMMARY:

The workshop has four women IMG presenters who each have had very different careers in psychiatry, but who are all inextricably linked by the experience of facing the challenges of being IMGs. Women comprise about 45% of psychiatric residents overall. International medical graduates constitute 44.4% of the 1996-97 PGY-I class of all psychiatric residents. The chairperson, Dr. Uma Naidoo, who is a PGY-III resident at the Harvard Longwood Psychiatry Program, will introduce the discussants and hand out question cards to the participants. Dr. Lymberis will draw on her experience as both a seasoned psychoanalyst and as the APA treasurer, to discuss the process of acculturation and re-integration. Dr. Carola Eisenberg, assistant professor and previous dean of students at Harvard Medical School, will focus on utilizing the IMG status to become a leading administrator and also a liaison to international affairs. Dr. Esther Knight, who works with an underserved population, will discuss how she utilized her personal interest to negotiate immigration difficulties, while still doing something that she enjoys academically. Dr. Naidoo will discuss the challenges facing women IMGs in residency and will sum up the workshop. In closing there will be a question and answer session.

REFERENCES:

1. Scully JH: APA Census of Residents, Washington, D.C., American Psychiatric Association, 1990-97

2. Weissman S: American psychiatry in the 21st century: the discipline, its practice, and its workforce. Bulletin of the Menninger Clinic 1994; 58:502-518

Issue Workshop 80
COGNITIVE-BEHAVIOR THERAPY OF SCHIZOPHRENIA

Chairperson: David G. Kingdon, M.D., *Southampton University, ITY Royal South Hants Hospital, Southampton, United Kingdom*

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, participants will be able to critically appraise the randomized controlled studies of CBT in schizophrenia (including those currently in press). They will be able to use techniques to improve adherence to medication, and work with hallucinations, delusions, thought disorder, and negative symptoms in early and resistant schizophrenia.

SUMMARY:

Participants will be able to review the evidence for the use of CBT in schizophrenia. They will be able to use techniques to assist engagement, use guided discovery to trace antecedents of onset, and explore patients' own and alternative explanations for delusional beliefs. With resistant delusions, they will be able to inference chain them to uncover and then work with schema. The use of hypothesis testing and relevant homework assignments will be discussed as will the use of diaries or, more usually, use of detailed recall to identify and overcome delusions of reference.

Participants will be able to assist patients in reattributing the origins of hallucinations, using a biopsychological model, empowering patients to resist commands and counter negative statements, and enabling them to develop coping strategies. Management strategies used with negative symptoms involving resetting goals and expectations will be examined, and with thought disorder, distinguishing and working with pertinent themes. Exploration of beliefs about medication and insight into schizophrenia using motivational interviewing techniques can be used in improving treatment adherence. Videotape demonstrations will be available. Participants will be encouraged to present case material for discussion and use role play in small groups to test out techniques.

REFERENCES:

1. Tarrier N, Yusupoff L, Kinney C, et al: Randomised controlled trial of intensive cognitive behaviour therapy for patients with chronic schizophrenia. Br Med J 1998; 317:303-7
2. Kingdon DG, Turkington D: Cognitive Behavioural Therapy of Schizophrenia. NY, Guildford Press, 1994

Issue Workshop 81
MEDICAL SAVINGS ACCOUNT PLANS: PUTTING YOU AND YOUR PATIENTS FIRST

Chairperson: David T. Springer, M.D., *35 Indian Spring Road, Media PA 19063*
Participants: James L. Pendleton, M.D. Howard F. Stock, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to recognize the features of MSA plans, compare them with managed care and traditional insurance plans, and recognize principles of a free market approach to medical care.

SUMMARY:

Learn how medical savings accounts plans can promote both you and your patients' freedom from managed care. The distinct features of MSA plans will be discussed, including free choice of doctor and treatment, increased confidentiality, de facto parity under the deductible, as well as low premiums, potential savings, and lower overhead.

Dr. David Springer will discuss how MSA plans compare with other insurance plans, and their impact on psychiatric practice. Dr. James Pendleton will discuss the extension of free market principles to medical expenditures, both below and above the deductible. Dr. Howard Stock will discuss the limitations of MSA plans in the current regulatory and tax environment, and ideas for the future of MSA plans.

A 30-minute period of questions and answers will complete the workshop. There will be a handout available discussing the setting up of an MSA plan for an individual or small corporation, including information about insurance plans available in each state.

REFERENCES:

1. Ferrara: More Than a Theory: Medical Savings Accounts at Work. CATO Institute Policy Analysis, No. 220
2. Shore: Why We Need to Move Beyond Managed Care and Managed Competition. Psychologist/Psychoanalyst Summer 1995; Vol. 15(3)

Issue Workshop 82
TEACHING PSYCHOTHERAPY IN A MANAGED CARE SETTING

Chairperson: James H. Scully, Jr., M.D., *Department of Psychiatry, University of South Carolina, 3555 Harden Street Extension, Columbia SC 29203*
Participants: George W. Ayers, D.S.W. Ronald E. Prier, M.D. Margaret A. Shugart, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to understand the components of developing a working relationship with a self-insured employer and their fiscal intermediary for developing a managed psychotherapy benefit for employees using residents as providers and training residents to practice in that framework.

SUMMARY:

The workshop will address novel approaches for teaching psychotherapy in a managed care environment. This workshop will focus on the development of relationships with a large state employee insurance plan, which permitted residents to gain the experience of providing psychotherapy in a managed care environment.

The residency program sponsored by the South Carolina Department of Mental Health and the University of South Carolina School of Medicine was having great difficulty in recruiting appropriate psychotherapy patients for second- and third-year residents. This deficit in appropriate patients was addressed by developing a contractual arrangement with the State Division of Insurance Services that would allow the residents to see state employees for a minimal copay. This added a significant benefit for employees and provided residents with a large patient base that had been unavailable to them.

The presentation will discuss the advantages of this arrangement over a standard Medicaid or other noncapitated arrangements with special populations and further explore the teaching potentials for preparing residents to work in a managed care environment.

REFERENCES:

1. Schreter RK: Coping with the crisis in psychiatric training. Psychiatry 1997 Spring; 60(1):51-9

2. Yager J, Docherty JP, Tischler GL: Preparing psychiatric residents for managed care. Journal of Psychotherapy Practice and Research 1997 Spring; 6(2):108-22

Issue Workshop 83

MEDICAID MANAGED CARE IN MARYLAND: EXPANDING ACCESS AND EARLY INTERVENTION FOR CHILDREN AND ADOLESCENTS

Chairperson: Albert A. Zachik, M.D., *Mental Hygiene Administration, 201 West Preston Street, Baltimore MD 21201*
Participants: Thomas J. Merrick, M.A. Karen Oliver, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize how public policies can provide powerful incentives to expand access, understand the interface between primary and psychiatric care and how to increase appropriate referrals, explain how new federal financing strategies and waivers can expand resources to both uninsured and privately insured clients, advocate for changes in their own state program.

SUMMARY:

The workshop will present information and data on how Medicaid reform in Maryland, using a Section 1115 Medicaid Waiver, broadly expanded access for children and adolescents in the state. Child and adolescent service recipients jumped to 41% of all individuals served—30,000 children were served last year. New services never before available to children and adolescents, currently the fastest growing provider sector, will be described. The relationship between primary care providers, primarily pediatricians, and psychiatric specialists in the system will be explored and the system design that helped to sensitize the expansion of psychiatric referrals will be described. In particular, a statewide response to the issues of ADHD and its treatment in primary and mental health care settings will be outlined. Similarly, the significant numbers of children involved with the child welfare system who gained access to the mental health system will be described. Innovative service approaches such as school-based services, and a public awareness media campaign will be discussed. A proposed Section 1915-C Medicaid Waiver, which further opens service eligibility to children whose parents may have private insurance resources, will be detailed. Maryland's efforts to obtain consumer reports about access and other facets of the system using statewide telephone and face-to-face surveys will also be described.

Participants will be assured at minimum, a 30-minute interactive question and answer period. The overarching goal of this interactive period will be to provide information geared toward participants' own public sector system and how they can advocate for similar reforms to expand financing and access for services.

AIDS PROGRAM
PART I: CLINICAL AND NEUROPSYCHIATRIC DIMENSIONS OF HIV DISEASE

Marshall Forstein, M.D., *24 Olmstead Street, Jamaica Plain, MA 02130-2910*

No. 1A
AIDS AND HIV DISEASE: A MEDICAL UPDATE

Douglas Ward, *1737 20th Street, NW, Washington, DC 20009*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will have a review of the medical, epidemiological and treatment issues associated with AIDS and HIV infection.

SUMMARY:

Undoubtedly, we are at a critical turning point in the AIDS epidemic. New technologies for measuring viral replication and mutation, potent antiretroviral regimens, and triple combination therapies have generated a wave of optimism and hope. These advances, however, have also introduced great clinical challenges for psychiatrists. And contrary to the declining trends, the face of the epidemic is changing as many more women, children and ethnic minorities become disproportionately infected. 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. 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 regimes, 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. Centers for Disease Control and Prevention: *Trends in the HIV and AIDS Epidemic.* U.S. Department of Health and Human Services, 1998.
2. Hogg RS, Heath KV, Yip B et al: Improved Survival Among HIV-Infected Individuals Following Initiation of Antiretroviral Therapy. *JAMA* 279(6):450–4, 1998.
3. Rabkin JGM, Ferrando S: A "Second Life" Agenda. Psychiatric Issues Raised by Protease Inhibitor Treatments for People with the Human Immunodeficiency Virus or the Acquired Immunodeficiency Syndrome. *Arch Gen Psych* 54:1049–1053, 1997.

No. 1B
NEUROPSYCHIATRIC MANIFESTATIONS AND THEIR TREATMENTS: A REVIEW

Marc Halman, M.D., *Dept. of Psychiatry, The Wellesley Hospital Jones Building, 334-160 Wellesley Street East, Toronto, Ontario, M4Y IJ37*; Karl Goodkin, M.D., *University of Miami School of Medicine, 1400 NW 10th Avenue, Dominion Tower, Room 803A, Locator M836, Miami, FL 33136*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will have a review of the spectrum of neuropsychiatric conditions that often exist with HIV infection and the range of effective psychopharmacological treatment approaches.

SUMMARY:

The involvement of psychiatrists in the diagnosis and treatment of HIV/AIDS patients is essential because of the prevalence of HIV-related neuropsychiatric complications, psychiatric comorbidity, as well as the psychodynamic aspects of HIV infection and disease. Clinical experience and research provide substantial evidence that HIV directly infects the brain, resulting in central nervous system (CNS) impairment and neuropsychiatric disorders, including HIV-1 associated dementia (HAD) complex, minor cognitive-motor disorder (MCMD), delirium, and psychosis. Current studies estimate that as many as 75 percent of all AIDS patients present symptomatic central nervous system consequences. As HIV/AIDS becomes increasingly a chronic disorder with the improvement of treatments and longer survival times, the incidence of HIV-related neuropsychiatric sequelae is expected to increase.

During this presentation, panelists will discuss primary infection of the central and peripheral nervous systems, cognitive-motor impairment, HIV-1 associated dementia, and delirium and review effective psychopharmacologic interventions and palliative treatments. Panelists will also review the diagnosis and treatment of various clinical psychiatric conditions and highlight pharmacotherapy, psychotherapies, and other nonpharmacological interventions. The sessions will include lecture and case discussion.

REFERENCES:

1. Navia BA: Clinical and Biological Features of the AIDS Dementia Complex. *Neuroimaging Clin No America* 7(3):581–592, 1997.
2. Goodkin K, Wilkie FL, Concha M, et al: Subtle Neuropsychological Impairment and Minor Cognitive-Motor Disorder in HIV-1 Infection: Neuroradiological, Neuropsychological, Neuroimmunological and Virological Correlates. *Neuroimaging Clin No America* 7(3): 561–580, 1997.
3. Goodkin K: Randomized Double-Blind Placebo-Controlled Trials of Peptide T for HIV-Associated Cognitive Impairment. *Archives of Neurology* 7:41–51, 1998.

AIDS PROGRAM
PART II: PSYCHIATRIC AND CLINICAL MANIFESTATIONS

Marshall Forstein, M.D., *24 Olmstead Street, Jamaica Plain, MA 02130-2910*

No. 2A
MOOD DISORDERS AND HIV DISEASE

Stephen J. Fernando, M.D., *NY Hospital, Cornell Medical Center, 445 E. 68th Street, #3K, New York, NY 10021*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will have knowledge of the clinical manifestations, differential diagnosis and treatment of HIV-related depression.

SUMMARY:

Psychiatric diagnosis in HIV-infected individuals is invariably a differential diagnosis which must include both HIV and non-HIV system disease. Among the most common psychiatric conditions are mood disorders, including depression and mania. Major depression has been detected in approximately 30 percent of patients. It is important that clinicians treating HIV patients recognize the symptoms that may complicate a diagnosis as well as the appropriate interventions for treating mood disorders. In this session, participants will review the clinical manifestations of and diagnostic criteria for major depression, discuss various treatments (both nonpharmaco-

logic and pharmacologic), and consider the prevalence and risk factors associated with suicide and HIV.

REFERENCES:

1. Markowitz JC, Kocsis JH, Fishman B et al: Treatment of Depressive Symptoms in HIV-Positive Patients. *Arch Gen Psychiatry* 55:452–458, 1998.
2. Lyketsos CG, Hoover DR, Guccione M et al: Changes in Depressive Symptoms as AIDS Develops. *Am J Psychiatry* 153(11):1430–1437, 1996.

No. 2B
PSYCHOSIS AND HIV DISEASE

Francine Cournos, M.D., *5355 Henry Hudson Parkway, #9F, Bronx, NY 10471-2839*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will have an increased awareness of the interaction between psychotic disorders and HIV-1 infection.

SUMMARY:

Clinicians and researchers working with HIV-infected psychotic patients need to be aware that patients may develop particular clinical syndromes by a variety of complex paths. The psychotic disorder may precede the HIV-1 infection, a common etiologic factor may predispose both the HIV-1 infection and the psychosis, or the HIV-1 infection may play an etiologic role, either directly or indirectly, in the onset of the psychosis. During this session, faculty will advance a variety of issues of importance to psychiatrists in clinical practice. Participants will examine the interaction between psychotic disorders and HIV-1 infection and review the essential elements in the medical and psychiatric evaluation of psychotic disorders.

REFERENCES:

1. Sewell DD, Jeste DV, Atkinson JH, Heaton RK, Hesselink JR, Wiley C, Thal L, Chandler JL, Grant I: HIV-Associated Psychosis: A Study of 20 Cases. San Diego HIV Neurobehavioral Research Center Group. *Am J Psych* 141(2):237-242, 1994.
2. Cournos F, Horwath E, Guido JR, McKinnon K, Hopkins N: HIV-1 Infection at Two Public Psychiatric Hospitals in New York City. *AIDS Care*, pp. 443-452, 1994.

No. 2C
SOMATIC SYMPTOMS AND THEIR PSYCHOLOGICAL IMPLICATIONS

Marshall Forstein, M.D., *24 Olmstead Street, Jamaica Plain, MA 02130-2910*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will have examined the role of the psychiatrist in the biological assessment and symptom management of HIV somatic conditions.

SUMMARY:

Clinical symptoms such as headaches, gastrointestinal problems, arthritis, fatigue, insomnia and sexual dysfunction are common in the spectrum of HIV disease. It is necessary to have a working knowledge of symptom etiology before psychotherapeutic options can be considered for their management. In this session participants will examine the myriad of somatic conditions, review assessment strategies, and consider various approaches to management. Following a lecture, participants will be encouraged to share their clinical experiences and questions with panelists.

REFERENCES:

1. Cohen PT, Sande MA, Volberding PA: *The AIDS Knowledge Base* (third edition). Lippincott, Williams and Wilkens, 1999.
2. Breitbart W et al: Pain Management and Psychosocial Issues in HIV and AIDS. *Am J Hosp Palliat Care* 13(1):20-29, 1996.

CLINICAL CASE CONFERENCES

1. CHRONIC PAIN SYNDROMES: REFRACTORY TO CONVENTIONAL TREATMENTS

Barbara A. Palmari, M.D., *35 Whittredge Road, Summit NJ 07901* Oliver Freudenreich, M.D., Thomas N. Wise, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will be familiarized with chronic pain syndromes and comorbid psychiatric illnesses, review multidisciplinary evaluation and management strategies of such syndromes, and discuss the role of somatization in chronic pain disorders.

SUMMARY:

Chronic pain syndromes are among the most common and frustrating presentations in primary care. Frequently, such patients are refractory to conventional medical interventions and are at risk for significant iatrogenesis. Psychiatrists, although less likely to encounter such patients in their practices, have much to offer to the multidisciplinary evaluation and management of such cases. This conference will demonstrate the heterogeneity of the chronic pain patient, using multiple case presentations. The phenomenology, etiology and general principles of evaluation of selected common pain syndromes will be outlined. The prevalence of comorbid psychiatric illnesses will also be reviewed.

Case discussion will focus on the various treatment and management strategies for these particular patients. Special emphasis will be placed on a review of the multidisciplinary (i.e., pharmacologic and psychotherapeutic) interventions most effective in these syndromes. Finally, the role of somatization and symptom magnification in chronic, refractory pain syndromes will be discussed.

REFERENCES:

1. Koenig T, Clark M: Advances in Comprehensive Pain Management. *Psychiatric Clin North America* 19:589–611, 1996.
2. Barsky A, Borus J: Somatization and Medicalization in the Era of Managed Care. *JAMA* 274:1931–1934, 1995.

2. MANIC DEPRESSIVE ILLNESS: OVER, UNDER OR MISDIAGNOSIS

Roslyn Seligman, M.D., *Associate Professor of Psychiatry, University of Cincinnati College of Medicine, PO Box 670559, Cincinnati, OH 45267-05559* Hagop S. Akiskal, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will be able to identify clinical factors that can lead to an overdiagnosis or misdiagnosis of manic depression.

SUMMARY:

Manic depression is a major public health problem affecting approximately one percent of the U.S. population. If there is no definitive history of mania or current mania, making an accurate diagnosis can be challenging. Other conditions such as Cluster B personality disorders, disorders of the SELF, and attachment disorders can mimic depression and can lead to over diagnosis and therapeutic failure. In this conference, the presenter will introduce the case of a 31-year-old man with a 25-year history of increasing difficulty and age-related changes in diagnosis. The patient manifested an episodic course and became dysfunctional with failures in school, work and family. He also displayed addictive behaviors including drugs and gambling. The diagnosis of manic depression, ADD and anxiety disorder and their concomitant pharmacological treatments did not improve the patient's functioning. Recent psychotherapy has yielded slow, but definite improvement. The patient's course under different periods of diagnostic understanding and subsequent treatments affords us the opportunity to examine syndromes that mimic some features of manic depression, but require a different therapeutic approach.

REFERENCES:

1. Akiskal HS: The Prevalent Clinical Spectrum of Bipolar Disorders: Beyond DSM-IV (Review). *J of Clin Psychopharm* 16(2):45–145 (supplement), 1996.
2. Kohut H: *The Restoration of the Self.* New York International Universities Press, 1977.
3. Blacker D, Tsuant MT: Contested Boundaries of Bipolar Disorder and the Limits of Categorical Diagnosis in Psychiatry. *Am J Psychiatry* 149:11, 1992.

3. REFRACTORY DEPRESSION AND ECT

Mark D. Beale, M.D., *Institute of Psychiatry, MUSC, 171 Ashley Avenue, Charleston, SC 29425-0001,* Teresa A. Rummans, M.D., Harold A. Sackeim, M.D., Richard D. Weiner, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation the participant will understand when a patient with refractory major depression should be referred for ECT.

SUMMARY:

Refractory major depression is now the most common reason for referral to ECT, yet specific clinical criteria for such a referral remain unclear. The situation is made even more difficult in the setting of comorbid mental and physical disorders. This clinical case conference will focus on this common clinical problem and will address the value of ECT for this population as well as the decision-making process for determining if and when ECT should be utilized.

REFERENCES:

1. American Psychiatric Association: *The Practice of ECT: Recommendations for Treatment, Training and Privileging.* American Psychiatric Press, Inc., Washington, DC, 1990.
2. Devanand DP, Sackeim HA, Prudic J: Electroconvulsive Therapy in the Treatment-Resistant Patient. *Psychiatry Clin. North America* 14:905–923, 1991.

4. CONTINUOUS CLINICAL CASE CONFERENCE PART I AND II TREATING PATIENTS WITH MEDICALLY UNEXPLAINED SYMPTOMS

Ralph Saintfort, M.D., *16 Union Park #3 Boston, MA 02118-3700,* Arthur J. Barsky III, M.D., Carla Cantor, Frank de Gruy, M.D., Brian Fallon, M.D., Javier I. Escobar, M.D., Julie Lieb, M.D., James L. Stinnett, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this two-day presentation, the participant will be able to characterize, compare and distinguish the somatoform disorders; understand the role and functions of the psychiatric consultant in managing patients with medically unexplained complaints; and learn about cognitive/behavioral therapy and pharmacotherapy in treating somatoform disorder patients.

SUMMARY:

This conference will focus on understanding, diagnosing and treating the somatoform disorders, with the emphasis on hypochondriasis and somatization disorder as prototypes. Clinical case examples will be amplified with presentations of the patient's viewpoint and that

of the primary care physician. The differential diagnosis of the somatoform disorders will then be discussed. Finally, there will be presentations on the role of the psychiatric consultant, and of the cognitive/behavioral therapy and the pharmacotherapy of the somatoform disorders.

REFERENCE:

1. Barsky AJ: A 37-year Old Man with Multiple Somatic Complaints. *JAMA* 278:673–679, 1997.
2. Ford CV: *The Somatizing Disorders. Illness As a Way of Life.* Elsevier Biomedical, New York, 1983.

DEBATE

RESOLVED: MEDICAL SAVINGS ACCOUNTS WILL IMPROVE ACCESS TO MENTAL HEALTH CARE

Moderator: Donna M. Norris, M.D.
Affirmative: Frederick K. Goodwin, M.D. and Pierre Vincent, M.D.
Negative: Captane P. Thomson, M.D. and Arthur L. Lesser, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants will understand what Medical Savings Accounts (MSAs) are, how they work and how they can strengthen the doctor-patient relationship. Participants will also learn about the risks of MSAs and if they will advance or impede the cause of universal access to health care; what their impact on our nation's overall health status will be; and if there is an alternative way to work with this concept in a more positive way to make insurance more affordable, portable, universal and beneficial to the whole community.

SUMMARY:

Affirmative:

Efforts to deal with the negative impact of managed care are of two kinds: 1) the development of alternatives that return economic control to the patient; and 2) expanded regulation of managed care through legislation or litigation. The problem with regulatory solutions is that, by increasing the role of government, they may actually further compromise the freedom of individual professionals and patients. There will be a review of the historical factors that have distorted the financing of health care in the U.S. during the second half of this century, principally the imposition of wage freezes, which fueled the development of "wage equivalents," and health benefits designed to circumvent wage freezes. The resultant "blank check" era of comprehensive coverage set in motion the ever-enlarging cycle of overutilization-oversupply, which in turn eventually stimulated the top-down controls, i.e., managed care. An MSA eliminates the tax penalty for those assuming financial responsibility for their own routine health care. The affirmative will describe how MSAs work, review the data on the health status of MSA participants and their use of preventive services, show evidence for and against adverse selection, and propose that this kind of consumer empowerment can increase access to quality mental health care.

Negative:

The MSA/Catastrophic insurance plan is attractive to the young and healthy but does little to further the social purpose of health insurance, to spread the risk of having a rare but financially ruinous accident or illness. As it now stands there is little incentive for the poor to invest in a tax sheltered MSA or even to pay for catastrophic coverage. As proposed, the MSAs may detract from universal coverage. They may help briefly with portability between jobs, but only so long as one can still pay the catastrophic premium. Tax sheltered MSAs cost shift away from the sick by subsidizing the healthy and wealthy and do little to control costs or the overall proportion of the GDP devoted to health (now at 14% in the U.S.). They offer initial choice of provider, at least until the managed catastrophic benefit is reached, when many expenses (e.g., eyeglasses, psychotherapy) could be denied. Finally, they provide a disincentive to preventive service (mammograms, Pap smears, immunizations, etc.) which may worsen our already lagging infant mortality rates, etc. The APA Committee on Universal Access to Health Care has proposed an alternative approach for your consideration.

REFERENCES:

1. Ferrara P: More Than a Theory: Medical Savings at Work. *Policy Analysis* 22, CATO Institute, March, 1995.
2. Tanner M: Medical Savings Accounts: Answering the Critics. *Policy Analysis* 228, CATO Institute, March, 1995.
3. U.S. General Accounting Office Report to Congressional Committees: *Medical Savings Accounts: Results from Surveys of Insurance,* December 1998.
4. Bunce KC: The Basics of Medical Savings Accounts. *Association Management* 50(2):85-90, 1998.

FORUMS

1. WHAT'S REALLY GOING ON IN PSYCHIATRY? THE APA PRACTICE RESEARCH NETWORK

Co-Chairpersons: John S. McIntyre, M.D. and Harold Alan Pincus, M.D.
Participants: Ivan Montoya, M.D., Ana Suarez, M.P.H., Terri L. Tanielian, M.A.,

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation participants will be able to understand the principles and rationale for practice-based research in psychiatry, design research studies for implementation within the PRN, and discuss current psychiatric treatment practice patterns and relevant clinical information gathered through the Practice Research Network with relation to psychiatric patients.

SUMMARY:

The APA Practice Research Network (PRN) conducts clinical and services research. With funds from the MacArthur Foundation and CMHS, the PRN is expanding to a nationally representative network of 1,000 psychiatrists. This forum provides an update on the PRN and recent findings. Findings from the National Survey of Psychiatric Practice, a large national probability sample survey of APA members, will highlight critical clinical, financial, and other psychiatric issues of importance. This study collects nationally representative data on psychiatrists' professional activities, work settings, and patient caseloads. The study of psychiatric patients and treatments provides data systematically characterizing PRN members, their practices, patient caseloads, and clinical treatment patterns. It provides detailed clinical and diagnostic data on PRN patients and the specific types and combinations of treatments provided. Findings from the Child and Adolescent Pilot Treatment Study of ADHD will be presented highlighting patterns of medication use for children with ADHD and factors which are associated with variations in psychopharmacologic treatment patterns. Plans for a larger study investigating these issues will be discussed. Key findings from other PRN studies will also be presented along with related data on psychiatric practice from other national databases.

REFERENCES:

1. Zarin D, Pincus H, West J, McIntyre J: Practice-Based Research in Psychiatry. *American J of Psych* 154:1199–1208, 1997.
2. Zarin D, Peterson B, West J, Suarez A, Marcus S, Pincus H: Characterizing Psychiatry: Findings from the 1996 National Survey of Psychiatric Practice. Submitted to *American J of Psych.*

2. THE GLOBALIZATION OF PSYCHIATRY: CHALLENGES AND OPPORTUNITIES

Co-Chairpersons: Rodrigo A. Munoz, M.D. and Norman Sartorius, M.D.
Participants: Harold I. Eist, M.D., Robert O. Pasnau, M.D., Ahmed M.F. Okasha, M.D., Steven M. Mirin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants will be able to understand the process of globalization taking place around the world in the socioeconomic and political arenas. Additionally, they will also learn about the impact of this globalization process vis-a-vis the psychiatric profession.

SUMMARY:

During the last two to three decades, a process of globalization has evolved around the world with primary emphasis in the socioeconomic and political domains. Examples of this process are the development of the North Atlantic Free Trade Agreement (NAFTA) and the consolidation of the European market which includes a single currency. As this globalization process evolves, its impact on the professional field is growing rapidly. Examples of this impact can be seen in the priority given by the World Psychiatric Association to its regional meetings (conferences) around the world and the internationalization of the Annual Meeting of the American Psychiatric Association. It is, therefore, imperative that we examine this globalization process and design the appropriate strategic plans to meet our profession's challenges in this regard, as well as take full advantage of the opportunities that it offers. In the forum, a full examination and analysis of the areas in which psychiatrists and other mental health providers can make a global contribution based on collaborative efforts with other psychiatric organizations around the world will be made. The time is ripe to prepare our profession for the 21st Century.

REFERENCES:

1. Ruiz P: Assessing, Diagnosing and Treating Culturally Diverse Individuals: A Hispanic Perspective. *Psychiatric Quarterly* 66(4):329–341, 1995.
2. Ruiz P, Venegas-Samuels K, Alarcon RD: The Economics of Pain: Mental Health Care Costs Among Minorities. *Psychiatric Clinics of North America* 18(3):659–670. 1995.

3. SAFE SCHOOLS AND DANGEROUS KIDS: PATHWAYS TO VIOLENCE

Chairperson: James Garbarino, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, participants will understand the links between child maltreatment, rejection and temperamental difficulties in the child as challenges to caregivers, including teachers, and understand the school as a context for the display or remediation of aggressive behavior in children and youth.

SUMMARY:

Youth violence is a major problem in the United States. Understanding its origins in the early experience of children is important for interpreting the actions of violent youth and acting to reduce their aggression. This presentation seeks to illuminate these issues by tracing the developmental pathways taken by difficult children who become criminally violent youth. It focuses on the accumulation of risk factors in the lives these children. These risk factors include the experiences of child maltreatment and other forms of trauma, difficult temperaments, parental and teacher mishandling of troubled children, and the social toxicity of the community. Contributors to the toxicity of the social environment for children and youth include instability of relationships, civic cynicism, terminal thinking, economic polarization, desensitization to violence, "the spiritual crisis," and the nastiness of popular culture. The effects of this social toxicity are felt and expressed most by the most vulnerable youth (e.g., those from destabilized families, those subject to racism and poverty, and those with disabilities). Efforts to deal with the issues of social toxicity involve both strengthening youth to decrease their vulnerability, and simultaneously detoxifying the social environment.

REFERENCES:

1. Garbarino J: *Raising Children in a Socially Toxic Environment.* Jossey-Bass Publishers, San Francisco, CA, 1995.
2. Garbarino J: *Lost Boys: Why Our Sons Turn Violent and How We Can Save Them.* The Free Press, New York, NY, 1999.

4. CAN WE TALK? PSYCHOTHERAPY BY PSYCHIATRISTS IN MANAGED CARE

Chairperson: Norman A. Clemens, M.D.
Participants: Robert A. Kimmich, M.D., Jesse H. Wright, M.D., Michael C. Hughes, M.D., William H. Sledge, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will understand how managed care affects the practice of psychotherapy by psychiatrists; be aware of strategies for providing effective psychotherapy in a managed care environment; and know the economic and clinical rationale for providing psychotherapy by psychiatrists in any health care system including managed care.

SUMMARY:

Managed care has had a profoundly adverse effect on psychotherapy services by psychiatrists. This panel of members and liaisons of the Commission of Psychotherapy by Psychiatrists will review the effects of managed care on psychotherapy and the psychiatrist-patient relationship, address ways to deal with the challenges that have resulted, and discuss coping strategies for continuing to provide psychotherapy. These include integrated psychotherapy and psychopharmacology; short-term problem-focused psychotherapies; brief versus "ultra-brief" psychotherapies; preserving longer-term, intensive treatment for those who need it; confidentiality and communications; private practice issues; strategies for managing psychotherapy so as to make it generously available; and the economic and clinical rationale for providing psychotherapy.

REFERENCES:

1. Lazar S (ed): Extended Dynamic Psychotherapy: Making the Case in an Era of Managed Care. *Psychoanalytic Inquiry (Supplement).* The Analytic Press, Hillsdale, NJ, 1997.
2. Goldman W et al: Outpatient *Utilization Patterns of Integrated and Split Psychotherapy and Pharmacotherapy for Depression.* Psychiatric Services 49:477–482, 1998.

5. HATE FOR LOVING: HOW SOCIETAL OPPRESSION IMPACTS LESBIAN AND GAY MENTAL HEALTH

Chairperson: Daniel W. Hicks, M.D.
Participants: Jeanine Cogan, M.D., Lynn S. Feldman, D.O., Mark H. Townsend, M.D., Neill Williams, M.D., Randy Pumphrey, D.Div.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will have an awareness of the special mental health difficulties for gay men and lesbians due to continued areas of unrecognized societal oppression; be educated about how they can help in the battle against homophobia to improve the health of their patients; and know how they can help their lesbian and gay patients combat internalized homophobia through various support groups and programs.

SUMMARY:

Despite many advances, it is still a difficult world for gay men and women to come out, gain self-respect and achieve full self-realization without going through a great deal of emotional distress and often serious psychiatric sequelae. This forum will discuss some of the major threats that still exist against gay men and lesbians in our society. The brutal slaying of Matthew Shepard, a young gay college student, points out the real fear that by being openly gay or lesbian, you can suffer violence or be killed. The advertisements offering "cures" for lesbians and gay men through reparative therapy purport to be compassionate, yet the real funding and motivation is political, and the "treatment" involved is not only scientifically invalid, but can be dangerous. Most mainstream churches are struggling with the issue of whether to accept or reject homosexual members and clergy, and on any day, you can tune in to hate-filled preaching against homosexuals on religious radio and television programs. With more role models and media visibility, gay and lesbian youth are coming out earlier, but often at the price of hatred, violence, depression, suicide and substance abuse. In the last year, the U.S. congress, and many state legislatures have felt the need to protect their citizens by enacting laws against gay and lesbian marriages. This non-recognition of our loving and long-term relationships does incredible damage to the health and security of our families and our community.

REFERENCES:

1. Stein TS, Cabaj RP (eds.): The Textbook of Homosexuality and Mental Health. American Psychiatric Press, Washington, DC, 1996.

6. UPDATE ON THE PRACTICE GUIDELINE FOR THE TREATMENT OF PATIENTS WITH BPD

Co-Chairpersons: John S. McIntyre, M.D. and Deborah A. Zarin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will be updated on the overall progress of the APA practice guidelines effort and obtain feedback/answer questions on a wide variety of issues relating to the project in general and the development of the BPD guideline.

SUMMARY:

The APA practice guidelines project has moved forward using an evidence-based process designed to result in documents which are both scientifically sound and clinically useful to practicing psychiatrists. The BPD guideline focuses on the evaluation, selection and application of both psychosocial treatments and pharmacologic interventions and provides a framework for clinical decision making. The foundation for treatment of each disorder is psychiatric management, which is combined with specific treatments in order to optimize patient outcome, formulating and implementing a treatment plan utilizing psychiatric management in conjunction with specific pharmacologic and psychosocial treatments will be discussed in the context of BPD. Attendees will be invited to comment on the broad array of issues relating to practice guidelines including guideline content, overall development procedures, dissemination and evaluation strategies, future guideline topics and implications for the field.

REFERENCES:

1. Zarin DA, Pincus HA, McIntyre JS: Editorial on Practice Guidelines. Am J Psych 150:2, 1993.
2. American Psychiatric Association: practice Guideline for Treatment of Patients with Borderline Personality Disorder. Am J Psych 151:12 (suppl), 1994.

7. MANAGING THE PROCESS OF CHANGE: QUALITY, FINANCING AND PATIENTS' RIGHTS

Chairperson: Eliot Sorel, M.D.
Participants: Rachel Jenkins, M.D., Laurie Flynn, M.A., Darrel A. Regier, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, participants will understand the process of integrating quality, financing and patients' rights to develop new health care systems for the 21st century.

SUMMARY:

Quality, financing and patients' rights are challenging physicians, advocacy groups, and policy makers to develop new responses and models for the health care systems of the 21st century. Financial considerations have, during this decade, driven health policy decisions in most Western countries.

Designing and implementing innovative health care systems that pay equal attention to quality, financing, and patients' rights is the shared task and responsibility of professional and advocacy organizations as well as policy makers.

The author compares health care systems' structures, financing, and outcomes and presents emerging decision making processes and new health care models that integrate quality, financing, and patients' rights.

REFERENCES:

1. Sorel E: Health: An Invaluable Asset for a Robust Economy and Democracy. In: *Church and Health in the Works* 34:86–87, 1997.
2. Blendon R et al: Satisfaction with Health Systems in Ten Nations. In: *Health Affairs* 9(2):185–192, 1990.

8. ETHICS AND HUMAN RIGHTS: AN INTERNATIONAL PROSPECTIVE

Chairpersons: Rodrigo A. Muñoz, M.D.
Co-Chairpersons: Robert O. Pasnau, M.D. Ahmed M.F. Okasha, M.D.,
Participants: Peter B. Gruenberg, M.D., Julio E. Arboleda-Florez, M.D., David S. Wahl, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will recognize different ethical applications with different cultures and societies and apply those to patient care.

SUMMARY:

Ethics in clinical practice of psychiatry is ever evolving in the field. The governing principles have their roots in age-old traditions which dictate the value to "do no harm." However, the interpretation of that principle varies from one society to another, from one culture to another, and even within such societies and cultures. This forum will attempt to address various instances of such dilemmas. In clinical practice, psychiatrists often face ethical dilemmas around personal conduct within the therapeutic relationships, example of boundary transgressions and variations between cultures will be offered. In relationships between psychiatrists and government activities, psychiatrists find themselves facing ethical dilemmas in the realm of applications of government policies or laws which may be contrary to medical ethics (i.e., state executions). The focus in this session will be on how psychiatrists' role as healers may interfere or compliment such activities. Finally, societal values can create conflicts for psychiatrists. Dilemmas will be presented with the hope of initiating dialogue to strengthen traditional values of medical practice and enable psychiatrists to effectively engage in public discussions making use of those traditions.

REFERENCE:

1. Weisstub DN, Arboleda-Florez J, Kaplan LV, Tancredi LR, Verdun-Jones SN: *Inquiry on Research Ethics.* Government of Ontario, 1995.
2. Mezzich JR: *Ethics in Psychiatric Education for Medical Students: A Commentary.* Current Opinion in Psychiatry, in press.

9. THE PATIENT NAMED SYBIL: DID ISSUES

Chairperson: Leah J. Dickstein, M.D.
Participants: Paul J. Fink, M.D., David Spiegel, M.D., Richard P. Kluft, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant will learn about the life outcome of a patient diagnosed with multiple personality disorder and in successful psychoanalytic treatment for the first time with this diagnosis over an eleven-year period.

SUMMARY:

The presenters will discuss their professional experiences in treating patients with multiple personality disorder, now called dissociative identity disorder (DID), over the past two decades. Dr. Dickstein knew Dr. Cornelia Wilbur and Sybil, and will share appropriate outcome evidence of successful therapy and a satisfying life. Dr. Speigel will offer neuroscience evidence for this diagnosis and its successful treatment. Dr. Paul Fink will offer his experiences with false memory syndrome and PTSD in patients.

REFERENCES:

1. Schreiber FR: *Sybil.* Regenery, Chicago, IL, 1973.
2. Dickstein LJ: My Long Distance Supervision with Cornelia Wilbur, M.D.: In: *Clinical Perspectives on Multiple Personality Disorder,* Kluft RP and Fine CG (eds). American Psychiatric Press, Inc., Washington, DC, 1995.

INDUSTRY-SUPPORTED SYMPOSIUM 1— THE COMPLEX FACE OF DEPRESSION: CLINICAL CHALLENGES IN THE DIAGNOSIS AND TREATMENT OF DEPRESSIVE DISORDERS
Supported by Forest Laboratories, Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize the considerable morbidity and mortality associated with underdiagnosis and undertreatment of depressive disorders throughout the life cycle; appreciate the similarities as well as the differences in the presentation of depression in various subpopulations such as children, adolescents, and the bereaved; evaluate the evidence in support of the efficacy of psychotherapeutic and pharmacotherapeutic interventions in these patients.

No. 1A
DIAGNOSIS AND TREATMENT OF CHILDHOOD MANIA

Elizabeth B. Weller, M.D., *Department of Psychiatry, University of Pennsylvania, 34th and Civic Center Boulevard, Philadelphia PA 19104;* Ronald A. Weller, M.D.

SUMMARY:

There is increasing evidence that childhood depression may be more prevalent and more similar to the adult-onset disorder than previously thought. Similarly, bipolar disorder, once believed to be nonexistent in prepubertal children, is now recognized in this population. Careful clinical evaluation and assessment of symptoms is essential for proper diagnosis and treatment, without which there is greater potential for these disorders to have deleterious effects on growth and development. Methods of assessment include diagnostic interviews, self-report inventories, structured interviews, and use of biologic markers. While both depression and bipolar disorder can be diagnosed in children using criteria similar to those for the adult population, age-related differences in cognitive functioning and language skills must be taken into account. In the psychiatric evaluation of children it is mandatory to obtain information from a number of sources (e.g., parents, teachers).

Relatively few data from controlled psychotherapeutic investigations or clinical trials are available; however, there is evidence that combined individual psychotherapy, parent education, and family therapy are effective. Clinical trials of the effectiveness of antidepressants (tricyclics and SSRIs) in children with depressive disorders have had inconsistent results. One study with a large sample size suggested fluoxetine is useful in treating children and adolescents with major depressive disorder. Lithium has been used to treat bipolar illness in children, although placebo-controlled data are lacking.

In this presentation, the reliability and validity of a new diagnostic instrument for use in children will be reviewed as well as results from treatment studies in prepubertal children with depression or bipolar disorder.

No. 1B
TREATMENT OF ADOLESCENT DEPRESSION

Richard C. Harrington, M.D., *Department of Psychiatry, University of Manchester, Childrens Hospital, Hospital Road, Pendlebury Manches, M27 4HA, United Kingdom*

SUMMARY:

Historically, depressive disorders in adolescence have been conceptualized as variants of the nonspecific class of childhood emotional disorder. Over the past decade, however, the field has shifted towards greater diagnostic refinement. Research evidence has shown that severe depressive disorders differ from other mental disorders in this age group in their epidemiology, outcome, and correlates. Treatment, therefore, includes not only general techniques of clinical management, but also a variety of treatments targeted to the symptoms of depressive disorder. Several different kinds of psychological treatment now exist for depression in adolescence. Probably the best studied is cognitive-behavior therapy (CBT), which seems to be effective in about two-thirds of cases. However, CBT has never been studied in adolescents with severe major depression. Psychopharmacological treatments of adolescent depression include the tricyclics, the serotonin-selective uptake inhibitors, and some of the newer antidepressants. Randomized trials have consistently failed to find significant differences between tricyclics and placebo, but there have been some promising early results with fluoxetine. The SSRIs are therefore probably the first-line psychopharmacological treatment for depression in adolescents. Most recent studies have shown that adolescents who remit from major depression have a high chance of relapse. Continuation treatments may therefore be indicated in some cases.

No. 1C
DECISION POINTS IN THE TREATMENT OF BIPOLAR DEPRESSION

Gary S. Sachs, M.D., *Bipolar Clinic, Massachusetts General Hospital, 15 Parkman Street, WACC-812, Boston MA 02114*

SUMMARY:

Clinicians face considerable challenges in treating bipolar disorder with its chronic, complex, and episodic course. A significant proportion of patients diagnosed with bipolar disorder suffers from recurrent episodes of mania and depression, both of which are potentially destructive. Since none of the therapeutic regimens currently available has proven curative for this illness, the treatment goal is to induce and sustain remission, or at least to result in fewer, briefer, or milder episodes.

Pharmacotherapy with mood stabilizers is the treatment of choice for bipolar disorder and mania; however, how best to treat low-level depression or residual depressive symptoms in a bipolar patient who is otherwise controlled on a mood stabilizer remains an open question. The clinician must carefully weigh the risks and benefits of therapeutic options, since a patient's need for acute treatment may conflict with a long-range goal of minimizing exposure to cycle-promoting agents. Treatment for depressed bipolar patients would consist of mood-stabilizing therapies, such as lithium, that ameliorate acute symptoms for depression without causing acceleration of cycling or inducing mania. Additionally, anticonvulsants that have come into use primarily as antimanics and mood stabilizers have been demonstrated to be effective treatment for depressed bipolar patients. ECT also is highly effective for bipolar depression, although most clinicians and patients prefer to hold it in reserve for particularly refractory episodes. Finally, while antidepressant medications may precipitate mania or worsen the course of the illness by decreasing intervals between episodes or inducing rapid cycling, clinical circumstances frequently exist that justify the use of these non-mood-stabilizing agents. This presentation will review data supporting various clinical strategies for the treatment of bipolar depression.

No. 1D
THERAPY FOR TRAUMATIC GRIEF

M. Katherine Shear, M.D., *Department of Psychiatry, University of Pittsburgh Medical Center, WPIC, 3811 O'Hara Street, Pittsburgh PA 15213-2593*; Ellen Frank, Ph.D., Holly G. Prigerson, Ph.D., Rona E. Pasternak, M.D., Charles F. Reynolds III, M.D.

SUMMARY:

In a series of studies carried out over the last five years, we have refined our understanding of bereavement-related psychological disorders and the kinds of treatment that are required for the amelioration of various forms of bereavement-related distress. Early investigations (e.g., Pasternak et al., 1993) revealed that while tricyclic antidepressants were effective in bringing about a remission of typical depressive symptoms, they had little effect on symptoms of grief. Simultaneously, we began to examine the extent to which specific grief symptoms might be associated with greater medical and psychiatric morbidity (Prigerson et al., 1995). We also began to explore the efficacy of interpersonal psychotherapy (Klerman et al., 1984), modified for the recently bereaved, in the treatment of bereavement-related depression. Ultimately, our assessment and treatment efforts led to the clinical description of a form of bereavement-related distress that we refer to as "traumatic grief" (Prigerson et al, submitted) and to the development of new treatments. We (Shear & Frank, 1998) are now developing and testing an intensive behavioral intervention for this condition that draws heavily on Foa's (1997) exposure therapy for victims of sexual assault. An overview of this treatment will be presented and examples of completed cases will be described in detail.

No. 1E
A LIFE-CYCLE APPROACH TO THE DIAGNOSIS AND TREATMENT OF DEPRESSIVE DISORDERS

David J. Kupfer, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Room 210, Pittsburgh PA 15213-2593*

SUMMARY:

It is now well established that depression can occur throughout the life cycle. Indeed, its presentation with respect to symptomatology, severity, level of functional impairment and response to treatment varies throughout the life cycle. A number of major factors are responsible for these apparent discontinuities. They include the age of onset, developmental stage, existence of other psychiatric symptomatology, and presence of physical disease. While discontinuities may be apparent with respect to response to treatment, both in terms of modality and level of response, it also needs to be stressed that the continuities of depression across the life cycle may ultimately turn out to be more important. Recent studies show that maintenance treatment of young adults, middle-aged individuals, and those with late-life depression are fairly similar. The long-term prognosis and outcome of recurrent depression appear to be similar across the life cycle. Aggressive recognition of episodes, immediate assessment and treatment, and assuming that the disease may require long-term management are fundamental principles of treating depression at any age. Not only is this approach recommended for recurrent major depression, but it is becoming clear that bipolar disorders and chronic depression may benefit from the same set of strategies.

REFERENCES:

1. Harrington R, Whittaker J, Shoebridge P, Campbell F: Systematic review of efficacy of cognitive behaviour therapies in childhood and adolescent depressive disorder. BMJ 1998;7144:1559–1563
2. Birmaher B: Should we use antidepressant medications for children and adolescents with depressive disorders? Psychopharmacol Bull 1998;34:35–39
3. Sachs GS. Treatment-resistant bipolar depression. Psychiatr Clin North Am 1996;19:215–236
4. Prigerson HG, Frank E, Kasl SV, et al: Complicated grief and bereavement-related depression as distinct disorders: preliminary empirical validation in elderly bereaved spouses. Am J Psychiatry 1995;152:22–30
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INDUSTRY-SUPPORTED SYMPOSIUM 2—REDEFINING TREATMENT-RESISTANT SCHIZOPHRENIA
Supported by Novartis Pharmaceuticals Corporation

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to address whether the current definition of treatment resistance for patients with schizophrenia should be amended to reflect an expectation of an improved level of overall functioning.

No. 2A
NATURAL COURSE AND OUTCOME OF SCHIZOPHRENIA

Thomas H. McGlashan, M.D., *Yale Psychiatric Institute, 184 Liberty Street, New Haven CT 06519*

SUMMARY:

The natural course of schizophrenia has often been described as heterogeneous. A century of empirical findings endorses such a view yet also attests to many recurrent patterns. This presentation will detail the play of both themes over the life course of the disorder. Included will be the overall variability of outcome, from permanent

cures to suicide. The phases of the disorder will be elaborated, including the premorbid phase with its inconstant neurodevelopmental markers, the prodromal phase and its current promise for early detection, the onset phase and its dimensional nature, the early-course phase and the public health hazard of untreated psychosis, the middle course with its plateau of stable disability, and the late course with improvement in some people and accelerated deterioration in others. The determining forces behind the course of disorder will be touched upon and mainly include neurobiological deteriorative processes on the one hand, host strength on the other, and the level of environmental stress mediating between these polarities.

No. 2B
PATHOGENESIS OF TREATMENT AND RESISTANCE IN SCHIZOPHRENIA

Jeffrey A. Lieberman, M.D., *Department of Psychiatry, University of North Carolina School of Medicine, 7025 Neurosciences Hospital, CB716, Chapel Hill NC 27599*

SUMMARY:

The majority of patients who develop schizophrenia in the course of their illness eventually experience persistent morbidity that does not respond to pharmacologic treatment. The severity of this residual morbidity, when it develops in the course of the illness, varies within this patient population. Various lines of evidence suggest that treatment resistance develops due to neurodevelopmental factors that may be part and parcel of the disease diathesis on one hand and the neurobiological consequences of disease pathophysiology following its onset on the other. This conception of treatment resistance suggests that therapeutic strategies that target the different components of treatment resistance may differ.

This presentation will describe various studies that have characterized the neurodevelopmental and pathophysiological determinants of treatment resistance and the effects of treatment in reversing them. These include studies of brain structure and function, neurochemistry, and neuropsychological assessment in the course of patients at different stages of the illness.

No. 2C
ALLEVIATION OF FUNCTIONAL IMPAIRMENT IN TREATMENT-RESISTANT SCHIZOPHRENIA

Herbert Y. Meltzer, M.D., *Department of Psychiatry, Vanderbilt University, 1601 23rd Avenue South, Suite 306, Nashville TN 37212;* Susan R. McGurk, Ph.D.

SUMMARY:

Functional impairment in schizophrenia is evidenced by deficits in work/academic function; familial, peer, and sexual relationships; increased morbidity and mortality; and poor quality of life. While treatment resistance to antipsychotic drugs is often conceptualized in terms of persistent positive and negative symptoms, it is the more general measures of function listed above that are the most meaningful markers of treatment resistance. New antipsychotic drugs differ in their ability to decrease positive and negative symptoms in neuroleptic-resistant patients. Data concerning their ability to improve some of the functional measures listed above will be presented. Evidence has accumulated that cognitive dysfunction in schizophrenia may be more important than negative and positive symptoms in the development of functional impairment, especially work/school function and attention to general medical well being. Mood symptoms are important for suicidality. This talk will discuss the development of cognitive impairment in schizophrenia and its relationship to poor functional outcome as well as the ability of newer antipsychotic drugs to reverse some of the cognitive impairments. The rate of suicide in schizophrenia is 9%–13% lifetime. Recent evidence suggests that there is a peak during the first decade of illness but that it remains high throughout the course of illness. While the rate may not differ in patients who do or do not respond well to typical neuroleptics, recent data suggest that clozapine treatment is associated with a markedly reduced suicide rate. Based upon changes in functional measures, it may be concluded that newer antipsychotic drugs have the ability to decrease the frequency and severity of treatment resistance in schizophrenia but some deficits persist in most patients.

No. 2D
EARLY INTERVENTION: APPROACH TO COMORBID SUBSTANCE ABUSE/SUBSTANCE USE DISORDER

Alan I. Green, M.D., *Department of Psychiatry, Harvard Medical School, 74 Fenwood Road, Boston MA 02115-6106*

SUMMARY:

Early intervention strategies have been proposed to improve the long-term course of schizophrenia. Trials with novel antipsychotics are underway to assess their role in patients in the early phase of the disorder. However, if such trials are to improve the course of schizophrenia, they must address the frequent comorbid problem of substance use disorder, which occurs in nearly 50% of patients with schizophrenia. Comorbid substance use disorder contributes strikingly to treatment resistance—to hospitalization, relapses, noncompliance, violence, and suicide in these patients. While psychosocial treatment programs aimed at "dual diagnosis" conditions may be helpful in controlling comorbid substance abuse, the typical antipsychotic drugs, which are effective for treatment of psychosis, appear to be of limited value in the treatment of comorbid substance abuse. Data from a number of groups, however, have suggested that the atypical antipsychotic clozapine may substantially limit substance use in the comorbid population. Lessening comorbid substance use through the use of a novel pharmacologic agent may be important to consider in attempts to improve the overall outcome of patients with schizophrenia.

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trial in first-episode patients. Harvard Review of Psych. 1995;3(1):1–9

INDUSTRY-SUPPORTED SYMPOSIUM 3—SPECTRUM OF DEPRESSION: NEW TREATMENT APPROACHES
Supported by Pharmacia & Upjohn Company, Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to review: (1) the possible involvement of noradrenergic systems in depression; (2) whether noradrenergic systems are particularly important for any subtype of depression; and (3) antidepressants post-tricyclics that affect noradrenergic systems in the brain.

No. 3A
ROLE OF NOREPINEPHRINE IN DEPRESSION

Pedro L. Delgado, M.D., *Department of Psychiatry, University of Arizona School of Medicine, 7402 AHSC, 1501 North Campbell Avenue, Tucson AZ 85724;* Francisco A. Moreno, M.D.

SUMMARY:

While some of the first hypotheses of the neurobiological basis of depression and the mechanisms of antidepressant drug action focused on the norepinephrine (NE) system, these hypotheses were all but forgotten with the advent of selective serotonin reuptake inhibitors (SSRIs). The recent introduction of reboxetine, a selective norephinephrine reuptake inhibitor (NRI), has led to a reawakening of interest in the effects of antidepressants on NE. This presentation will briefly review historical data on the role of NE in depression and antidepressant action, and more recent data on the effects of catecholamine depletion. Preclinical studies suggest that an enhancement of NE and/or serotonin 5-HT neurotransmission may serve as an initial event for therapeutic antidepressant action. The synthesis of brain 5-HT is dependent on plasma levels of the essential amino acid tryptophan (TRP). An 80% depletion of plasma TRP can be safely accomplished in humans within five hours by administering a single oral 100 gm TRP-free amino acid mixture. Brain NE and dopamine can be rapidly reduced by a two-day administration of 1 gm t.i.d. of the tyrosine hydroxylase inhibitor alpha-methyl-para-tyrosine (AMPT). This presentation will review the results from studies involving TRP depletion, AMPT-induced catecholamine depletion, or both in antidepressant-treated patients with depression.

The results of these studies show that rapidly interfering with 5-HT or NE synthesis transiently reverses antidepressant responses in most recently remitted depressed patients. Patients who have responded to a selective NRI re-experience depression during NE depletion; while those who have responded to an SSRI re-experience depression during 5-HT depletion. These data suggest that NE and 5-HT form independent pathways through which antidepressant drugs might mediate their therapeutic effects. More investigations of drugs that mediate their effects through one pathway or another are needed to ascertain the long-term differences between drugs in terms of the quality and stability of the responses.

No. 3B
ALTERNATIVES TO SSRIS IN THE TREATMENT OF DEPRESSION

Jack M. Gorman, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, New York NY 10032*

SUMMARY:

The introduction of the selective serotonin reuptake inhibitors (SSRIs) for the treatment of depression and other psychiatric illnesses nearly a decade ago has clearly revolutionized psychopharmacology. Five SSRIs are now available in the United States: fluoxetine, sertraline, paroxetine, fluvoxamine, and citalopram. These medications are as effective as tricyclic antidepressants (TCAs) for treating depression and anxiety disorders and have a much better profile for adverse effects. The success of the SSRIs has stimulated research into the role of abnormal serotonergic neurotransmission in a number of psychiatric illnesses. Although there is abundant evidence of serotonin (5-HT) abnormalities in depression, it is unlikely that any single neurotransmitter could explain the entire psychopathology of any illness. Furthermore, there is a great deal of clinical and preclinical evidence that 5-HT neurotransmission is intimately connected with a number of other neurotransmitter systems, including norepinephrine (NE). A number of other antidepressants have varying degrees of influence on both the NE and 5-HT systems or the NE system alone. These drugs include bupropion, nefazodone, venlafaxine, and mirtazepine. In addition, roboxetine, a pure NE reuptake inhibitor (NRI) that is available in Europe, has entered clinical trials in the United States. The success of these other medications, and the recent finding that even some SSRIs have effects on the NE system now stimulate our interest in understanding the interaction of 5-HT and NE neurotransmission in the pathogenesis of depression and other psychiatric illnesses. Further, influencing the NE system, rather than exclusively the 5-HT system, appears to alter the adverse side-effect profile of antidepressant medication in ways that may be favorable for the treatment of some depressed and anxious patients.

No. 3C
TREATMENT OF SEVERE DEPRESSION

Michael E. Thase, M.D., *Department of Psychiatry, University of Pittsburgh, 3501 Forbes Avenue, Room 916, Pittsburgh PA 15213*

SUMMARY:

Clinicians report that approximately 25%-33% of patients with depression are classifiable as severely depressed. Depressive severity, however, is not a unitary construct, and clinical impressions are influenced by a number of factors other than symptomatology. Such factors include psychiatric and medical comorbidity, personality pathology, suicidality, and inpatient status. Melancholia and psychotic depressions, the most classical forms of severe depression, are distinguished by a characteristic neurovegetative profile, a low rate of response to supportive/nonspecific interventions, and a greater "burden" of neurobiological dysfunction. These distinguishing features may be the result of progressively greater disturbances of both serotonin and norepinephrine neurotransmission and, hence, may underscore the value of treatments that have powerful effects on multiple monoaminergic systems.

No. 3D
NEW APPROACHES TO THE TREATMENT OF REFRACTORY DEPRESSION

Maurizio Fava, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC 812, Boston MA 02114*

SUMMARY:

Although most patients with depression respond well to initial pharmacologic treatment, as many as 30% to 40% fail to achieve an adequate response. In addition to the more traditional lithium and thyroid augmentation strategies, a number of new pharmacotherapeutic approaches are currently being used to help manage refractory depression, including the addition of another agent or the switch to

another antidepressant. Augmentation and switching strategies are often selected in order to obtain a different neurochemical effect (e.g., adding a relatively noradrenergic agent to a relatively serotonergic antidepressant). In particular, several studies have suggested that depressed patients refractory to treatment with selective serotonin reuptake inhibitors (SSRIs) may show good response to newer agents that have a pharmacological profile distinct from the SSRIs. Furthermore, preliminary studies have shown that the addition of SSRIs to either noradrenergic drugs such as the tricyclic antidepressants (TCAs) or dopaminergic agents may be efficacious, even though concerns about drug-drug interactions and tricyclic cardiac toxicity have limited the use of the TCA-SSRI combinations. The introduction of reboxetine, a relatively selective norepinephrine reuptake inhibitor (NRI), may increase the use of the latter therapeutic approach because of its better safety profile with respect to the TCAs. However, further studies are needed to guide clinicians in making treatment decisions for patients with refractory depression.

No. 3E
SOCIAL FUNCTIONING WITH THE NEW TREATMENTS FOR DEPRESSION

Myrna M. Weissman, Ph.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, Unit 14, New York NY 10032-2603*

SUMMARY:

There is increasing interest in assessments that capture a spectrum of outcomes beyond symptoms. Traditional depression scales assess the core biological features of the illness—mood, pessimism, and vegetative signs, (e.g., appetite and sleep loss). However, assessments of drive, motivation, performance, and quality of interpersonal relations (e.g., the social context once the symptoms are improved) may not be captured in the traditional symptom scales.

Economic considerations often drive the need for outcome measures that go beyond an evaluation of symptoms. Typically, new antidepressants are more expensive than older agents, particularly drugs like the tricyclic antidepressants. The current preoccupation with controlling health care expenditures has make it imperative that we justify the use of the new agents by gathering cost-effectiveness evidence that goes beyond a simple listing of the drug's side-effect profile or suicide potential. Health care payers want to know if these drugs improve compliance, result in fewer lost days at work, improve work performance, or provide other evidence for reduced economic and social burden.

This presentation will review assessments of social functioning for patients with depression that are potentially useful from an economic and scientific vantage point in the evaluation of old and new antidepressants.

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INDUSTRY-SUPPORTED SYMPOSIUM 4— TYPICAL PATIENTS, ATYPICAL CARE: AN INTERACTIVE CASE STUDY
Supported by Janssen Pharmaceutica and Research Foundation

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be better able to recognize good clinical outcome and incorporate established and novel uses of atypical antipsychotics into his/her daily treatment decisions.

No. 4A
PSYCHOSIS: A CLINICAL CASE STUDY

Prakash S. Masand, M.D., *Department of Psychiatry, SUNY Health Sciences Center, 750 East Adams Street, Syracuse NY 13210*

SUMMARY:

The talk will present a patient vignette that will include the presence of positive, negative, and mood symptoms in the setting of psychosis. Through an interactive audience participation system, the differential diagnosis of the case will be discussed and an overview of the patient's management will be explored. The advantages of the new generation of antipsychotics over the conventional antipsychotics and a comparison of their pharmacology will also be discussed in this interactive case format.

No. 4B
LONG-TERM MANAGEMENT ISSUES IN SCHIZOPHRENIA

David Pickar, M.D., *ETB/DIRP, National Institute of Mental Health, 900 Rockville Pike, Bethesda MD 20892*

SUMMARY:

The introduction of the new generation of atypical antipsychotics has over a relatively short term impacted considerably on the long-term management of schizophrenia. While these compounds share some overlapping pharmacological properties, they are far from identical and offer differing therapeutic profiles. The utilization of atypical antipsychotics in the treatment of first-break schizophrenia is now being addressed in controlled investigation. The transition from first break to long-term management is an area with significant opportunities for advanced therapeutics. This presentation will overview the pharmacological underpinnings of atypical antipsychotics and how these principles interact with the neurobiology of schizophrenia. Pharmacoeconomic considerations will be discussed. Developing strategies and future directions for drug development will be addressed.

No. 4C
BIPOLAR DISORDER: NOVEL STRATEGIES

Gary S. Sach, M.D., *Bipolar Clinic, Massachusetts General Hospital, 15 Parkman Street, WACC-812, Boston MA 02114*

SUMMARY:

Managing bipolar illness is a formidable challenge, even when attempted by the sophisticated clinician. It can be a rigorous diagnostic process in that bipolars, due to their egosyntonia, often have little awareness of their illness. And psychotic symptoms—contrary to the prevailing doctrine—are not pathognomic of any particular psychotic disorder as they've been reported in schizophrenia, mood disorders, dementia, and complex partial seizures of the temporal lobe region.

Prevailing studies indicate that when treating bipolar illness, the use of mood stabilizers alone does not represent adequate and complete treatment. Benzodizepines, antidepressants, antipsychotics, and electroconvulsive therapy have been used as adjunctive strategies, but all of them have significant disadvantages.

The pharmacologic treatment of bipolar disorder has recently been augmented by the introduction of the atypical antipsychotics which, when used as adjunctive therapy, may exhibit antidepressant and mood stabilizing properties while lowering the risk of extrapyramidal symptoms and tardive dyskinesia.

Drug interaction with antidepressants and mood stabilizers should naturally be a concern to the prescribing clinician, as should side effects such as sedation and weight gain. But because hypomania and mania are not often elicited from patients, making them hard to diagnose and treat, the atypical antipsychotics are a worthwhile addition to the psychiatrist's armamentarium.

No. 4D
COGNITIVE FUNCTIONING AND ITS EFFECT ON EVERYDAY OUTCOME

Philip D. Harvey, Ph.D., *Department of Psychiatry, Mt. Sinai Medical Center, One Gustave L. Levy Place, New York NY 10029*; Evelyn M. Howanitz, M.D., M. Parrella

SUMMARY:

Cognitive impairment in schizophrenia is very common and often quite severe. There are several different domains of impairment, including deficits in the ability to learn and remember new information, solve problems, and maintain attention in demanding situations. It has recently been discovered that cognitive impairment is related to functional ability, including self-care, social functioning, and occupational skills. Since these dimensions of functional ability are related to quality of life, cognitive impairment may be seen as both a direct and indirect predictor of quality of life. Thus, many aspects of an individual's everyday life are related to cognitive functioning. This relationship between everyday functioning and cognitive ability is not unique to schizophrenia, but since many patients with schizophrenia have considerable cognitive impairment, this is an important domain of the illness. This presentation will provide practical information on cognitive and functional assessment and on ways that this information can be incorporated into psychiatric treatment planning. Finally, the role of evaluation of the potential cognitive enhancing effects of novel antipsychotic medications in psychiatric practice will also be addressed.

No. 4E
REAL-WORLD OUTCOMES WITH NOVEL ANTIPSYCHOTICS

Robert R. Conley, M.D., *Department of Psychiatry, University of Maryland, PO Box 21247, Baltimore MD 21228;* Robert W. Buchanan, M.D.

SUMMARY:

As novel antipsychotics become more widely used in psychiatry, it is critical to assess the effect of these agents in regard to clinical outcome in real-world settings. The purpose of this study was to prospectively monitor and compare rehospitalization rates of patients treated with clozapine, risperidone, and olanzapine, with depot antipsychotics.

Patients were assessed from state psychiatric hospitals in Maryland. Records were available for the period March 1994 to May 1998 and included all patients discharged on one of these agents during this time period. Readmission rates were estimated by Kaplan-Meier survival curve analysis.

The probability of being readmitted within the first year following discharge on risperidone or clozapine was found to be 17% (N = 75) and 13% (N = 49), respectively. The preliminary recidivism rate during the same time period for depot neuroleptics (haloperidol and fluphenazine (N = 43)) was 26% for the first year. Rates for olanzapine will be presented at the meeting.

We found that both decanoate antipsychotics and atypical agents are associated with lower recidivism rates than previously published reports on conventional agents. The rates on atypicals appears to be lower than treatment with decanoates. Thus, atypicals may be more effective in preventing relapse, independent of issues of compliance.

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INDUSTRY-SUPPORTED SYMPOSIUM 5—SOCIETAL IMPACT OF ANXIETY DISORDERS: NEW DATA AND IMPLICATIONS FOR OUTCOME

Supported by SmithKline Beecham Pharmaceuticals

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize factors associated with increased economic burden of anxiety disorders, identify impairment in patients with social phobia and suggest means for improving quality of life, apply diagnostic principles to recognize anxiety disorders in patients with unexplained medical symptoms, appreciate the prevalence and impairment associated with substance abuse in patients with anxiety disorders and design treatment strategies, and apply currently accepted psychopharmacologic interventions for a successful outcome.

No. 5A
ECONOMIC BURDEN OF ANXIETY DISORDERS

Ronald C. Kessler, Ph.D., *Health Policy, Harvard University Medical School, 180 Longwood Avenue, Boston MA 02115*

SUMMARY:

Data are presented from the National Comorbidity Survey on the estimated adverse effects of anxiety disorders on role transitions and role functioning. The focus is on effects that create economic burdens for people with anxiety and their families. Retrospective information about age of onset of anxiety disorders was used to create time-varying predictors of the outcomes that were used in discrete-time survival models of role transitions. Early-onset anxiety disorders were found to be associated with truncated educational attainment, teen childbearing, premature marriage, marital instability, and employment instability. All of these role transitions, in turn, are associated with economic disadvantage. In addition, active anxiety disorders, especially when they occur in conjunction with depression, were found to be associated with reduced work performance. These results are discussed in relation to societal costs of anxiety disorders and potential cost offsets associated with early outreach and intervention for people with anxiety disorders.

No. 5B
THE DIRECT AND INDIRECT COSTS OF SOCIAL ANXIETY DISORDERS IN MANAGED CARE PATIENTS

David J. Katzelnick, M.D., *Madison Institute of Medicine, 7617 Mineral Point Road, Madison WI 53717;* Kenneth A. Kobak, Ph.D., Cindy P. Helstad, Ph.D., John H. Greist, M.D.

SUMMARY:

This study examined the direct costs (i.e., health care utilization) and indirect costs (i.e., lost wages, reduced productivity, disability, and decreased quality of life) in a large (180,000) managed care population. A sample of 9,375 adult enrollees from one of two representative HMO clinics were sent a questionnaire containing the three-item short form of the SPIN Social Phobia Scale and the MOS depression screener. Consenting subjects screening positive on either the SPIN or MOS, and a random sample of controls were called and administered the SCID Social Phobia module, the MINI, the SF-36, the Liebowitz Self-Rated Disability Scale (LSRDS), and the Work Productivity and Impairment Inventory (WPAI). Consenting patients also made a second call and were administered the HAMD, the Liebowitz Social Anxiety Scales (LSAS), and the Sheehan Disability Scale (SDS) by computer.

The prevalence rate of generalized social phobia (GSP) was 8.2%. Compared with controls with no diagnosis, patients with social phobia had significantly more missed work hours due to health, lower work and home productivity, greater overall disability on the LSRDS, more limitations on educational attainment and keeping a job, greater impairment on the Sheehan Work, Social, and Family scales, and poorer scores on all of the SF-36 subscales. The mean LSAS score was 73.61, similar to levels found in clinical trials.

No. 5C
TREATMENT-SEEKING FOR MEDICALLY UNEXPLAINED SYMPTOMS: RELATIONSHIP WITH GAD AND PANIC DISORDER

Wayne J. Katon, M.D., *Department of Psychiatry, University of Washington, Box 356560, Seattle WA 98195;* Mike Von Korff, M.D.

SUMMARY:

The cost-offset literature that was largely developed in the 1960 to 1980 era suggested that psychiatric treatment of medical patients with distress or DSM-IV psychiatric disorders would lead to overall medical cost savings. Higher mental health costs for psychosocial interventions would be offset by lower medical costs. Most of these data, however, were collected prior to the managed care era, and the highest savings in medical costs were in aging patients and in medical inpatient days. In the era of managed care, inpatient days have been markedly decreased for any medical condition and most surgeries are done in ambulatory surgery settings.

Almost all new medical or surgical treatments and technologies are more expensive than older treatments, and their effectiveness is measured by cost effectiveness and incremental cost-effectiveness equations. Cost effectiveness measures the cost of a new treatment over the effectiveness. Effectiveness can be measured in symptoms, function, or years of life, but a quality measure is recommended so that the cost per quality can be compared against other new treatments and technologies. Cost-effectiveness equations were developed for large samples, but psychiatric studies have begun to apply these equations to effectiveness studies with samples in the one to two hundred range. Statisticians have critiqued this application because direct costs typically have high standard deviation and wide confidence intervals. These issues will be critically addressed in this lecture.

No. 5D
ANXIETY AND SUBSTANCE USE DISORDERS: PREVALENCE, DIAGNOSIS AND TREATMENT ISSUES

Henry R. Kranzler, M.D., *Department of Psychiatry, University of Connecticut Health Center, 263 Farmington Avenue, Farmington CT 06030-2103*

SUMMARY:

Anxiety symptoms and disorders are common among individuals with alcohol or drug dependence. Increased health care costs and decreased productivity associated with this comorbidity underscore its clinical relevance. Since evidence suggests that in some substance-dependent patients anxiety symptoms may resolve during persistent abstinence, the capacity to differentiate transient from persistent anxiety states has important treatment implications. Psychosocial support and coping skills training to maintain abstinence in substance-dependent patients are recommended for treatment of transient anxiety states. The use of medication should be reserved for persistent

anxiety states. Because benzodiazepines can produce dependence and can cause overdose in combination with alcohol or other CNS depressants, these medications are not recommended for treatment of anxiety in substance-dependent patients. Placebo-controlled trials of buspirone, a nonbenzodiazepine anxiolytic, suggest that this medication is useful in the treatment of alcoholics with generalized anxiety. Although comparable studies of the use of SSRIs in substance-dependent patients with comorbid panic disorder or social phobia are not yet available, these medications are probably safe and may be efficacious in this setting.

No. 5E
HOW TREATABLE ARE ANXIETY DISORDERS?

David V. Sheehan, M.D., *Department of Psychiatry, University of Southern Florida, 3515 East Fletcher Avenue, Tampa FL 33613-4706*

SUMMARY:

As long as the anxiety disorders are viewed as individual burdens restricted to individual patients, it is difficult to convince society to treat them with the same degree of concern accorded other mental disorders. This presentation takes the position that the anxiety disorders impose costs that are not restricted to individual patients but also affect employers, health insurance systems/managed care, and our national economy.

The true costs of the anxiety disorders, however, cannot be fully assessed without an assessment of the adequacy of available treatments. The focus of this presentation is on the effectiveness of current treatment approaches to the spectrum of anxiety disorders including panic disorder, social phobia, generalized anxiety disorder, obsessive-compulsive disorder, and PTSD. The relative merits of different treatments and whether all the disorders respond equally well or even to the same treatments will be reviewed. The limitations of existing treatments and areas in need of improvement in the development of new treatments will be highlighted. The role of these treatments and of research endeavors to develop new and better treatments in reducing the total social costs of the anxiety disorders will be discussed. For example, SSRIs and MAO inhibitors are more effective in social phobia than tricyclic antidepressants or beta blockers. Serotonergic antidepressants are more effective in OCD than noradrenergic antidepressants. SSRIs are more effective in panic disorder than tricyclics or benzodiazepines.

With the exception of benzodiazepines, most of the medications used for anxiety disorders take several weeks to receive good, reliable benefit. During this time many patients stop taking their medications. This is an area that calls for new drugs to be developed with more rapid onset of action.

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INDUSTRY-SUPPORTED SYMPOSIUM 6—TREATMENT-RESISTANT DEPRESSION: UNITED STATES AND EUROPEAN PERSPECTIVES
Supported by the International Academy for Biomedical and Drug Research

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize accurately and rapidly the risk factors for treatment-resistant depression (TRD); diagnose early TRD; and institute appropriate treatment algorithms for the management of TRD.

No. 6A
TREATMENT-RESISTANT DEPRESSION: GUIDELINES FOR EARLY DIAGNOSIS AND RECOGNITION

Lewis L. Judd, M.D., *Department of Psychiatry, University of California at San Diego School of Medicine, 9500 Gilman Drive, La Jolla CA 92093–0603*

SUMMARY:

It is generally accepted that there are three major goals in the treatment of major depressive episodes: (1) removal of depressive symptoms; (2) reduction or elimination of the associated impairment; and (3) the prevention of episode relapse or recurrence. Failure to achieve any or all of these treatment goals should be used to define treatment-resistant depression (TRD). Standard definitions of TRD will be described and reviewed in terms of their clinical usefulness. Focus of this presentation will be on failure to achieve all three therapeutic goals, but emphasis will be placed on that aspect of treatment resistance that specifically relates to the goals of preventing and/or delaying a major depressive episode relapse or recurrence. Recent data will also be presented that raise the question of whether the current definitions of TRD may be too narrow and should attend to the variable of prevention or delay of episode relapse as one of the defining features. The presentation will also discuss whether the definition of TRD should be extended to those who do not resolve their major depressive episodes (MDEs) to a full asymptomatic status not just as a failure to resolve the MDE or episode level symptoms. These issues will be discussed within the panel and with the audience.

No. 6B
RISK FACTORS IN TREATMENT-RESISTANT DEPRESSION

Michael E. Thase, M.D., *Department of Psychiatry, University of Pittsburgh, 3501 Forbes Avenue, Room 916, Pittsburgh PA 15213*

SUMMARY:

The origin of the term "resistant depression" is anchored in both medical microbiology and psychoanalysis. In contemporary practice, we use the term more descriptively, i.e., this depression is resistant to antidepressants A, B, and C. Little can be said about the pathophysiology of a "resistant depression"—people fail to improve during pharmacotherapy for a number of reasons, including inadequate treatment, noncompliance, and misdiagnosis. Psychiatric and medical comorbidity, personality pathology, chronicity, social support, substance abuse, and depressive subtype also influence the probability of responding to an antidepressant. One of the most daunting tasks facing clinicians evaluating the hard-to-treat depressed patient is cataloguing past medication trials and determining if the trials were of adequate dosage or duration. Yet, this is necessary to guide selection of the next trial, specifically to maximize a relatively low chance of success. Thase and Rush (1997) have suggested a classification procedure based on the number of antidepressant classes that have been tried, in adequate dose and duration, without an acceptable response. Although some empirical evidence is available to support choices of alternates therapies for stages I through IV of antidepressant resistance, more rigorous research on various treatment algorithms and combinational approaches is long overdue.

No. 6C
TREATMENT ALGORITHMS IN TREATMENT-RESISTANT DEPRESSION: EUROPEAN PERSPECTIVE

Julien Mendlewicz, M.D., *Department of Psychiatry, Erasme Hospital, Route de Lennik 808, 1070, Brussels, Belgium*

SUMMARY:

European strategy for management of treatment resistant depression (TRD) is both similar to and different from the U.S. strategy. The European approach to TRD is very methodical as follows: (1) a detailed review of the patient's diagnosis to ensure that indeed, this is a patient with a unipolar depressive disorder and to make sure that misdiagnosis is not present; (2) comorbidity is evaluated in detail, especially the presence of drug or alcohol abuse; and in the elderly if there are any CNS organic problems; (3) the patient's medication history is reviewed in great detail to ensure that the patient has received the correct medication and has been on a therapeutic dosage for the time necessary for a therapeutic effect to be achieved.

After the diagnosis of TRD is made, the first step is to leave the patient on the same antidepressant medication, but to augment it with other treatments. Specifically, the following are used by European clinical researchers: sleep deprivation technologies, lithium augmentation, thyroid supplementation, anticonvulsant supplementation, and more recently, supplementation with pindolol. If these fail, then a switch in antidepressant drug class is initiated. In this case, an antidepressant from a new class, with a different drug neurotransmitter mechanism, is selected. Usually this involves moving from TCA antidepressants to one of the SSRI antidepressants. If this does not work, then the newer antidepressant, which has a selective action on various neurotransmitter systems is initiated, such as the drugs with selective action in the noradrenergic, dopaminergic nervous system. If there are psychotic elements present, the atypical neuroleptics may be used in combination with antidepressant medication. These would include lanzopine, risperidone, olanzepine, clozapine, etc. With this methodical approach, European psychiatrists are able to achieve a high level of response from treatment-resistant depressives. Each of these steps will be discussed in detail, and the differences between the U.S. and European approaches will be highlighted in panel and audience discussions.

No. 6D
TREATMENT ALGORITHMS IN TREATMENT-RESISTANT DEPRESSION: UNITED STATES PERSPECTIVE

Madhukar H. Trivedi, M.D., *Department of Psychiatry, University of Texas Southwestern Medical Center, 5959 Harry Hines Boulevard, #520, Dallas TX 75235*

SUMMARY:

Algorithms provide strategies and tactics for treatment of depression. The tactics for the treatment of depression are designed to optimize or maximize the strategies chosen. Medication algorithms can be helpful for the physician in identifying the most consistent, safe, and effective treatments. Although numerous attempts have been made to develop algorithms for the pharmacotherapy of depression, none have been specifically designed for use in TRD patients. A meta-analysis of randomized controlled trials found that with an intent-to-treat sample, response rates were approximately 50%, whereas full remission was found in only 30%–35% of patients. Additionally, studies of medication efficacy have seldom aimed at comparing the benefits of several medication options given either initially or sequentially in treatment in the face of partial or nonresponse. Groups of patients not responding to the first steps have been labeled as having a treatment-resistant or treatment-refractory depressive illness. Definitions of what constitutes an adequate medication trial, such as dose and duration, vary considerably, as do criteria for full, partial, and nonresponse, contributing to the inadequacy of current research for the management of these patients. Algorithms provide a synthesis of information and decision trees to clinicians that would otherwise be difficult to assimilate and implement into everyday practice. The test of these treatment algorithms will provide us with more accurate data of the prevalence of truly TRD patients.

No. 6E
TREATMENT RESISTANCE IN GERIATRIC DEPRESSION

Cornelius L. Katona, M.D., *Department of Psychiatry, University College, Ridinghouse Street, London, E97AL, England*

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 with depression contributes significantly to treatment-resistant depression (TRD). This is due to the uncooperativeness of patients, spuriously high endorsement of somatic items, and coexistent cognitive impairment. As a result, depression in the physically ill elderly patient goes unrecorded, untreated, or is resistant to treatment. Such depression may interfere with social functioning and self-care and may also impede physical 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. There have been controlled trials of antidepressant treatment in elderly patients, partly because the majority of them have contraindications to older tricylcic antidepressants, but available evidence (which will be reviewed) supports their use. Treatment algorithms will be emphasized when depressed elderly patients do not respond to treatment. Trials of safer

antidepressants, such as the SSRIs and newer drugs, will be discussed in light of improving therapeutic responses in geriatric patients.

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INDUSTRY-SUPPORTED SYMPOSIUM 7— A DECADE OF SEROTONIN STUDIES: BEYOND DEPRESSION
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to summarize the effectiveness and current treatment guidelines for SSRIs and other serotonergic modulators for patients with OCD, panic disorder, premenstrual dysphoria, dysthymia, and PTSD, all of which have been shown to be linked to serotonergic dysregulation.

No. 7A
OCD: SEROTONIN SPECIFICITY *SANS PAREIL*

John H. Greist, M.D., *Madison Institute of Medicine, 7617 Mineral Point Road, Suite 300, Madison WI 53717*

SUMMARY:

Obsessive-compulsive disorder (OCD) has always fascinated psychiatrists. Until recently, fascination was accompanied by frustration as the predominant psychoanalytic theories of etiology failed to guide useful treatment. Recognition of the biological and behavioral underpinnings of OCD and effective treatment with potent serotonin reuptake inhibitors (SRIs) and behavior therapy (BT) have significantly advanced our ability to help sufferers. Put simply, SRIs are the pharmacologic treatment of choice for OCD. Norepinephrine reuptake inhibitors and dopamine blockers, by themselves, are ineffective treatments for OCD. Several lines of evidence have converged to prove convincingly that serotonin is importantly involved in the pathophysiology and treatment of OCD. Every potent serotonin reuptake inhibitor studied to date is effective as a treatment for OCD. All SRIs that have sought FDA approval have received it, with small study populations that bespeak a homogenous disorder. Despite the prominent specificity of serotonin in pathology and psychopharmacology, treatment response is typically partial, and issues of dosing and duration are pivotal in optimizing benefit. The roles of buspirone, beta blockers, benzodiazepines, lithium, MAOIs, and intravenous clomipramine all illuminate our understanding of serotonin's primacy as a neurotransmitter in obsessive-compulsive disorder, the paradigmatic serotonin disorder.

No. 7B
PANIC DISORDER: ETIOLOGY AND TREATMENT

Mark H. Pollack, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC-815, Boston MA 02114*

SUMMARY:

Efforts to understand the pathogenesis of panic disorder have included ongoing attempts aimed at elucidating its underlying biological basis. A growing body of research examining the underlying pathophysiology of panic disorder points to neurobiologic abnormalities including dysregulations in serotonergic, noradrenergic, and other neurotransmitter systems, as well as abnormalities in autonomic and respiratory mechanisms. In addition, the effectiveness of a number of pharmacologic agents for the treatment of panic disorder has been clearly demonstrated, with the selective serotonergic reuptake inhibitors now considered as first-line agents for the treatment of this condition. In this presentation we will review current conceptualizations regarding the pathophysiology of panic disorder and discuss new developments for its treatment.

No. 7C
DYSTHYMIC DISORDER: SSRI TREATMENT UPDATE

David L. Dunner, M.D., *Center for Anxiety and Depression, University of Washington, 4225 Roosevelt Way NE, #306, Seattle WA 98105-6099*

SUMMARY:

Dysthymic disorder is a form of mild chronic depression. The disorder often begins early in life and is persistent. Considerable effects on psychosocial functioning have been shown in individuals who have dysthymic disorder. Although initially felt to be particularly responsive to psychotherapy, modern studies suggest that a variety of antidepressant treatments are efficacious for patients with dysthymic disorder. The ideal antidepressant for patients with this

condition should have acute efficacy and long-term tolerability. Tricyclic antidepressants are less well tolerated in milder than more moderate and severe forms of major depression, suggesting that newer medications such as SSRIs might be preferable to tricyclic antidepressants for the treatment of patients with dysthymic disorder. Over the past five years, several treatment studies have been undertaken in patients with dysthymic disorder. This presentation will present the current status of treatment studies of medications and psychotherapy for dysthymic disorder. In general SSRIs have been shown to be of better tolerability than tricyclic antidepressants for patients with dysthymic disorder. The use of psychotherapies such as interpersonal psychotherapy and cognitive behavior therapy, as well as combined pharmacotherapy treatment, will be discussed.

No. 7D
PREMENSTRUAL DYSPHORIC DISORDER: A ROLE FOR SEROTONIN?

Tana A. Grady-Weliky, M.D., *Department of Psychiatry, University of Rochester, Box 601, 601 Elmwood Avenue, Rochester NY 14542*

SUMMARY:

Premenstrual dysphoric disorder (PMDD) affects 8% of reproductive age women. PMDD is characterized by marked mood swings, depressed mood, and irritability and/or anxiety accompanied by significant reduction in social and/or occupational functioning. These symptoms occur exclusively during the luteal phase of the menstrual cycle with remission within one to two days of menses onset. Prior to making a diagnosis of PMDD, symptoms must be prospectively rated on a daily basis for at least two months verifying this distinct pattern across the menstrual cycle.

A wide range of pharmacologic treatment options have been utilized for the management of PMDD, including hormonal therapies, psychopharmacological therapies, e.g. antidepressants, anxiolytics, and mood stabilizing agents, and alternative therapies, e.g. hypericum (St. John's Wort). Many of these agents have been found to be helpful both in the reduction of mood and anxiety symptoms and in the improvement of social and/or occupational functioning. In recent years the majority of clinical treatment research for PMDD has focused on the use of antidepressant agents. Serotonin-selective reuptake inhibitors, SSRIs, have been the most studied antidepressant agents. Clomipramine, fluoxetine, and sertraline have all been found to be more effective than placebo in the treatment of PMDD. Open studies have also found that paroxotine, nefazodone, and fluvoxamine may be effective in the treatment of PMDD. Several comparison studies of SSRIs compared with other nonserotonergic antidepressants suggest that SSRIs may be more effective in the treatment of PMDD. This is suggestive of a possible role for serotonin in the etiology of PMDD.

This talk will review the clinical treatment research findings for the management of PMDD. Additionally, preliminary investigations regarding the possible role of serotonin in the etiology of PMDD will be addressed.

No. 7E
THE NEUROBIOLOGY AND TREATMENT OF PTSD: A FOCUS ON SEROTONIN

Dennis S. Charney, M.D., *Department of Psychiatry, Yale University, 25 Park Street, New Haven CT 06519*

SUMMARY:

The neurobiological consequences of exposure to severe psychological stress involve alterations in a number of neurotransmitters, neuropeptides, and amino acid transmitters. These changes consequently produce dysfunction in neural circuits that mediate the complex symptomalogy associated with post-traumatic stress disorder. This presentation will review preclinical and clinical investigations that have identified stress-induced disturbances in serotonin neuronal function. In addition, the findings of PTSD trials with a spectrum of drugs that affect serotonin actively will be presented.

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INDUSTRY-SUPPORTED SYMPOSIUM 8—OPTIMIZING TREATMENT OUTCOME IN DEPRESSION
Supported by Organon Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should become familiar with commonly used clinical strategies aimed at improving both compliance and response in the treatment of depression; learn the relative risks and benefits of therapeutic approaches to treatment resistance and how to deal with the issues that emerge in the context of maintenance treatment with antidepressants; and be able to recognize when it is best to combine psychotherapy and pharmacotherapy to improve treatment outcome in depression.

No. 8A
APPROACHES TO THE ENHANCEMENT OF PATIENT COMPLIANCE

Pedro L. Delgado, M.D., *Department of Psychiatry, University of Arizona School of Medicine, 7402 AHSC, 1501 North Campbell Avenue, Tucson AZ 85724*

SUMMARY:

The number of safe and effective medication treatments for depression has increased significantly over the past 10 years. Relative to the older tricyclic antidepressants and monoamine oxidase inhibitors, the newer medications offer comparable efficacy with fewer side effects and a markedly reduced risk for serious adverse effects. In spite of these benefits, and in spite of the extensive and successful efforts that have been made to inform the general population about

the diagnosis and treatment of depression, many patients do not comply with treatment recommendations. While specific factors such as side effects lead to high rates of noncompliance with medication treatment, noncompliance is a multifactorial phenomenon. The reasons for noncompliance can include rational and intentional decisions based on beliefs about the illness, concerns over side effects, ineffectiveness of treatment, complexity of the regimen, costs of the medication, decisions influenced by the symptoms of the disorder, the presence of substance abuse, lack of confidence in the provider, and many other cultural and attitudinal factors.

This presentation will review the patient- and provider-related factors that influence compliance with psychotropic drug treatment of depression and discuss strategies for enhancing compliance. In particular, the decision-making process for selecting an antidepressant agent and management of the treatment course will be a focus of discussion. Short- and long-term side effects of antidepressant agents will be contrasted, and strategies for reducing side effects without losing the antidepressant response will be presented.

No. 8B
MANAGEMENT OF NONRESPONSE AND INTOLERANCE: SWITCHING STRATEGIES

Maurizio Fava, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC 812, Boston MA 02114*

SUMMARY:

Switching antidepressants is one of the most common strategies in the management of depressed patients who do not tolerate or respond to drug treatment. In particular, the emergence of acute side effects such as agitation and insomnia or of long-term side effects such as weight gain and sexual dysfunction, frequently leads clinicians to switch antidepressant agents. This approach has been supported by a number of studies that have found that many depressed patients who are unable to tolerate a specific antidepressant treatment benefit from being switched to another antidepressant agent. Similarly, studies on non- and partial responders to antidepressant treatment have shown relatively good response to being switched to other antidepressants. The strategy of switching is often more acceptable to patients and less costly than polypharmacy, and the risk of significant drug-drug interactions is markedly reduced and limited to the initial phases of treatment. However, switching from relatively short-acting selective serotonin reuptake inhibitors to antidepressants of other classes may be associated with a risk for discontinuation-emergent adverse events. In summary, switching strategies appears to be a safe and effective approach to the treatment of depressed patients who are intolerant of or nonresponsive to antidepressant treatment. Further studies are needed to establish whether switching patients from one antidepressant class to another is more effective than switching to drugs of the same class.

No. 8C
COMBINED DRUG TREATMENTS: PROS AND CONS

J. Craig Nelson, M.D., *Department of Psychiatry, Yale University, 20 York Street, New Haven CT 06504*

SUMMARY:

Combined pharmacologic treatment strategies have been used in depression for a variety of purposes. They are widely used in refractory depression to enhance response. They have been used to speed up response, especially in inpatients. They may be helpful in patients who develop tachyphylaxis. Combined drug treatments have also been used to enhance effects on specific target symptoms. For example, benzodiazepines have been used with antidepressants to reduce anxiety. Trazodone has been used with antidepressants to enhance sleep. Antipsychotic treatments have been used with antidepressants in psychotic depression. This presentation will review the various uses of combined strategies in depression, the evidence supporting their efficacy, and their methods of administration. Their advantages and disadvantages will be considered. Treatments that have been reported to enhance initial efficacy will receive special emphasis.

No. 8D
CLINICAL ISSUES IN LONG-TERM TREATMENT WITH ANTIDEPRESSANTS

John M. Zajecka, M.D., *Department of Psychiatry, Rush-Presbyterian Medical Center, 1725 West Harrison, Suite 955, Chicago IL 60612*

SUMMARY:

Optimal recovery from depression requires adherence to treatment throughout the acute, continuation, and maintenance phases of treatment. There is an increasing recognition of the importance of long-term antidepressant treatment, particularly for depressive subtypes such as chronic and recurrent depression. Practical clinical issues in the identification and management of continuation and maintenance antidepressant treatment will be discussed including the educational strategies to ensure compliance and the management of potentially late-onset side effects that may impair compliance and/or optimal recovery, such as sexual dysfunction, weight gain, and asthenia.

No. 8E
COMBINING PSYCHOTHERAPY AND PHARMACOTHERAPY: WHAT ARE THE ADVANTAGES?

Ellen Frank, Ph.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh PA 15213-2593;* David J. Kupfer, M.D., Robert A. Karp, M.D.

SUMMARY:

While the combination of pharmacotherapy and psychotherapy represents the ideal standard of practice in the minds of many clinicians, empirical evidence to support the advantages of combining pharmacotherapy with psychotherapy has been variable. With the advent of highly effective and now highly tolerable antidepressant medication and the codification of effective clinical management strategies for the pharmacotherapy of depression, it has become increasingly difficult to show the superiority of combined pharmacotherapy and psychotherapy over high-quality pharmacotherapy alone in the treatment of depression.

The studies that have examined this question with respect to the acute and maintenance treatment of both major depression and chronic depression/dysthymia will be reviewed. Particular emphasis will be placed on those special populations in whom there is evidence for a significant advantage of combination treatment over pharmacotherapy or psychotherapy alone. There is emerging evidence that elderly individuals with recurrent depression might be one such population. Particular demographic, clinical history, and treatment process variables that might predict a superior outcome with combination treatment will also be discussed.

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INDUSTRY-SUPPORTED SYMPOSIUM 9—MOOD AND THE MIND: THE SCIENCE AND ART OF NEW AND EMERGING TREATMENT ALTERNATIVES

Supported by Janssen Pharmaceutica and Research Foundation

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to evaluate and compare conventional treatment modalities to newer treatment options for patients with mood and schizoaffective disorders; to compare and contrast efficacy, side effects, and compliance issues; examine the role that anxiety/depression and early adverse life experiences may play in exacerbating this condition.

No. 9A
THE ROLE OF EARLY ADVERSE LIFE EXPERIENCE IN THE DEVELOPMENT OF MOOD DISORDERS

Charles B. Nemeroff, M.D., *Department of Psychiatry, Emory University, 1639 Pierce Drive, Suite 4000, Atlanta GA 30322*

SUMMARY:

Early untoward life stresses, including child abuse or neglect, are associated with an increase in the prevalence of depression in adulthood. Results of a series of preclinical studies in rodents and nonhuman primates and a pilot clinical study suggest that CRF-containing neurons are rendered persistently supersensitive to stress after exposure to neonatal stress. Studies have documented CRF neuronal hyperactivity in drug-free depressed patients as evidenced by hypothalamic-pituitary-adrenal (HPA) axis hyperactivity, increased cerebrospinal fluid CRF concentrations, and a reduced number of CRF receptors in frontal cortex, the latter finding presumably due to CRF receptor down-regulation in response to CRF hypersecretion. Results of animal studies confirm these findings. Clinical studies in depressed women with a history of sexual abuse in childhood or adolescence compared with depressed women without such history reveal an increased HPA axis response to stress. These data support the CRF hypothesis of depression and suggest that alterations in CRF neurons mediate the effects of early trauma in increasing an individual's vulnerability to depression. The therapeutic implications of these findings will be discussed.

No. 9B
BIPOLAR DISORDER AND THE EFFECTIVENESS OF ATYPICAL ANTIPSYCHOTICS

K.N. Roy Chengappa, M.D., *Department of Psychiatry, Western Psychiatric Institute, 3811 O'Hara Street, Pittsburgh PA 15213*

SUMMARY:

Before the introduction of lithium and other mood stabilizers, antipsychotics were the treatment of choice for acute mania. Use of conventional antipsychotics, however, is associated with adverse events, particularly extrapyramidal symptoms and tardive dyskinesia; moreover, patients with bipolar disorders may be at greater risk for these symptoms than patients with schizophrenia or other psychoses. Many patients do not show long-term stability with mood stabilizers and may need therapy with antipsychotics, either as adjunctive agents or as monotherapy. While the older antipsychotic agents were effective for mania, patients with bipolar illness fared worse in their depressed phase on these medications. Atypical antipsychotics are now the drugs of choice for acute or maintenance therapy in bipolar patients. In studies involving bipolar patients, clozapine has been shown to be effective as monotherapy or when combined with mood stabilizers, with response rates better than those for schizophrenia. Risperidone has been found to have mood-stabilizing properties, and patients with treatment-refractory bipolar disorder have responded to risperidone given alone or in combination with a mood stabilizer. There is now evidence to indicate that olanzapine may also have a role in the treatment of affective symptoms of bipolar disorder.

No. 9C
WHAT CAN WE EXPECT FROM NEW THERAPEUTIC APPROACHES TO SCHIZOAFFECTIVE AND MOOD DISORDERS?

Jack M. Gorman, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, New York NY 10032*

SUMMARY:

Interaction with the serotonin (5-HT) neurotransmission system is considered a requirement for improving depressed mood. The selective serotonin reuptake inhibitors have proved effective and well tolerated when combined with, for example, antipsychotic medication in depressed patients with schizoaffective illness or a mood stabilizer in depressed patients with bipolar disorder. New evidence suggests that affecting other brain systems in addition to or instead of the 5-HT system may ameliorate depression. First, atypical antipsychotics have antidepressant properties enabling their use as monotherapy for depressed schizoaffective patients. Second, mood stabilizers may vary in antidepressant properties. Reports indicate that lamotrigine, despite significant adverse side effects, may be effective for depressed bipolar patients. In addition, research suggests that topiramate also may be an exciting new compound for this disorder. Third, antidepressants that influence the noradrenaline system (e.g., bupropion, nefazodone, venlafaxine, mirtazepine, and reboxetine), either alone or combined with 5-HT effects, appear to have an important role in the treatment of depression. Current clinical trials are exploring the role of antidepressants with novel mechanisms, including inhibitors of substance P and corticotropin-releasing hormone (CRH). There is ample data that CRH may be hypersecreted in depressed patients and contributes to the regulation of mood.

These new agents, which interact with brain peptides instead of amines, may be an important breakthrough in antidepressant treatment in the next century.

No. 9D
THE ANXIETY/DEPRESSION DIMENSION OF SCHIZOPHRENIA: HOW IMPORTANT IS IT?

Lili C. Kopala, M.D., *Department of Psychiatry, Dalhousie University, 5909 Jubilee Road, Halifax, NS, B3H 2G2, Canada*

SUMMARY:

Depressive symptoms and anxiety are common in the prodromal phases of schizophrenia. Whereas first-generation antipsychotic agents may reduce positive psychotic symptoms, dysphoria or fully syndromal depression may emerge or worsen. Drug-induced dysphoria and depression appear to be less prominent with the second-generation antipsychotics. Studies evaluating the effects of second-generation antipsychotics on positive and negative symptoms, anxiety/depression, cognition, and excitement show diminution of depression and anxiety in drug-naïve, first episode schizophrenic patients. Similar results were obtained in a group of chronically ill patients treated with risperidone. Preventing suicide and substance abuse are important considerations in optimizing the treatment of schizophrenia and associated depression. Evidence indicates that optimizing treatment in the early stages of psychosis can lead to better long-term outcomes: It is clear that targeting positive symptoms only will not achieve these goals.

No. 9E
POLYPHARMACY: NEW WAYS OF COMBINING DRUG THERAPIES FOR BETTER RESULTS

S. Nassir Ghaemi, M.D., *Department of Psychiatry, George Washington University, 2150 Pennsylvania Avenue, NW, 8th Floor, Washington DC 20037*

SUMMARY:

Treating bipolar disorders differs from treating depression or schizophrenia. The best approach is to provide a balanced combination of medications (e.g., lithium, anticonvulsants, antidepressants, and mood-stabilizing adjuncts) to minimize depressive and manic symptoms without causing instability of mood. When lithium was the only mood stabilizer available, it was common to add antidepressant and antipsychotic agents to the regimen. However, conventional antipsychotics posed the risks of tardive dyskinesia and extrapyramidal effects and often led to depression. Moreover, antidepressants were frequently associated with acute mania and the induction of rapid cycling and the possible worsening of the bipolar disorder. Newer therapies offer the expectation of safer treatments of bipolar disorders. New anticonvulsants such as valproate and lamotrigine can be combined with lithium. Atypical antipsychotics such as risperidone and olanzapine appear to have mood-stabilizing effects and cause fewer extrapyramidal symptoms than do the conventional neuroleptics. The newer antidepressants, particularly paroxetine and bupropion, may be safer than tricyclic antidepressants when used with mood stabilizers. Systematic polypharmacy provides optimal treatment for many patients with bipolar disorder. The new generation of psychotropic agents, when used carefully with aggressive mood-stabilizing agents, appears safer than the older antidepressants and antipsychotics.

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INDUSTRY-SUPPORTED SYMPOSIUM 10—ANXIETY AND DEPRESSION IN THE ADOLESCENT: CLINICAL IMPLICATION OF EMERGING DATA
Supported by SmithKline Beecham Pharmaceuticals

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to appreciate the prevalence of mood and anxiety disorders in children and adolescents, recognize familial and behavioral risk factors, apply criteria for diagnosing and treating children with depressive or anxiety disorders, and design safe and effective antidepressant treatment regimens for children.

No. 10A
CURRENT STATUS OF THE DIAGNOSIS AND TREATMENT OF DEPRESSION AND ANXIETY IN ADOLESCENTS

Karen D. Wagner, M.D., *Division of Children's and Adolescents' Psychiatry, University of Texas Medical Branch, 301 University Boulevard, Route 0425, Galveston TX 77555*

SUMMARY:

Depression in children and adolescents is a serious disorder that may have adverse consequences on a child's academic, social, and family functioning. Recognition and accurate diagnosis of depression in this age group are essential. Given the chronicity of this disorder and its potential extension into adulthood, identification of effective treatment is necessary. Recent studies support the efficacy of selective serotonin reuptake inhibitors and question the usefulness of tricyclic antidepressants in this age group. Investigation of newer antidepressants for childhood depression are underway. Recent attention has been given to the identification and diagnosis of anxiety disorders in children. Obsessive-compulsive disorder often has onset in early childhood and tends to have a chronic course with symptoms that change over time. Clomipramine and the selective serotonin

reuptake inhibitors have been shown to be effective treatments for childhood obsessive-compulsive disorder. Recognition of social phobia in childhood has been a recent focus and systematic treatment studies are warranted.

No. 10B
DEVELOPMENTS IN THE TREATMENT OF ADOLESCENT DEPRESSION

Rachel G. Klein, Ph.D., *Department of Psychology, New York State Psychiatric Institute, 722 West 168th Street, Unit 80, New York NY 10032*

SUMMARY:

Studies of the pharmacological treatment of child and adolescent depression with tricyclic antidepressants have given relatively little evidence for significant superiority of those compounds over placebo. However, two controlled studies of specific serotonin reuptake inhibitors (SSRIs) have found statistically and clinically significant efficacy of those compounds compared with placebo for child and adolescent depression. One study examined fluoxetine in both children and adolescents and the other examined paroxetine in adolescent depression. These studies will be reviewed in depth with particular attention to the type and degree of depression at intake and end of treatment, the outcome measures, the medication dosing strategy and final medication dose, and to side effects. This review will provide a rational basis for the pharmacological treatment of clinical depression in youth.

No. 10C
TREATMENT OF THE ADOLESCENT WITH OCD

Henrietta L. Leonard, M.D., *Department of Psychiatry, Brown University/Rhode Island Hospital, 593 Eddy Street, Providence RI 02903*

SUMMARY:

Research developments from studies using the serotonin-reuptake inhibitors (SRIs) or cognitive-behavioral therapy (CBT) have shown efficacy for children and adolescents with obsessive-compulsive disorder (OCD). The recent development of the AACAP Practice Parameters for the Assessment and Treatment of Children and Adolescents with OCD, and the Expert Consensus Guidelines, have provided an important addition to the field. Psychophamacologic approaches will be emphasized in this presentations, including issues of choosing an agent, treating partial and nonresponders, and need for long-term maintenance will be reviewed. Additionally, assessment and treatment of the subgroup of children for whom the OCD symptoms may be related to infections will be discussed, including the implications for novel treatment and prevention strategies.

No. 10D
SOCIAL PHOBIA/SOCIAL ANXIETY DISORDER

Stanley P. Kutcher, M.D., *Department of Psychiatry, Dalhousie University, 5909 Jubilee Road, Lane Building, Room 408, Halifax, NS, B3H 2E2, Canada*

SUMMARY:

Social phobia is an anxiety disorder with significant morbidity that commonly has its onset in the adolescent years. Prevalence rates are thought to reach 10% of the population in this age group.

Social phobia is not well understood and has only recently become an area of study in child and adolescent psychiatry. Comorbidity with other disorders, particularly simple phobia, agoraphobia, alcohol and drug abuse, and major depression, is high. The longitudinal course tends to be chronic with significant impairments.

Treatment for social phobia has been understudied but includes psychological and biological therapies. The SSRIs and buspirone are the best-studied psychotropic interventions in this age group.

This presentation will review the current knowledge about and treatment of social phobia in children and adolescents.

No. 10E
SAFETY CONSIDERATIONS FOR THE USE OF ANTIDEPRESSANTS IN ADOLESCENTS

Neal D. Ryan, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh PA 15217*

SUMMARY:

While the SSRIs appear to offer a relatively benign safety profile in children and adolescents paralleling that seen in adults, some children and adolescents may still require treatment with tricyclic antidepressants. It appears that children and adolescents may be relatively more susceptible to the cardiotoxic effects of these compounds in overdose or with accumulation in the minority who metabolize the compounds very slowly. In addition, there have been questions raised about cardiovascular toxicity of TCAs in children leading to "sudden death." These issues will be reviewed and the magnitude of these hazards estimated. Guidelines will be presented to monitor treatment so as to minimize these potential risks. This will allow the clinician to make a rationale choice about the use of TCAs either as a second- or third-line agent in depression, as second-line agent in OCD, or as a second-line agent in ADHD.

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INDUSTRY-SUPPORTED SYMPOSIUM 11—INTERVENING DURING THE PRODROMAL PHASE OF SCHIZOPHRENIA
Supported by Synthélabo

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the temporal development of psychopathology and cognitive impairment in schizophrenia, recognize the prodromal features of schizophrenia and the extent of our ability to identify people at risk for schizophrenia by various types of methodologies, and appreciate the treatment strategies and the therapeutic implications of intervening during the prodromal period.

No. 11A
COGNITIVE FUNCTION AND THE COURSE OF SCHIZOPHRENIA

Herbert Y. Meltzer, M.D., *Department of Psychiatry, Vanderbilt University, 1601 23rd Avenue South, Suite 306, Nashville TN 37212;* Suzanne Zachary, Ph.D., William T. Summerfelt, Ph.D.

SUMMARY:

Impairment in the major domains of cognition such as working memory, storage memory, semantic memory, executive function, attention, vigilance, and fine motor performance is characteristic of schizophrenia. The level of impairment in schizophrenia in these domains averages 0.5–2.5 standard deviations below normal in most studies. The level of impairment in first episode schizophrenic patients following treatment with typical neuroleptic drugs is only slightly less than that in more chronic schizophrenic patients, indicating that the impairment is present from the onset of psychosis and is only slightly progressive. Studies of children with one or two parents with schizophrenia indicate that some types of cognitive impairment are present before the onset of psychosis, but the level is far less than that present at the first episode and does not have the same consequences for education and work function that the cognitive impairment in late adolescent and adult schizophrenia appears to have. These findings indicate that there is a high probability that cognitive impairment develops during the prodrome period, i.e., the variable length period of emerging psychopathology and social dysfunction prior to the first appearance of psychosis. This talk will review data on the development of the cognitive impairment of schizophrenia during the prodrome period and the possible intervention with novel antipsychotic drugs to prevent its full emergence. The biological basis for this cognitive impairment will be considered.

No. 11B
PREDICTING SCHIZOPHRENIA

Michael Davidson, M.D., *Memory Clinic, Beitan, 39A, Telhajhomer 52621, Israel;* Abraham Reichenberg, M.A., Jonathan Rabinowitz, D.S.W., Mark Weiser, M.D., Zeev Kaplan, M.D., Mordehai Mark, M.D.

SUMMARY:

Subtle cognitive and behavioral abnormalities are often manifest in apparently healthy adolescents who later develop schizophrenia. This study investigated whether these subtle abnormalities could be utilized as markers to detect vulnerability for schizophrenia. We linked the Israeli Draft Board Registry, which contains cognitive and behavioral assessment data on *all* 16 to 17 year old Israeli adolescents with the National Psychiatric Hospitalization Case Registry, which contains data on *all* psychiatric hospitalizations in the country (cases).

A logistic regression analysis indicated that the strongest predictors for future schizophrenia were deficits in social relations (OR = 2.9, CI = 2.22–3.94), organizational ability (OR = 1.4, CI = 1.09–1.81), and intellectual functioning (OR = 1.5, CI = 1.30–1.83). When comparing cases and matched control non-cases, the prediction model had a positive predictive value of 72% and an overall rate of correct classification of 87.5% (model chi-square = 117, df = 3, $p < 0.0001$). The model was also applied to the entire draft board registry and yielded a sensitivity of 74.7%, specificity of 99.7%, and positive predictive value of 42.7%.

In addition, we found that we could predict with reasonable accuracy, based on the same variables, between individuals who will receive a diagnosis of schizophrenia and of affective disorders. Finally, we compared the cognitive and behavioral antecedents of twins discordant for schizophrenia within the pair and with pairs of healthy twins. We found that both affected and nonaffected twins performed worse than the members of the nonaffected pair of twins. This supports the notion that the subtle cognitive and behavioral abnormalities are inherited and that a second event, inherited or acquired, must intervene in order for psychosis to become manifest.

No. 11C
PREPSYCHOTIC INTERVENTION IN SCHIZOPHRENIA: A STITCH IN TIME?

Patrick D. McGorry, Ph.D., *Department of Psychiatry, University of Melbourne, c/o EPPIC 35 Poplar Road, Parkville, Victoria, 3052, Australia;* Lisa J. Phillips, M.Psy., Allison R. Yung, M.B., Allison Blair, M.B., Shona Francey, M.Psy., George Patton, M.D., Narelle Hearn, Dominic Germano, M.Psy., Jenny Bravin, M.Psy.

SUMMARY:

The prepsychotic or prodromal phase in schizophrenia and related psychoses is often of significant duration and is a phase during which much of the psychosocial damage wrought by these disorders occurs. Recently it has been shown that it is possible to identify patients with a substantially enhanced risk of early transition to frank psychosis. Specific analyses examining predictive factors will be presented.

In parallel with continuing prediction-oriented research, we are conducting a randomized controlled trial (nonblinded) of intervention in patients at high risk for early transition. Patients are randomized to nonspecific needs-based intervention or more specific treatment with low-dose risperidone (1-2 mg per day for six months) and cognitively oriented therapy (three months). Duration of monitoring and follow-up is 12 months. The study is still in progress and, as a result, duration of follow-up is variable. At September 1998, nine out of 27 subjects in the nonspecific intervention group have become psychotic. This contrasts with five out of 27 subjects in the specific treatment sample. Data will be presented as a completer analysis and also intention-to-treatment methodology. The implications will be discussed.

No. 11D
PRODROMAL SIGNS: CRUCIAL INFORMATION AT BOTH THE THEORETICAL AND PRACTICAL LEVEL

Yves Lecrubier, M.D., *Clerambault, Inserm U302 Pavillon Hospital, Salpetriere-47 Boulevard Hospital, Paris 75013, France*

SUMMARY:

There is epidemiological evidence that the existence of premorbid symptoms is the rule rather than the exception in schizophrenic patients. A pattern of signs, although rather unspecific, does exist

during childhood. More specific premorbid cognitive impairment and symptoms are observed in teenagers and adolescents. During the three to five years before the onset of the first episode, the existence of some negative symptoms is present in most patients. It is likely that these symptoms reflect the most stable chronic symptomatology observed lifetime in schizophrenics, although they may fluctuate during acute episodes. It is therefore crucial to explore whether the early signs derive from a nonspecific risk factor or reflect the same process as symptoms appearing later. We therefore will discuss what the link between these different periods could be and what could explain the differences between signs observed at different life periods.

Psychodevelopmental consequences of the pathological process should probably be given as much importance as the neurodevelopmental process, at least in children with early psychological difficulties. Therapeutic implications will be discussed.

No. 11E
THE PRODROME: CLINICAL FEATURES AND EARLY DETECTION

Thomas H. McGlashan, M.D., *Yale Psychiatric Institute, 184 Liberty Street, New Haven CT 06519*

SUMMARY:

The prodrome to psychosis has not heretofore been a focus of much attention because the earliest stages are often highly subjective and symptomatically quiet. Most of the descriptions that exist are reconstructed retrospectively from interviewing patients with established disorders. These descriptions will be summarized. The first prospective attempt to describe and quantify the prodrome clinically comes from Australia, where McGorry and colleagues have identified three subtypes of individuals at very high risk for becoming psychotic in the subsequent year. In New Haven, we have gathered and developed these retrospective and prospective observations into a Scale of Prodromal Symptoms (SOPS) to identify prodromal at-risk states in young people. We are using it as a diagnostic tool and quantitative measure of severity of prodromal signs and symptoms in a clinical trial of early treatment. Descriptions will be presented of ongoing cases that we feel represent prototypic forms of the prodrome.

Theoretically, early intervention in the prodrome holds great promise. However, it depends upon early detection, which operationally has proven to be a major challenge because the prodrome is infrequent and elusive. The consciousness of entire networks of providers, educators, and families must be raised to the level of essentially recognizing a new clinical entity while concomitantly minimizing stigma-driven denial of true risk for serious mental illness. Strategies developed for early detection will also be described and illustrated.

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INDUSTRY-SUPPORTED SYMPOSIUM 12—ARE ATYPICAL ANTIPSYCHOTICS ALSO MOOD STABILIZERS?
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize the historical role of conventional antipsychotics in the treatment of bipolar disorder and their side effects; demonstrate an understanding of the potential thymoleptic properties of the atypical antipsychotics and their potential role in the treatment of patients with bipolar disorder.

No. 12A
PHARMACOLOGIC MECHANISMS OF MOOD STABILIZATION AMONG ATYPICAL ANTIPSYCHOTICS

Paul E. Keck, Jr., M.D., *Biological Psychiatry, University of Cincinnati, 231 Bethesda Avenue, Cincinnati OH 45267*

SUMMARY:

Unlike standard antipsychotic agents that appear to have unidirectional antimanic properties and frequent neurological side effects, emerging data suggest that atypical antipsychotics may have different thymoleptic profiles and are associated with fewer neurological side effects. These new agents possess a number of pharmacologic properties that may underlie different thymoleptic effects. Antagonism of $5HT_{2A}$ receptors, a mechanism common to clozapine, risperidone, olanzapine, quetiapine, and ziprasidone, may confer antidepressant activity. Similarly $alpha_2$ adrenergic receptor blockage (clozapine, risperidone) may produce antidepressant effects by enhancing presynaptic norepinephrine release. Binding affinity for the M_1 receptor (clozapine, olanzapine) may confer thymoleptic properties. Like standard antipsychotics, postsynaptic dopamine D_2 receptor blockage may account for antimanic effects. Finally, serotonin and norepinephrine reuptake inhibition and potent $5HT_{1A}$ and $5HT_{1D}$ affinity may confer antidepressant effects for ziprasidone.

No. 12B
ATYPICAL ANTIPSYCHOTICS: TREATMENT OF ACUTE MANIA

Susan L. McElroy, M.D., *Department of Psychiatry, University of Cincinnati College of Medicine, 231 Bethesda Avenue, ML 559, Cincinnati OH 45267-0559*

SUMMARY:

Antipsychotics are commonly used in the treatment of patients with acute mania. However, the use of standard antipsychotics in acute mania is associated with a number of limitations. These include the risk of extrapyramidal symptoms, including tardive dyskinesia, and depressogenic properties. New antipsychotic agents may possess bidirectional thymoleptic properties as well as antipsychotic activity with minimal extrapyramidal side effects. For example, substantial open data suggest that clozapine has acute and long-term antimanic

efficacy in bipolar disorder, including in patients who are treatment refractory. A double-blind, controlled trial showed that olanzapine was superior to placebo in the short-term treatment of acute bipolar mania with or without psychotic features. Preliminary data suggest other atypical antipsychotics may have therapeutic effects in bipolar mania as well. In this presentation, research on the use of novel antipsychotics to treat mania will be reviewed. In addition, preliminary guidelines for the use of these agents in this disorder will be proposed.

No. 12C
ATYPICAL ANTIPSYCHOTICS: TREATMENT OF DEPRESSION

Richard C. Shelton, M.D., *Department of Psychiatry, Vanderbilt University, 1500 21st Avenue South, Suite 2200, Nashville TN 37212*

SUMMARY:

There is growing evidence that atypical antipsychotics may be effective for mood disorders. For example, there is a body of literature on the benefit of atypicals in bipolar disorder, especially in the manic state. However, there also is evidence of benefit in depressed patients. This includes the impact of atypicals in the depression associated with schizophrenia or schizoaffective disorder. As an example, Tollefson and colleagues showed that olanzapine (OLZ) was superior to haloperidol in reducing depressive symptoms in schizophrenic patients. This presentation will include a review of a recent clinical trial of the atypical antipsychotic OLZ, alone and in combination with fluoxetine (FLX), in the treatment of refractory unipolar major depression (MDD). Atypicals with potent antagonism of the 5-HT2A receptor appear to enhance dopamine release in the frontal cortex and striatum, which could be the theoretical basis for effects on both depression and the negative symptoms of schizophrenia. This study involved 32 persons with MDD refractory to prior trials of both SSRIs and NSRIs, randomly assigned to treatment with OLZ + FLX or either agent used singly with placebo. The combined treatment group showed a rapid and sustained effect compared with OLZ or FLX used alone. These results support the benefit of atypicals in depressive disorders, especially refractory depression. Practical and theoretical implications will be discussed.

No. 12D
EFFICACY AND TOLERABILITY OF MAINTENANCE PHARMACOTHERAPY IN BIPOLAR DISORDERS

John M. Zajecka, M.D., *Department of Psychiatry, Rush-Presbyterian Medical Center, 1725 West Harrison, Suite 955, Chicago IL 60612*

SUMMARY:

There is an increasing awareness of the need for maintenance treatment for the treatment of bipolar disorders. Optimal treatment outcomes depend upon long-term efficacy and tolerability of specific treatment modalities. Long-term pharmacological treatment strategies will be reviewed, including data on efficacy, tolerability, and practical management issues.

No. 12E
HEALTH BELIEFS AND COMPLIANCE IN BIPOLAR DISORDER

Peter J. Weiden, M.D., *Department of Psychiatry, St. Luke's/Roosevelt Hospital, 411 West 114th Street, Suite 3B, New York NY 10025*

SUMMARY:

Medication noncompliance for patients with bipolar disorder will be reviewed within the framework of the Health Belief Model (HBM). The HBM states that medication compliance in chronic diseases depends on: (1) perceived susceptibility to the illness, (2) perceived consequences from the illness, (3) perceived benefits of medication, and (4) perceived costs of taking medication.

Perceived susceptibility is influenced by the lifetime number of episodes and degree of understanding about the nature of the episodes. Both of these factors evolve slowly, with better understanding of disease susceptibility developing gradually.

Perceived consequences are often distorted because it may be difficult to grasp the harmful consequences of having manic symptoms, especially when grandiosity predominates or when accomplishments are attributed to having the illness.

Perceived benefits of medication can be attenuated in bipolar disorder because of delayed onset of efficacy, or because "residual" depressive symptoms are interpreted as evidence that medication is not working.

Perceived costs of medication range from psychologic costs of stigma to the risk of life-threatening side effects (e.g. lithium toxicity). Most frequent, however, are side effects that the physician does not consider to be "serious" but the patient does. Examples include cognitive problems, tremor, weight gain, dermatological problems, GI symptoms, and subtle but distressing EPS. Fortunately, because of treatment advances in bipolar disorder, these problems can often be successfully treated.

Notice that the HBM emphasizes patients' perception, not the medical reality. The clinical challenge is to align patient perceptions within the framework of medically acceptable risk/benefit decisions. Fortunately, ways in which bipolar symptoms affect perceptions are often predictable and amenable to psychoeducation. Also, new pharmacologic treatments expand treatment options *and* remain acceptable from the patient's point of view.

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INDUSTRY-SUPPORTED SYMPOSIUM 13—COMPLEXITY: PHARMACOLOGIC MANAGEMENT ISSUES IN BPD

Association for Research in Personality Disorders

Supported by Glaxo Wellcome Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to have a fuller appreciation of the complexities involved in prescribing psychotropic medication to patients with borderline personality disorders and have information pertinent to considering and

solving some of these complexities so that they might more rationally prescribe medications to these patients.

No. 13A
PSYCHOBIOLOGIC UNDERPINNINGS OF BPD

Larry J. Siever, M.D., *Department of Psychiatry, Mount Sinai School of Medicine, 1 Gustave Levy Place, Box 1230, New York NY 10029;* Antonia S. New, M.D., Harold W. Koenigsberg, M.D., Monte S. Buchsbaum, M.D., Rachel Yehuda, Ph.D., Joel Gelernter, M.D., Robert A. Grossman, M.D.

SUMMARY:

While borderline personality disorder is a complex disorder comprising a set of behavioral/psychologic traits and symptoms, it has become increasingly clear that underlying psychobiologic vulnerabilities contribute to the development of this disorder. Two key domains that appear to be vulnerable in borderline personality disorder are impulse control and affect regulation. Impulse dyscontrol has been related to deficiencies in the serotonin system in a series of studies utilizing metabolite measures, responses to psychopharmacologic agents, and receptor measurements in brain and peripheral tissue. New studies suggest that inhibitory regions in the cortex, particularly orbital frontal cortex, which are heavily innervated by serotonin, are significantly less responsive to agents that increase serotonergic activity including fenfluramine in impulsive (particularly borderline) personality disorder patients and meta-chlorophenylpiperazine (m-CPP) in impulsive alcoholic patients. Genetic variance in genes related to serotonergic system are also associated with impulsive aggression. For example, an allele or variant of the 5-HT_{1b} gene is associated with impulsive aggression in personality disorder patients, and its effects seem to be synergistic with a history of environmental abuse. Other data suggest that a history of abuse may modulate the hypothalamopituitary axis (HPA axis) and its relationship to the serotonin system, which may be a mechanism by which environmental traumas play on genetic substrates in borderline patients. Excessive affective responsiveness can be documented in responses to pharmacologic agents such as physostigmine in borderline patients and can also be tested in functional imaging studies of limbic regions in response to affectively charged stimuli. These psychobiologic underpinnings have implications for psychopharmacologic treatment in that the selective serotonin reuptake inhibitors seem to be helpful in reducing impulsive behaviors, while mood stabilizers, which may reduce limbic irritability, may have beneficial effects in diminishing affective instability. Furthermore, these biologic vulnerabilities may have important implications for how patients with borderline personality disorder internalize their experience of themselves and others in maladaptive ways that influence their relationships with those they are close to and thus may have important implications for their psychotherapeutic treatment as well.

No. 13B
SYMPTOM-DRIVEN ALGORITHMS AS GUIDES TO THE PHARMACOLOGIC TREATMENT OF BPD

Paul H. Soloff, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh PA 15213-2593*

SUMMARY:

A pharmacologic approach to treating patients with personality disorders is based on evidence that some dimensions of personality are mediated by variations in neurotransmitter physiology and are responsive to medication effects. Borderline personality disorder is defined, in part, by dysregulation of affect, impulsive-aggressive behavior, and cognitive-perceptual distortions, which may reflect underlying disturbances of neurotransmitter function. Using a dimensional definition of symptom domains, treatment algorithms have been developed for cognitive-perceptual symptoms, affective dysregulation, and impulsive-behavioral dyscontrol in personality-disordered patients. Pharmacotherapy is directed at state symptoms during periods of acute decompensation and trait vulnerabilities, which represent the diathesis to future episodes. Treatment algorithms are constructed using rules that consider strength of empirical evidence, safety, and speed of effect in making treatment recommendations. To be most broadly applicable and most conservative, these algorithms assume treatment in an outpatient setting. This paper will present three algorithms for symptom-specific pharmacologic treatment of patients with BPD.

No. 13C
COMBINING PSYCHOPHARMACOLOGY WITH THE DIALECTICAL BEHAVIOR THERAPY OF BPD

Marsha M. Linehan, Ph.D., *Department of Psychiatry, University of Washington, Guthrie Hall, Room 119, Box 351525, Seattle WA 98195-1525*

SUMMARY:

A diagnosis of borderline personality disorder is associated with marginal outcomes when treatment is provided as usual in the community and with worse outcome than found in standardized psychosocial and/or pharmacotherapy treatments of Axis I disorders such as major depression, obsessive-compulsive disorder, bulimia, and substance abuse. Despite recent advances in the pharmacotherapy of BPD, it is commonly assumed that some form of psychosocial intervention is also necessary. Medication compliance among patients with BPD has been problematic, with upwards of 50% of patients and 87% of their therapists reporting misuse of their medications. One of the better known treatments currently for BPD is dialectical behavior therapy (DBT), a cognitive-behavioral intervention aimed at the seriously and persistently disordered BPD patient. DBT is a programmatic intervention with various treatment modes interwoven within a common treatment philosophy and set of intervention strategies. DBT recognizes the need for using medications in these patients. In DBT, the clinical management of pharmacotherapy follows the overall DBT philosophy and general guidelines. The clinical management of pharmacotherapy in DBT incorporates a specified set of assumptions about patients, a set of strategies for interacting with patients that includes prescription principles that emphasize medication usage and medications that are safe, simple, specific, scientific, and super-fast in action (the five Ss). The prescription principles also include guidelines for interacting with other members of the DBT treatment team. These guidelines and principles with respect to pharmacotherapy will be discussed in detail.

No. 13D
THE IMPACT OF PSYCHOPHARMACOLOGY ON PSYCHOSOCIAL AND INTERPERSONAL ISSUES IN THE TREATMENT OF BPD

John G. Gunderson, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont MA 02478*

SUMMARY:

The meanings attached to medications by patients with borderline personality disorder make noncompliance, distorted reporting, and difficulty assessing effectiveness common. The borderline patients' attributions to medications are typically contaminated by both overvaluation and devaluation. Either side of such splits introduces significant hazards into the treatment and into the course of the treatment. Examples of such hazards will be described. Though most management problems result from the borderline patients' misattributions

in these situations, psychiatrists too can also contribute to the difficulty. The patient's attitudes can be easily influenced by a psychopharmacologist's attitudes and style. Of particular importance is the temptation for the prescribing doctor to underestimate his/her personal significance to the borderline patient. A measured, modest, pragmatic, empirical approach that appreciates the inevitably subjective basis for examining the effectiveness of any given psychopharmacologic agent is needed.

No. 13E
ISSUES CREATED BY A PSYCHOPHARMACOLOGIST/PSYCHOTHERAPIST

Kenneth R. Silk, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center, Box 0704, Ann Arbor MI 48109-0704*

SUMMARY:

Split treatment or medication back-up occurs when the psychopharmacotherapy and the psychotherapy for a given patient are provided by two different people. While such a situation can always be problematic, it becomes even more complicated when medication back-up occurs with a patient who has a diagnosis of borderline personality disorder (BPD). In addition, more and more patients with BPD are being treated not only with some form of psychotherapy, but with pharmacologic agents as well. The medication back-up situation is one primed for splitting and for other reactions to occur. Given that an essential feature of most patients with a diagnosis of BPD is disordered interpersonal relationships, the psychotherapist-psychopharmacologist division needs to be thought about in light of these relationships. Issues that should be carefully considered when entering into a split treatment include: (1) the relationship between the psychotherapist and the prescriber; (2) the meaning of the medication to both the psychotherapist and the prescriber, (3) the meaning of the medication to the patient, (4) the limitation of the effectiveness of the medication, (5) the role of the medication in the overall treatment and treatment plan for the patient, (6) the lethality of the medication, and (7) the relationship of interpersonal crises and affective storms to the timing of medication initiation or dosage change. These issues will be elaborated upon during the presentation. Attention to each of these issues during the process of medication back-up by all participants in the management of patients with BPD facilitates rational psychopharmacologic planning and treatment while diminishing polypharmacy and pharmacologic confusion and disappointment on the part of the patient, the psychotherapist, and the psychopharmacologist.

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INDUSTRY-SUPPORTED SYMPOSIUM 14—CLINICAL FRONTIERS IN THE SLEEP/PSYCHIATRY INTERFACE
Supported by Wyeth-Ayerst Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to identify the differential diagnosis of insomnia and hypersomnolence and devise strategies for diagnosis and intervention; (2) recognize characteristic polysomnographic aberrations in depression, PTSD, and pain syndromes and their management; and (3) recognize that sleep and wakefulness are not mutually exclusive states, as evidenced by the parasomnias, and identify diagnostic features of these disorders.

No. 14A
INSOMNIA AND HYPERSOMNOLENCE: OLD PROBLEMS WITH NEWER TREATMENTS

Karl Doghramji, M.D., *Department of Psychiatry, Jefferson Medical College, 1015 Walnut Street, Suite 319, Philadelphia PA 19107*

SUMMARY:

Sleep-related complaints abound in the practice of psychiatry; 70% of depressives, 90% of psychotic patients, and 80% of C/L patients complain of disturbed sleep. Disturbed sleep is also highly prevalent in the general population; nearly half of all Americans above the age of 18 complain of insomnia during the course of a year, and a striking 12% of the general population suffer from chronic insomnia. Studies also reveal that insomnia is associated with an increased risk of having psychosocial and occupational difficulties, cognitive impairments, accidents, and may even contribute to mortality. Hypersomnolence afflicts 10%–20% of the population and has been known to contribute to numerous catastrophes such as the explosion of the space shuttle Challenger and the grounding of the oil tanker Exxon Valdez. This presentation will review central mechanisms governing sleep and daytime alertness. It will also review the prevalence and impact of sleeplessness and daytime hypersomnolence and will stress the potentially important, yet poorly recognized, role of excessive daytime somnolence in the day-to-day practice of psychiatry. The evaluation of these two symptoms will also be discussed, emphasizing the formulation of a differential diagnosis based on polysomnographic and office-based techniques. Options for management will be presented, including pharmacological agents, behavioral techniques, phototherapy, and psychotherapy, emphasizing the value of a multimodal approach.

No. 14B
EMERGING LINKS BETWEEN DEPRESSION AND SLEEP

J. Christian Gillin, M.D., *Department of Psychiatry, University of California at San Diego, VAMC, 3350 La Jolla Village Drive, San Diego CA 92161-0001*

SUMMARY:

This presentation will explore the complex and potentially mutually reinforcing relationship that may exist between depression and sleep. Subjective and polysomnographic alterations in depression, both in the acute phase and following remission, will be reviewed,

and their implications will be explored regarding diagnosis, vulnerability to relapse, and the pathophysiology of depression itself. The role of serotonin in depression, the sleep of depressives, and the sleep-related aspects of antidepressant therapy will be reviewed. The effects of antidepressants and other therapeutic agents on polysomnographic patterns of depressives will be reviewed, and the implications of these findings will be discussed regarding the selection of pharmacologic agents.

No. 14C
MANAGEMENT OF SLEEP DISTURBANCES IN PTSD

Thomas C. Neylan, M.D., *Psychiatry Service 116N, University of California at San Francisco, VAMC, 4150 Clement Street, San Francisco CA 94121*

SUMMARY:

The National Comorbidity Survey estimates that the lifetime prevalence of PTSD in the United States population is 7.8%. Multiple studies have demonstrated that PTSD patients complain of recurrent nightmares and sleep continuity disturbances, which are listed separately in the reexperiencing and hyperarousal clusters in the DSM-IV criteria. Sleep disturbances are the symptoms most frequently reported by patients receiving treatment in PTSD specialty clinics. This presentation will begin with a brief review of the data suggesting a common pathophysiology between sleep disturbances and PTSD. Following that, the main focus will be on a strategy for evaluating and treating nightmares and insomnia in PTSD patients. The treatment of sleep disruption relies foremost on the optimal treatment of the PTSD intrusions and hyperarousal symptoms. Management must also include an evaluation and treatment of comorbid medical disorders, substance use (e.g. caffeine, alcohol), and sleep disorders (e.g. nocturnal myoclonus, sleep apnea). Nonpharmacologic strategies for improving sleep, such as behavior modification, relaxation, and dream rehearsal therapy, will be presented. Data on pharmacologic treatment of nightmares will be presented. The risks and benefits of hypnotics for insomnia in PTSD patients will be discussed, and a treatment algorithm for the acute and chronic use of hypnotics will be presented.

No. 14D
PAIN AND SLEEP: NEUROBIOLOGICAL AND CLINICAL ISSUES

Mitchell J.M. Cohen, M.D., *Department of Psychiatry and Human Behavior, Jefferson Medical College, 1652 Thompson Street, Philadelphia PA 19107*

SUMMARY:

Sleep abnormalities are commonly encountered in patients with chronic pain. Pain is fundamentally activating through spinoreticular pathways and the paleospinothalamic component of the spinothalamic tract. Comorbid anxiety and depression, medication use, and altered daily activity levels contribute to a multifactorial pathogenesis of these sleep abnormalities. Spinal pain, myofascial pain, headache, and pelvic pain are among pain conditions in which sleep problems have been specifically studied. Sleep disorder is one criterion for the diagnosis of fibromyalgia, and some reports suggest specific electroencephalographic findings in this condition. Some population data suggest pain is the most common cause for a secondary sleep disturbance. Various data demonstrate associations between depressive symptoms and sleep disturbance in pain patients. In the clinical course of chronic pain, some data suggest sleep disturbance and depression become self-sustaining in the central nervous system and independent of the specific peripheral pain generator. This presentation reviews these neurobiological issues, exploring central linkages of pain, sleep, and affective disturbances. Data on sleep disturbances in chronic pain conditions and associations with depression are summarized. Chronic pain is costly in terms of individual suffering, medical utilization, and productivity losses. This presentation concludes by outlining pharmacologic and behavioral treatment strategies that can mitigate these costs.

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INDUSTRY-SUPPORTED SYMPOSIUM 15—DEPRESSION: ACHIEVING REMISSION AND COMPLIANCE: CLINICAL CHALLENGES AND SOLUTIONS
Supported by Bristol-Myers Squibb

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to (1) document the recurrent and chronic nature of depressive episodes; (2) learn strategies for matching patients with treatment; (3) review treatments of depression that include illness-focused short-term psychotherapies; (4) evaluate cost-effectiveness of the various choices, and (5) learn how to maximize response.

No. 15A
SELECTING THE RIGHT ANTIDEPRESSANT FOR YOUR PATIENT

Norman Sussman, M.D., *Department of Psychiatry, New York University School of Medicine, 20 East 68th Street, Suite 204, New York NY 10021-5836*

SUMMARY:

All antidepressants are comparable in terms of overall clinical response for all patients. However, the quality, severity, and probability of side effects are important considerations in drug selection and significant factors in patient adherence to treatment. Unlike response to treatment, which is largely unpredictable for any given patient, the probabilities of specific side effects are known and therefore more predictable.

Other than the lack of response to the medication, the largest risk to successful treatment is discontinuation of the regimen by the patient—usually in response to specific side effects. Since each drug has a known side-effect profile, the success of the treatment is greatly enhanced when the patient's life profile is matched to the drug's side-effect profile to provide the least conflict.

The selection of the right drug for your patient depends not only on finding the one that works, but also on determining which side effects are most important to the patient and consequently are likely to cause discontinuation. In choosing a drug that avoids those side effects that are most significant to each patient's lifestyle, the chances

of discontinuation are reduced and the chances for effective treatment are enhanced.

No. 15B
PSYCHOTHERAPY OF CHRONIC DEPRESSION: EFFICACY, TOLERABILITY, COMPLIANCE AND COST

John C. Markowitz, M.D., *Department of Psychiatry, Cornell University Medical College, 445 East 68th Street, Suite 3N, New York NY 10021*

SUMMARY:

Long-term psychodynamic psychotherapy was once considered the treatment of choice for chronic depressions, many of which were considered character disorders rather than mood disorders. In 1980, the authors of DSM-III shifted "depressive personality" to the affective disorders section, calling it dysthymic disorder. Pharmacotherapy trials have subsequently demonstrated the efficacy of antidepressant medications for many chronically depressed patients.

In the same interval since 1980, numerous randomized clinical trials have demonstrated the efficacy of time-limited, diagnosis-targeted psychotherapies as treatments for acute major depression. Cognitive behavior therapy (CBT) and interpersonal psychotherapy (IPT) have been the two best-tested interventions. Since not all chronically depressed patients respond to, tolerate, or accept treatment with medication, the question arises as to whether these brief psychotherapies also provide efficacious treatment for chronic depression. Data are limited, but not unpromising. This presentation will review the literature and describe ongoing treatment trials that address the use of psychotherapy, alone and combined with pharmacotherapy, as treatment for chronic depression.

No. 15C
CHRONIC DEPRESSION: PSYCHOTHERAPY AND PHARMACOTHERAPY: ADDITIVE OR SYNERGISTIC?

Martin B. Keller, M.D., *Department of Psychiatry, Butler Hospital/ Brown University, 345 Blackstone Boulevard, Providence RI 02906*

SUMMARY:

Depression is now recognized as highly prevalent, with a pernicious course requiring sustained intensive treatment. Lifetime rates of depression were reported by the National Comorbidity Study at between 17% and 19%. (Kessler et al., 1994). Evidence that depression is a chronic and recurrent condition has consistently emerged from the National Institute of Mental Health Collaborative Depression Study (CDS). The psychosocial and physical impairment, comorbidity, and high suicide rate associated with chronic and recurrent depressive disorders, coupled with a high economic burden, demand the investigation of optimal treatment strategies. The widespread belief that chronic depressive disorders are resistant to pharmacotherapy is unjustified. Increasing evidence to support the efficacy of pharmacological intervention in chronic and recurrent forms of depressive disorders must now be translated to appropriate guidelines for long-term management and increased efforts to raise awareness of the need for a long-term approach to depression.

This presentation will review data from an acute, continuation, crossover, and maintenance study of the treatment of chronic major depression and double depression with certraline and imipramine. There continues to be a need to test the acute and long-term efficacy of psychotherapy alone and in conjunction with pharmacotherapy in the treatment of chronic depression. Exciting new data will be presented on the combined treatment of double depression and chronic major depression. A 12-site, collaborative combined treatment study investigating the therapeutic efficacy of nefazodone and cognitive behavior therapy, the Nefazodone/CBT-CD Chronic Depression Study, will be described. This study is an ongoing randomized clinical trial to test the therapeutic efficacy of cognitive behavior therapy alone, nefazodone alone, and combination treatment in an acute, crossover, and maintenance study design. A total of 660 chronically depressed outpatients have been recruited and processed through an acute phase (12 weeks), crossover phase for nonresponders, continuation phase (16 weeks), and maintenance phase (52 weeks). Results from the acute phase will be presented, including clinical characteristics and demographics of the subjects. This project is the largest combined treatment study ever undertaken and the first investigation of its kind with chronically depressed outpatients.

No. 15D
MAXIMIZING RESPONSE IN PARTIAL AND NONRESPONDERS TO ANTIDEPRESSANTS

Russell T. Joffe, M.D., *Department of Psychiatry, McMaster University Medical Center, 1200 Main Street West, Room 2E1, Hamilton, ONT, L8N 3Z5, Canada;* William M. Singer, M.D., Anthony J. Levitt, M.D.

SUMMARY:

Up to half of depressed patients will have a partial or non-response to optimum antidepressant treatment. Combination and augmentation strategies offer alternatives to antidepressant substitution, the most common approach to the incomplete antidepressant responder. There are several advantages to augmentation or combination strategies including comparable or enhanced rates of response and reduced delay in onset of treatment response compared with substitution. Disadvantages of augmentation/combination strategies include the lack of a large empirical database to support their efficacy and, of particular clinical importance, drug interactions.

The pros and cons of augmentation/combination strategies vs. substitution will be critically reviewed. Particular attention will be paid to the major augmentation strategies including lithium, triiodothyronine (T3), buspirone, pindolol, and psychostimulants. A review of the efficacy and side effects of various antidepressant combination strategies will also be presented. Particular attention will be paid to potentially clinically important drug interactions with the various augmentation and combination strategies.

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INDUSTRY-SUPPORTED SYMPOSIUM 16—LONGITUDINAL ASPECTS OF ALZHEIMER'S DISEASE MANAGEMENT

Supported by Eisai Inc., Pfizer Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the rationale for early intervention in AD, understand factors that influence progression rates, be able to list several potentially disease-modifying therapies, and recognize the stage-specific issues in AD management.

No. 16A
THE PRE-ALZHEIMER'S DISEASE CONDITION

John C. Morris, M.D., *Department of Neurology, Washington University, 660 South Euclid, Campus Box 8111, MDC, St. Louis MO 63110*

SUMMARY:

The availability of drugs for the symptomatic therapy of Alzheimer's disease (AD) has increased emphasis on the accurate detection of the disorder in its earliest stages. It can be difficult, however, to distinguish cognitive function associated with nondemented aging from the cognitive changes of very mild dementia. The border zone between aging and dementia variously has been termed "preclinical AD," "age-associated memory impairment," and "mild cognitive impairment." Accumulating evidence suggests that: (1) the "pre-Alzheimer's" condition can be recognized by available clinical methods, (2) there is a predictable rate of progression in pre-Alzheimer's" individuals to the development of more overt dementia, and (3) "pre-Alzheimer's" brains almost always demonstrate fully developed AD histopathology. For many individuals, therefore, the "pre-Alzheimer's" condition may represent the earliest symptomatic stage of AD. These findings suggest that AD can be clinically diagnosed earlier than is commonly accepted and have important implications for prevalence estimates of AD and for management decisions.

No. 16B
BEHAVIOR MANAGEMENT OVER THE COURSE OF ALZHEIMER'S DISEASE

Jeffrey L. Cummings, M.D., *Department of Neurology, University of California at Los Angeles, Reed Neurosciences Center, 710 Westwood Plaza, Los Angeles CA 90095*

SUMMARY:

Alzheimer's disease (AD) is a progressive neurodegenerative disease that passes through presymptomatic, prodromal, early, mild, and severe stages. In the presymptomatic stage of the disease there are no cognitive or behavioral symptoms, but pathological changes are accruing in the brain. In the prodromal phase of the disease the patient lacks sufficient symptoms to make a diagnosis of AD but cognitive and behavioral changes below the diagnostic threshold occur. Depression, anxiety, apathy, and irritability are the first neuropsychiatric symptoms to appear in AD and may mark the prodromal period. As the patient progresses through the prodromal period and develops enough dysfunction to diagnose AD, behavioral symptoms become more prominent. Apathy with reduced motivation, disengagement, loss of interest, and reduced affect is particularly characteristic of the mild phase of AD. Depression, irritability, psychotic symptoms, disinhibition, and episodes of agitation may also occur. As the disease progresses, behavioral symptoms become more marked, and most patients eventually exhibit agitated behavior. Pharmacotherapy may substantially relieve neuropsychiatric symptoms in AD. Cholinesterase inhibitors, antipsychotic agents (novel or conventional), antidepressants, and antiepileptic drugs may reduce behavioral disturbances. The progressive course of AD requires a changing repertoire of psychotropic agents that respond to the evolution of different behavioral disorders over the course of the illness.

No. 16C
DISEASE-MODIFYING AGENTS AND STUDY DESIGNS

Ronald C. Peterson, M.D., *Department of Neurology, Mayo Foundation, 200 First Street, SW, Rochester MN 55905*

SUMMARY:

In recent years, several new pharmaceutical treatments for Alzheimer's disease have been approved. These compounds are designed to treat the cognitive and behavioral aspects of Alzheimer's disease. Alternatively, a great deal of research is being done on disease modifying agents. Clinical trials can be designed to study one or both of these aspects of compounds for the treatment of Alzheimer's disease. The current longitudinal treatment trial for patients with a mild cognitive impairment will be discussed. This trial includes two active treatment arms and a placebo arm involving 720 patients over a three-year treatment interval. The primary efficacy measure will be the rate of conversion of subjects from mild cognitive impairment to Alzheimer's disease. The design characteristics of this trial and the measures used to assess efficacy will be discussed. Studies concerning other therapeutic agents for symptomatic and disease-modifying effects in the context of study design will be discussed.

No. 16D
MODELING PROGRESSION: IMPLICATIONS FOR TREATMENT

Rachelle S. Doody, M.D., *Department of Neurology, Baylor College of Medicine, 6550 Fannin, Suite 1801, Houston TX 77030*

SUMMARY:

Modeling progression of Alzheimer's disease (AD) is complicated because: (1) Patients are diagnosed at variable time intervals after initial symptoms; (2) Progression rates may change over time; (3) Choice of measures influences apparent rate; (4) Clinical symptom heterogeneity; (5) Statistical assumptions. Initial dementia severity, comorbid conditions, modification of risk and protective factors, and antidementia drugs may also influence progression.

If decline in AD is not linear, decline rates early in AD will not correlate with subsequent rates, but might still be consistent, i.e., fast, intermediate, or slow. MMSE data for nearly 200 subjects demonstrated this lack of linear correlation, although a majority of patients demonstrate linear decline at some point. We have also shown that estimated initial decline is consistent with subsequent decline in nearly 300 AD patients ($p < 0.001$, log rank test; $p = 0.002$, Cox analysis). Estimated initial decline is highly correlated with MMSE.

Interpretation of clinical trials data is complicated by differences in decline of placebo groups across studies and by inclusion of patients with variable levels of severity. To date, studies have not assessed whether the mix of slow, intermediate, and fast progressors or the percentage of patients experiencing linear decline in treatment and placebo groups has influenced study outcomes.

No. 16E
MANAGEMENT APPROACHES ADAPTED TO THE STAGE OF ALZHEIMER'S DISEASE

Peter V. Rabins, M.D., *Department of Psychiatry, Johns Hopkins Hospital, 600 North Wolfe Street, Meyer 279, Baltimore MD 21287-7279*

SUMMARY:

The progression of cognitive impairment in Alzheimer disease follows a relatively predictable course. Some generalizations can also be made about noncognitive symptoms but there is more variability. Therefore, management strategies over the course of the illness need to take into account the cognitive and noncognitive symptoms of the disorder at each stage as well as the needs of caregivers at that stage. This presentation will review management issues that are common during the presentation/diagnosis stage, during the early and middle stages in which mood and noncognitive symptoms become more prominent, and during the later stages in which cognitive and physical impairments become prominent, and management issues focus on functional impairments in walking, eating, and self-care. Late-stage issues of hospice care, eating difficulties, and nursing care for bed-bound states will also be reviewed.

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INDUSTRY-SUPPORTED SYMPOSIUM 17—SUICIDE: CLINICAL/RISK MANAGEMENT ISSUES FOR PSYCHIATRISTS

Suicide Research Division of the National Mental Illness Screening Project and McLean Hospital Bipolar and Psychotic Disorders Program

Supported by Solvay Pharmaceuticals, Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to identify, assess, and discuss: suicidal intent/risk patients; the role of antidepressants in suicide and the best treatment options/medication for patients at risk; the specific risks of suicide that accompany bipolar disorder, including lithium treatment and its discontinuation; requests from seriously ill patients for assisted suicide; four basic clinical profiles of suicide and their treatments; suicide liability in clinical practice.

No. 17A
A PROTOCOL FOR THE ASSESSMENT OF SUICIDE

Douglas G. Jacobs, M.D., *Department of Psychiatry, Harvard Medical School, One Washington Street, Suite 304, Wellesley Hills MA 02481*

SUMMARY:

This presentation will suggest a way of incorporating the current understanding of suicide into clinical suicide assessments. Suicide has many causes: the victim's probable psychiatric diagnosis, comorbid substance use and medical illness, personality structure, life experiences, and contemporaneous circumstances all contribute to their vulnerability to suicide. Although prediction of which individuals will complete suicide is not possible, known risk factors must be considered in the clinical assessment of individual patients.

Careful and repeated assessment of suicidality is the key to good clinical care of the suicidal patient. This presentation will cover important aspects of the clinical assessment of suicidality including diagnostic and environmental factors and those specific to the individual's experience of suicidality. Instituting a suicide assessment protocol is recommended when treating a suicidal patient. The protocol covers necessary areas for questioning as well as suggestions for the frequency of future assessments. This focus on assessment and planned reassessment provides a clearer picture of the patient's status than the commonly used no-suicide contract without giving clinicians a false sense of security.

No. 17B
BIPOLAR DISORDER AND SUICIDE

Kay R. Jamison, Ph.D., *Department of Psychiatry, Johns Hopkins University, 720 Rutland Avenue, Meyer 4-181, Baltimore MD 21205*

SUMMARY:

Fifteen to 20% of individuals with untreated or inadequately treated manic-depressive (bipolar) illness will commit suicide. Most of these deaths are preventable. This presentation will focus on the importance of early and correct diagnosis, aggressive treatment, the important adjunctive role of psychotherapy, the lethality of mixed states, the usefulness of advance planning directives, and the crucial importance of understanding the clinical phenomenology of suicidal thought and behavior.

No. 17C
LITHIUM DISCONTINUATION AND SUICIDE

Ross J. Baldessarini, M.D., *Department of Psychiatry, Harvard Medical School/McLean Hospital, 115 Mill Street, MRC 316, Belmont MA 02178-1048*

SUMMARY:

Bipolar depression is much more common than has been appreciated and carries an unusually high risk of lethality. Recent meta-analysis of published and new data comparing suicidal risk rates in treated and untreated bipolar disorder patients strongly indicates reduced suicidal risk during long-term treatment with lithium, by about seven-fold, that is not shown for alternative treatments. New data based on the long-term observation of bipolar I and II disorder patients in a mood disorders clinic found long delays to treatment despite high early suicidal risk, and further supported a strong reduction of suicidal risk during treatment with lithium. After lithium was discontinued for clinical reasons (typically, electively, after prolonged stability), there was a sharp increase of affective morbidity, with a marked increase of suicidal acts (22-fold) and fatalities (14-fold) in the first year, particularly in depressed and dysphoric recur-

rences, with lesser risks at later times, and limiting of risk by half by slow tapering off lithium.

These findings strongly support the need for more assertive and specific attention to the clinical diagnosis and safe management of persons with bipolar depression and for further studies of all mood-altering agents for their effect on suicidal behavior. The evidence reviewed indicates that lithium maintenance therapy virtually stands alone as a medical treatment, with substantial evidence of a selective and long-sustained beneficial effects on suicidal behavior.

No. 17D
PROFILES OF COMPLETED SUICIDE

Jan A. Fawcett, M.D., *Department of Psychiatry, Rush-Presbyterian Medical Center, 1753 West Congress Parkway, Chicago IL 60612*

SUMMARY:

Recent studies have found severe anxiety symptoms to be acute risk factors for suicide. Findings suggest that it is important to monitor the presence and severity of anxiety symptoms experienced by the patient as a useful risk indicator of immediate suicide. Two pathways to suicide have been proposed: anxiety/agitation and impulsive self-aggression possibly related to low brain serotonin function and low serum cholesterol. There are certainly more to be identified. There are four clinical profiles of suicide and treatment recommendations: (1) Agitation and severe anxiety associated with psychosis in an inpatient: Aggressive treatment is needed. (2) Partial response with recurrent symptoms of anxiety and undiagnosed depression: Requires aggressive treatment of the anxiety and depression. The clinician must also address delusional symptoms. (3) Suicidal acting out in borderline disorder, associated with anxiety and anticipated loss: Treatment with a low dose of antipsychotic medication may decrease the patient's need for suicidal behavior. Special care must be given during periods of impending "abandonment" or loss. (4) Interpersonal loss in depression, associated with a history of drug/alcohol abuse and impulsive behavior: Very close follow-up may help to pick up the changes (improvements with relapses of depression) and guide the clinician's response.

No. 17E
SUICIDE, ASSISTED SUICIDE AND MEDICAL ILLNESS

Herbert Hendin, M.D., *American Foundation for Suicide Prevention, 120 Wall Street, 22nd Floor, New York NY 10005*

SUMMARY:

Two-thirds of patients interviewed two weeks after an assisted suicide request show a significant decrease in their desire to die. Like other suicidal individuals, patients who desire an early death during a serious or terminal illness are usually suffering from a treatable depressive condition. Although pain and other factors contribute to their wish for death, researchers have found depression to be the only factor that significantly correlates with the wish for death. Because a patient finds relief in the prospect of death, does not mean that the decision is appropriate. Patients who are depressed and suicidal may appear calm and less depressed after deciding to end their lives, whether by themselves or with assistance.

Psychiatrists are more experienced than most physicians in recognizing the interactive nature of crucial decisions. This is particularly important in evaluating requests for assisted suicide and euthanasia, which are usually the result of an interaction in which the needs and character of family, friends, and doctor play as big and often bigger roles than those of the patient. Supporting or denying a request to die is not an adequate response. A comprehensive psychiatric assessment must include inquiring into the source of the patient's desperation and undertaking to relieve it.

No. 17F
LIABILITY AND SUICIDE

Thomas G. Gutheil, M.D., *Department of Psychiatry, Massachusetts Mental Health Center, 74 Fenwood Road, Boston MA 02115*

SUMMARY:

This presentation will cover the fundamentals of malpractice, including the four necessary elements: negligence, doctor-patient relationship, "proximate cause," and damages. In general, malpractice litigation results from the combination of a bad outcome and bad feelings.

Outpatient suicide, inpatient suicide, and suicide after release or escape from the hospital will be reviewed along with questions that arise about the care in each setting. The three legal conceptualizations of the patient in suicide cases will be discussed: (1) Patient as child; physician as negligent parent, (2) Patient as product; physician/hospital as creator of defective product, (3) Bereaved family as victims; physician's insurance policy as source of funds.

Empirical studies demonstrate relatively low accuracy of prediction and low forseeability of dangerous acts by patients. Nevertheless, the courts rule as though failure to predict and prevent dangerousness constitutes negligence. General liability prevention guidelines for clinicians will be presented.

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INDUSTRY-SUPPORTED SYMPOSIUM 18—OPTIMIZING WELLNESS ACROSS THE LIFE CYCLE OF SCHIZOPHRENIA

Supported by U.S. Pharmaceuticals, Pfizer Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the factors that are critical to successfully manage schizophrenia throughout the unique phases of this illness. Topics include prodromes and first episodes, relapse prevention, managing compliance with treatment, and mortality in schizophrenia.

No. 18A
MANAGING THE FIRST EPISODE

John M. Kane, M.D., *Department of Psychiatry, Hillside Hospital, 75-59 263rd Street, Glen Oaks NY 11004-1150*

SUMMARY:

The initial treatment of an individual who has developed schizophrenia is a critical challenge, first of all because there are all too often inordinate delays in seeking, accepting, or receiving appropriate treatment. Second, the effectiveness and acceptability of the earliest treatment strategies will in all likelihood set the stage for what follows. Third, at this phase of the illness, good treatment response is likely for most patients, leading in many cases to an underestimation of the risk of recurrence. As a result, many patients discontinue medication with a high rate of relapse. Until recently, lack of prospective data and few long-term treatment trials, coupled with concern about the long-term adverse effects of conventional antipsychotics, resulted in hesitancy to strongly recommend maintenance treatment for more than one year following recovery from a first episode. New generation drugs appear to be associated with significantly reduced risk of adverse effects, including tardive dyskinesia. This, coupled with more data from prospective studies, could alter our recommendations. The challenge of psychoeducation and patient acceptance will continue, however, to be an important focus.

No. 18B
MEETING LONG-TERM TREATMENT GOALS: RELAPSE PREVENTION AND MORE

Nina R. Schooler, Ph.D., *Department of Research, Hillside Hospital, 75-59 263rd Street, Glen Oaks NY 11004*

SUMMARY:

The goals of maintenance treatment in schizophrenia are to preserve the gains made during acute treatment, prevent symptom exacerbation, seek further improvement in psychopathology, enhance social functioning, and improve quality of life. Meeting these goals has represented an elusive target. A brief review of recent long-term clinical trials of neuroleptic medication and psychosocial treatment (e.g., Schooler et al, 1997) will provide an estimate of the effects of these established treatments on long-term outcome.

One of the promises of second-generation antipsychotic medication is that long-term outcome will be improved through several mechanisms: improved symptom efficacy, enhanced compliance because of reduced side effects, and improved social functioning mediated by improved prevention of relapse and improvements in cognition. Studies of such long-term effects of second-generation antipsychotic medications are limited. However, data from a 12-month study comparing ziprasidone with placebo treatment in clinically stabilized but hospitalized schizophrenic patients provide the opportunity to estimate long-term effects on symptom exacerbation, psychopathology, and side effects (Arato, 1997). The implications of the findings from this study for long-term community outcome with second-generation antipsychotic medications will be discussed in relation to the extensive body of data about the older medications.

No. 18C
IMPROVING COMPLIANCE AND BUILDING ALLIANCES

Peter J. Weiden, M.D., *Department of Psychiatry, St. Luke's/Roosevelt Hospital, 411 West 114th Street, Suite 3B, New York NY 10025;* Annette Zygmunt, M.S.

SUMMARY:

Noncompliance is traditionally associated with ruptures in the therapeutic relationship. Doctors may blame their patients for disobedience, or patients may blame their doctors for shortcomings of their medications. Shifting to a wellness approach means addressing compliance issues in ways that enhance the alliance rather than erode it.

Assessment and alliance: Honest reporting of compliance can be facilitated by normalizing noncompliant behavior and remaining nonjudgmental when noncompliance is reported. When trying to understand the reasons behind noncompliance, taking the patient's point of view can further build an alliance.

Psychosocial management: Psychoeducation needs to match the patient's knowledge level and family's underlying health beliefs. Key components of compliance-oriented therapy include normalizing symptoms within a stress-vulnerability model, avoiding diagnostic labels, and focusing on how to reach life goals instead of just staying out of the hospital (Kemp, 1996).

Efficacy issues: Clinicians need to consider using *either* a long-acting, depot conventional antipsychotic *or* an atypical antipsychotic, with depot usually favored for persistent noncompliance unrelated to side effects. However, efficacy problems are often the underlying cause of relapse. Then, noncompliance is a sign of relapse, not a cause, and the central issue becomes improving efficacy.

Side-effect considerations: As EPS problems diminish with the newer medications, other side-effect concerns will become more prominent (e.g., amennorhea and weight gain), and non-EPS concerns also need to be considered when optimizing a patient's sense of wellness. Ultimately, whichever medication is chosen, it is important to always remain in touch with side-effect concerns.

No. 18D
SCHIZOPHRENIA TOWARDS THE END OF THE LIFE CYCLE

Trey Sunderland, M.D., *Department of Geriatric Psychiatry, National Institute of Mental Health, 10 Center Drive, MSC1264, 10-3D41, Bethesda MD 20892*

SUMMARY:

Any discussion of geriatric schizophrenia and other psychoses must first differentiate between issues concerning the treatment of a long-term condition in the elderly and the diagnosis and management of new symptoms occurring late in life. For long-term schizophrenia patients entering their later years, new pharmacologic challenges naturally arise, including increased drug sensitivities, comorbid medical conditions, the confounding cognitive declines associated with age and chronic illness, and the late-emerging sequelae of long-term treatment of schizophrenia. The more challenging academic issues in geriatric schizophrenia involve the differential diagnosis and etiology of late-onset schizophrenia or delusional disorder and the relationship between geriatric schizophrenia and other cognitive disorders, such as Alzheimer's disease (AD), in the elderly. For instance, AD patients often display delusional psychosis and/or negative symptoms, suggesting that coordinated evaluations and treatment approaches may be of benefit to selected subsets of each group. Furthermore, the cholinergic system provides another arena for both direct comparison of similarities as well as paradoxical contrasts between these conditions.

To date, there are still large gaps in the knowledge base in geriatric schizophrenia, especially when compared with declines associated with normal aging and AD, suggesting that further studies are required to better understand the neurobiologic and clinical interactions between these important conditions in the elderly.

No. 18E
MORBIDITY AND MORTALITY IN SCHIZOPHRENIA

Daniel E. Casey, M.D., *Department of Psychiatry, Veterans Affairs Medical Center, 3710 SW US Veterans Hospital Road, Portland OR 97201*

SUMMARY:

Schizophrenia is life-long debilitating illness for most patients. In addition to the substantial difficulties and disabilities associated with schizophrenia, there is an increased rate of morbidity and mortality compared with age-matched populations. Possible explanations for increased morbidity include that patients with schizophrenia are less able to participate in the care of their coexisting medical illness, such as heart disease and diabetes. Also, behaviors such as the exceptionally high rates (greater than 50%) of cigarette smoking in patients with schizophrenia contribute to excess morbidity. Additionally, patients with schizophrenia are overweight, as measured by body mass index, when compared with a similar population without schizophrenia. Increased mortality is also a well-recognized feature of the long-term course of schizophrenia. Rates of depression are estimated to be 10–20 times higher than the population without schizophrenia. Lifetime suicide rates approximate 8%–10% of patients with schizophrenia. Additionally, the increased morbidity from coexisting medical conditions may contribute to higher overall death rates in patients with chronic psychosis. The role of new, novel (atypical) antipsychotics may play a complex role in affecting the long-term outcome of morbidity and mortality. Evidence suggests that the new agents have greater efficacy in managing negative symptoms and may have antidepressant efficacy. Thus, they may improve the drive and ability to participate in the care of coexisting medical illness and may aid in reducing suicides. However, weight gain, which is associated with some of the novel antipsychotics, may increase the morbidity and mortality risks of other medical conditions. These data regarding morbidity and mortality in schizophrenia as well as the complex role of novel antipsychotic agents will be reviewed and analyzed.

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2. Schooler NR, Keith SJ, Severe JB, et al: Relapse and rehospitalization during maintenance treatment of schizophrenia: the effects of dose reduction and family treatment. Archives of General Psychiatry 1997;54:453–464
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INDUSTRY-SUPPORTED SYMPOSIUM 19 (PART 1)—ANXIETY AND DEPRESSION: CAUSE OR EFFECT?
Supported by Wyeth-Ayerst Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the effect of pre-existing anxiety on the risk for developing secondary depression, the clinical consequences of coexisting anxiety and depression, the effect of the changes in DSM diagnostic hierarchy, and the treatment implications of comorbid anxiety and depression.

No. 19A
NEUROBIOLOGY OF ANXIETY AND MOOD DISORDERS

Jeremy D. Coplan, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, Unit 24, New York NY 10032*

SUMMARY:

There is a striking overlap between anxiety and depressive disorders with respect to comorbidity, nosology, treatment response, and neurobiological features. Corticotropin-releasing factor (CRF) is modulated by and modulates brain monoamine systems (serotonin, norepinephrine, and dopamine) and also regulates the organism's response to stress via the hypothalamic-pituitary-adrenal (HPA) axis. CRF has assumed an important role in understanding the neurobiology of anxiety and mood disorders. CRF administered to animals can produce signs and symptoms of mood and anxiety disorders. HPA axis hyperactivity is well documented in major depressive disorder (MDD). Overactivity of CRF in MDD is suggested by elevations in CSF of drug-free depressives and normalization following response to pharmacological and electroconvulsive treatment. HPA axis overactivity in panic disorder (PD) is similar to, but less dramatic than, that observed in MDD. Although CSF CRF does not appear elevated in PD, central CRF hyperactivity, as reflected by plasma cortisol levels and hyperventilation, is observed in lactate-sensitive PD patients. In post-traumatic stress disorder (PTSD), CSF CRF elevations are observed. In contrast to MDD and PD patients, PTSD patients exhibit HPA axis suppression. Unraveling the diverse manifestations of CRF/HPA axis dysfunction in anxiety and mood disorders may enhance understanding of clinical course and treatment response.

No. 19B
WHY DO ANXIOUS PEOPLE BECOME DEPRESSED?

Philip T. Ninan, M.D., *Department of Psychiatry, Emory University, 1701 Uppergate Drive, Room 126, Atlanta GA 30322;* Donald J. Newport, M.D.

SUMMARY:

The National Comorbidity Survey reported that 58% of individuals with a lifetime episode of major depression also met criteria for an anxiety disorder. The anxiety disorder developed first in 68% of individuals with major depression, developing, on average, 11 years later. So why do anxious people become depressed, and what are the implications of suffering from both conditions?

Anxiety disorders are heterogenous even within each diagnostic label, similar to major depression. Thus a simple explanation of the association of the two conditions is unrealistic. More recent editions of the DSM have suspended hierarchical rules that gave priority to

major depression in the presence of an anxiety disorder. Comorbidity in medicine defines the presence of two diseases with separate pathophysiologies. However, psychiatric diagnoses are syndromal clustering of symptoms, and a more appropriate term is cosyndromal. The epidemiologic literature uses the term comorbidity as simply meaning co-occurrence of symptoms. The primary-secondary distinction based on the sequence of symptom development has considerable value, but the reliability of the assessment of the temporal development of symptoms has been questioned.

Potential implications when an anxiety disorder and major depression coexist will be explored, with treatment recommendations for clinicians presented.

No. 19C
TREATMENT OF ANXIOUS/DEPRESSED PATIENTS

R. Bruce Lydiard, M.D. *Department of Psychiatry, Medical University of South Carolina, 171 Ashley Avenue, Suite 404, Charleston SC 29425*

SUMMARY:

Depression and anxiety co-occur frequently in patients who seek treatment for depression. Studies indicate that over half of patients presenting with major depression may have a concomitant anxiety disorder. Another significant percentage of patients have subdiagnostic anxiety or depressive symptoms that are clinically significant. The most common anxiety disorders in patients seeking treatment for depression include generalized anxiety disorder, panic disorder, and social phobia. There is virtally no information regarding optimal treatment of patients with comorbid major depression and anxiety common, optimal treatment is essential.

After highlighting the existing literature, potential treatment strategies will be presented. The ideal situation is the use of one agent for both anxiety and depression. Other strategies used will be determined by the clinical picture. These include the use of combined anxiolytics and antidepressants, augmentation with other agents, cognitive/behavioral treatments, and others. Finally, some of the remaining questions will be discussed.

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1. Ballenger JC: Comorbidity of panic and depression: implications for clinical management. Int. Clin Psychopharmacol 1998; 13 Suppl 4:S13–S17.
2. Winokur G: The concept of secondary depression and its relationship to comorbidity. Psychiatric Clinics of North America 1990;13:567–583.
3. Lydeard RB, Brawman-Mintzer O: Anxious depression. J Clinical Psychiatry 1998;59 (Suppl 18):10-17

INDUSTRY-SUPPORTED SYMPOSIUM 19 (PART 2)—ANXIETY AND DEPRESSION: CAUSE OR EFFECT?
Supported by Wyeth-Ayerst Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the effect of pre-existing anxiety on the risk for developing secondary depression, the clinical consequences of coexisting anxiety and depression, the effect of the changes in DSM diagnostic hierarchy, and the treatment implications of comorbid anxiety and depression.

No. 19A
THE IMPACT OF DEPRESSION ON THE COURSE OF ANXIETY DISORDERS

Jane L. Eisen, M.D., *Butler Hospital, Brown University, 345 Blackstone Boulevard, Providence RI 02906;* Martin B. Keller, M.D., Robert Stout, Ph.D.

SUMMARY:

There has been increasing interest over the past decade in the co-occurrence of depressive and anxiety symptoms. The relationship between depression and anxiety has been investigated systematically in the Harvard Anxiety Disorder Research Project (HARP), a large, prospective study of 711 subjects with DSM-III-R anxiety disorders followed longitudinally for six to nine years. Comorbidity between DSM-III-R major depression and certain anxiety disorders, (panic disorder, generalized anxiety disorder, and/or social phobia) was found to be quite high. We have examined the effect of major depression on the likelihood of remission from these anxiety disorders and on psychosocial functioning. At baseline, 26% of subjects with panic disorder, 35% with social phobia, and 39% with generalized anxiety disorder were in current episodes of major depressive disorder. The presence of major depression at intake was significantly associated with morbidity, comorbidity, and psychosocial functioning in patients with panic disorder. Decreased psychosocial functioning (work and social functioning impairment and lower GAS scores) were found in patients with major depression and panic disorder at intake vs. those with panic disorder without major depression. Increased comorbidity with Axis II personality disorders was more prevalent in the major depression plus panic disorder group as was increased frequency of post traumatic stress disorder. The total number and frequency of panic symptoms, age of onset of panic symptoms, sex, age distribution, and educational and occupational level were similar regardless of whether patients had comorbid depression. Increased morbidity (significantly more suicide attempts and hospitalizations) was found in patients with both a depressive disorder and panic disorder. HARP findings suggest a continuum of risk associated with depressive disorders in patients with anxiety disorders, while more severe mood disorders were associated with higher risk of suicidal behavior. Almost all subjects who made suicide attempts or gestures in the past had histories of depressive disorders and all patients who attempted suicide during follow-up met criteria for a depressive disorder. Major depression at intake did not predict likelihood of remission from panic disorder over five years. However, remission from depression during the course of this study was associated with recovery from panic disorder over time. In addition, higher levels of depression severity lengthened the time that patients stayed in an episode of panic disorder. How these findings inform treatment and psychoeducation of the patient with both major depression and an anxiety disorder will be discussed.

No. 19B
ANXIOUS DEPRESSION: CLINICAL CHARACTERISTICS AND TREATMENT OPTIONS

James C. Ballenger, M.D., *Department of Psychiatry, Medical University of South Carolina, 850 MUSC Complex, Suite 553, Charleston SC 29425*

SUMMARY:

Depression and anxiety often coexist. As it was initially conceived, the term "anxious depression" was clinically useful because it described a subgroup of depressed patients with specific features and differential treatment response. However, changes in the DSM diagnostic system that now allow for concurrent diagnosis of anxiety and mood disorders, can more specifically allow for identifications of clinical subgroups of depressed patients. When anxiety and depres-

sion co-occur, patients are typically more severely ill, more treatment resistant and experience increased morbidity and more suicide attempts. Attention to particular features of both anxiety and depression may theoretically have significant effects on treatment outcome.

This presentation will highlight some historical aspects of "anxious depression" and will also review some aspects of the differential diagnosis of coexisting depression and anxiety. At least half of patients presenting with depression have a comorbid anxiety disorder. An additional subgroup have clinically significant anxiety symptoms. The most commonly observed anxiety disorders detected in patients seeking treatment for depression include generalized anxiety disorder, panic disorder, and social phobia. The literature regarding optimal treatment of patients with comorbid major depression and anxiety disorders is scanty. 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 literature, potential treatment strategies will be presented and remaining questions will be discussed.

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INDUSTRY-SUPPORTED SYMPOSIUM 20 (Part 1)—NEW CLINICAL ADVANCES IN MANAGING ANXIETY AND DEPRESSIVE DISORDERS THROUGHOUT THE LIFE CYCLE

Supported by Bristol-Myers Squibb

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to demonstrate practical strategies for selecting antidepressants, diagnose and treat PTSD and panic disorder using the latest pharmacological approaches, and list treatment options for ADHD in children and anxiety disorders in the elderly.

No. 20A
A GUIDE FOR THE RATIONAL SELECTION OF ANTIDEPRESSANTS BASED ON THEIR SIDE-EFFECT PROFILES

Norman Sussman, M.D., *Department of Psychiatry, New York University School of Medicine, 20 East 68th Street, Suite 204, New York NY 10021-5836*

SUMMARY:

Consideration of potential side effects is an important aspect of antidepressant drug selection and use. While no single agent or class of agents has emerged as having superior efficacy (if variability in effectiveness does exist, it has not been demonstrated in controlled studies), both research and clinical experience show that there are significant differences in side effects. Knowledge of potential side effects and the management of side effects once they emerge represent an essential aspect of clinical skill, especially for psychiatrists.

Side effects can be classified in three categories based on temporal features. Early-onset, time-limited side effects emerge at the outset of treatment, but abate or disappear with time. These side effects can often be managed by using lower doses and using slow upward dose titration. Early-onset, persistent side effects occur at the start and continue largely unchanged over time. Late side effects do not emerge until weeks or months have passed. The latter two types of adverse events more typically require the addition of a second drug to offset the side effect. Sexual dysfunction and sleep disturbances associated with SSRIs and venlafaxine, for example, may respond to add-on medication. However, several drugs do not produce sexual dysfunction. These are nefazodone, mirtazapine, and bupropion. For patients in whom impairment of sexual performance or desire represents a potential barrier to compliance, these agents represent reasonable choices. Nefazodone and mirtazapine do not produce significant sleep disturbance or activation, such as agitation or anxiety, making these drugs preferred agents in cases where patients are anxious or have insomnia. The SSRIs are known for their appetite-suppressing properties early in treatment, but clinical experience and some controlled studies suggest that they actually cause weight gain in some patients during long-term treatment. Weight gain associated with mirtazapine tends to be an acute effect that diminishes with time. Contrary to their image as activating agents, SSRIs produce considerable sedation and lethargy in a substantial minority of patients. Nefazodone is mildly sedating early in treatment, but this side effect diminishes with ongoing treatment.

No. 20B
LONG-TERM TREATMENTS OF DEPRESSION: WHAT TO DO WHEN ANTIDEPRESSANTS STOP WORKING

Anthony J. Rothschild, M.D., *Department of Psychiatry, University of Massachusetts Medical Center, 55 Lake Avenue North, Room S7-802, Worcester MA 01655*

SUMMARY:

Many patients with unipolar depression experience a return of depressive symptoms while taking a constant maintenance dose of an antidepressant ("antidepressant tachyphylaxis," "poop-out"). Data from published reports of antidepressant tolerance will be reviewed that indicate a return of depressive symptoms occurring during maintenance antidepressant treatment in 9%–33% of patients. Possible explanations for this phenomena will be discussed including the loss of placebo effect, pharmacological tolerance (either pharmacodynamic or pharmacokinetic), increase in disease severity, change in disease pathogenesis (either due to or independent of antidepressant therapy), the accumulation of a detrimental metabolite, unrecognized rapid cycling, and prophylactic inefficacy. Several strategies have been proposed to overcome tolerance to antidepressants including adjusting the medication dosage (obtaining serum levels where appropriate), augmentation with various medications, the use of drug holidays, and switching to a different antidepressant. Data in support of these strategies as well as their practical application by busy clinicians will be discussed.

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INDUSTRY-SUPPORTED SYMPOSIUM 20 (Part 2)—NEW CLINICAL ADVANCES IN MANAGING ANXIETY AND DEPRESSIVE DISORDERS THROUGHOUT THE LIFE CYCLE
Supported by Bristol-Myers Squibb

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to demonstrate practical strategies for selecting antidepressants, diagnose and treat PTSD and panic disorder using the latest pharmacological approaches, and list treatment options for ADHD in children and anxiety disorders in the elderly.

No. 20A
EMERGING CLINICAL STRATEGIES FOR COMPREHENSIVE TREATMENT OF PTSD

Thomas A. Mellman, M.D., *Department of Psychiatry, Veterans Affairs Medical Center, 1201 NW 16th Street, 116A, Miami FL 33125*

SUMMARY:

Recent epidemiological studies estimate the lifetime prevalence of PTSD to be 8% among adults in the United States. Most cases of PTSD feature comorbidity and about one-third persist for many years. The more common antecedents of PTSD include sexual and other assaultive violence, traumatic losses, and war trauma. Risk for PTSD increases as a function of the duration and intensity of trauma. PTSD, however, develops and persists in the minority of most trauma-exposed populations. Efforts in the field are therefore focusing on understanding mechanisms of pathogenesis with the goal of improving and developing interventions for treatment and prevention.

Clinical and experimental evidence implicate emotional information processing in PTSD. Exposure and related cognitive-behavioral therapies (CBTs) target intrusive thought processes and cognitive distortions. CBTs have been demonstrated to be effective, with most of the evidence coming from rape victims. The rationales for medication treatment for PTSD includes frequent comorbidity and overlap with mood and anxiety disorders, heightened physiologic reactivity, and sleep disturbance. Alterations of specific neurobiological systems are supported by studies utilizing neuroendocrine probes and neuroimaging. Despite these advances, research on medication treatment for PTSD is at an early stage. The status and potential utility of treatments that affect mood regulation, sleep disturbance, and serotonergic, noradrenergic, and other neurotransmitter systems will be reviewed.

PTSD appears to be a complex disorder with a range of presentations. Guidelines will be suggested for treatment planning, with consideration of the nature of the trauma, duration of PTSD, and prominent symptomatology and comorbidity.

No. 20B
NEW ADVANCES IN THE TREATMENT OF PANIC DISORDER

Justine M. Kent, M.D., *Department of Psychiatry, Columbia University, 722 West 168th Street, Unit 24, New York NY 10032;* Laszlo A. Papp, M.D., Jeremy D. Coplan, M.D., Jack M. Gorman, M.D.

SUMMARY:

Until recently, the mainstay of panic disorder pharmacotherapy has been the tricyclic antidepressants, the high-potency benzodiazepines, and the monoamine oxidase inhibitors. The serotonin reuptake inhibitors (SSRIs) have rapidly become the first-line treatment for panic disorder due to demonstrated efficacy, superior side-effect profiles, and easy-to-follow dosing regimens. The current generation of SSRIs have little to no anticholinergic and cardiac side effects; however, a major drawback of treatment remains the high incidence of sexual side effects and weight gain. A new generation of antidepressants may address some of these shortcomings. The highly specific serotonin reuptake inhibitor citalopram and the serotonin-norepinephrine reuptake inhibitor venlafaxine have now been shown to be effective treatments for panic disorder. The antidepressants nefazodone, mirtrazepine, and moclobomide are also being used in treatment. Other agents with promise include the partial GABA agonist pagoclone and the anticonvulsant gabapentin. Pharmacologic treatment strategies for patients with refractory panic disorder include adding a tricyclic and/or benzodiazepine to SSRI therapy or changing to a newer antidepressant. Children and elderly patients tolerate lower doses best, while first-line treatment for these groups is preferably cognitive-behavioral therapy (CBT). Pharmacologic strategies incorporating newer medications combined with CBT may result in superior outcomes for patients.

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INDUSTRY-SUPPORTED SYMPOSIUM 21 (Part 1)—BEYOND EFFICACY IN PSYCHOSIS: PATIENT SATISFACTION, COMPLIANCE AND OUTCOMES
Supported by Zeneca Pharmaceuticals

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize that evaluating pharmacologic treatments of psychosis goes beyond efficacy and includes measures of safety and effectiveness. Indicators for effectiveness include improvements in patients' quality of life, satisfaction, and adherence/compliance. Involving the caregiver can also enhance effectiveness and lead to better outcomes (eg, clinical, social, and vocational).

No. 21A
ANTIPSYCHOTIC MEDICATION AND COGNITION

Alexander L. Miller, M.D., *Department of Psychiatry, University of Texas Health Sciences Center, 7703 Floyd Curl Drive, San Antonio TX 78284-6200;* Dawn I. Velligan, Ph.D., C. Christine Bow-Thomas, Ph.D.

SUMMARY:

Patients with schizophrenia frequently show specific deficits in cognitive performance superimposed on a generalized impairment. Acute exacerbations of schizophrenia impair cognitive performance above and beyond baseline deficits. Conventional antipsychotics may ameliorate the deficits that are secondary to acute exacerbations, but do not help core deficits and impair some aspects of performance. Anticholinergic medications worsen memory-based task performance. Atypical antipsychotics, as a group, seem to improve cognitive performance relative to conventional antipsychotics. The profile of changes in cognitive performance with atypicals can be related to

dose and to pharmacologic properties of the particular agent. Since improved cognitive abilities potentially improve long-term outcomes, the identification of cognitive deficits is a key step in defining appropriate psychosocial interventions. Choosing the antipsychotic that is least likely to interfere with cognitive function and monitoring its dosage to optimize cognition can lead to better patient satisfaction and overall outcome.

No. 21B
PRACTICAL MANAGEMENT OF AGITATION AND AGGRESSION

Soo Borson, M.D., *Department of Psychiatry, University of Washington School of Medicine, 1959 NE Pacific Street, Box 356560, Seattle WA 98195*

SUMMARY:

This presentation focuses on techniques for the safe use of atypical antipscyhotics in the management of agitation and aggression in elderly demented patients, and highlights evidence for their clinical efficacy in aggression associated with schizophrenia, mental retardation, brain injury, autism, and personality disorders with episodic aggression outbursts. Agitated and aggressive behaviors symptomatic of a broad range of mental disorders across the lifespan often frighten and distress patients, can endanger others, and are prominent causes of long-term psychiatric hospitalization. Successful long-term control of recurring disruptive behaviors requires both effective pharmacotherapy and a firm, individualized "safety net" designed for each patient in the context of his or her social and health care network. Drug treatments that work include antipsychotic agents, anticonvulsants, and, for acute management only, short-acting benzodiazepines. Strategies for optimizing treatment effectiveness and adverse outcomes include systematic longitudinal behavioral assessment; monitoring for early detecting of cognitive, behavioral, and neurological side effects; and advance planning for alternative approaches should initial treatment fail. For patients with and without dementia, pscyhosocial interventions enhance overall outcomes, and include: (1) maintaining a flexible, long-term, personalized psychotherapeutic orientation to care; (2) forming bridging alliances between patients, family members, case managers, landlords or sheltered care staff, and primary care physicians; (3) creating opportunities for positive social exchange and realistic appraisal of the patient's situation, through individual and group therapies and activity programs when indicated; and (4) educating members of the patient's caring network about the nature of aggressive behavior and techniques for de-escalating confrontational interactions and reducing risk of their recurrence. Combining pharmacologic with psychosocial interventions offers a model of comprehensive care that is proactive and implies ongoing advocacy for the patient's best interests, both within and beyond the clinical setting.

No. 21C
EXTRAPYRAMIDAL SIDE EFFECTS AND TARDIVE DYSKINESIA: IMPACT ON COMPLIANCE AND OUTCOME

John M. Kane, M.D., *Department of Psychiatry, Hillside Hospital, 75-59 263rd Street, Glen Oaks NY 11004-1150*

SUMMARY:

Although conventional antipsychotic drugs revolutionalized the care of patients with schizophrenia, their propensity to produce adverse neurologic side effects has remained a considerable drawback. These adverse effects have contributed to problems in a number of domains. First, acute extrapyramidal side effects such as dystonia and akathesia can be subjectively distressing and lead to fearfulness of treatment and noncompliance. Second, phenomena such as akinesia and akathesia can interfere with functioning. Third, akathesia can mimic tension or psychotic agitation and akinesia can mimic some aspects of negative symptoms, thereby complicating differential diagnosis and sometimes leading to treatment errors. Fourth, these adverse effects may require adjunctive treatment with pharmacologic agents that carry their own burden of adverse effects (including the potential cognitive changes associated with anticholinergic agents). Fifth, the slowness, rigidity, and lack of spontaneity associated with drug-induced parkinsonism or even the mild abnormal involuntary movements associated with tardive dyskinesia can add to the stigmata of schizophrenia, making patients look strange or peculiar and adding unnecessarily to the burdens and obstacles associated with the illness.

The new generation antipsychotic agents such as risperidone, olanzapine, and quetiapine are associated with significantly fewer such effects and represent an important advance in improving both outcome and benefit-to-risk ratio.

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INDUSTRY-SUPPORTED SYMPOSIUM 21 (Part 2)—BEYOND EFFICACY IN PSYCHOSIS: PATIENT SATISFACTION, COMPLIANCE AND OUTCOMES
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No. 21A
HYPERPROLACTENEMIA AND SEXUAL DYSFUNCTION: RELATIONSHIP TO PATIENT SATISFACTION AND ADHERENCE

Lili C. Kopala, M.D., *Department of Psychiatry, Dalhousie University, 5909 Jubilee Road, Halifax, NS, B3H 2G2, Canada*

SUMMARY:

Concerns about sexual and reproductive function are common among people taking psychotrophic medications, especially antipsychotics. Many patients are uncomfortable discussing these issues. As clinicians, knowing about the underlying hormonal consequences of antipsychotic therapy and listening to what really matters to patients about this aspect of their lives should improve the overall well-being of persons with serious mental illness. Elevation of prolactin is commonly associated with dopamine blockade. Hyperprolactinemia, in turn, affects the production of sex hormones in men and women, resulting in a wide variety of complaints (e.g., decreased sexual interest and performance, sub-fertility) and possibly some longer-term health problems (e.g., negative effects on bone mass, cardiovascular function). Patients with psychotic disorders often have lifelong illnesses and require long-term treatment with antipsychotics. The goal of this presentation is to increase the awareness of the sexual and reproductive-related side effects of these necessary medications and to encourage clinicians to inquire about multiple domains of health. Choosing antipsychotics that are less likely to affect these domains could have a positive impact upon the overall treatment outcome by improving patient satisfaction and, consequently, adherence with their antipsychotic medication.

No. 21B
INVOLVING THE CAREGIVER TO OPTIMIZE OUTCOMES IN PSYCHOSIS

Laurie M. Flynn, M.A., *National Alliance for Mentally Ill, 200 North Glebe Road, Suite 1015, Arlington VA 22203*

SUMMARY:

In today's rapidly changing environment, patients and physicians must rely more strongly than ever on families. The advent of new treatments and the introduction of managed care for seriously ill people requires skill and patience if outcomes are to be improved. Families routinely play many essential roles vital to effective management of psychosis. These roles include the following:

—Primary daily caregiver
—Historian of patients' setbacks and progress
—Moral support and encouragement during crisis
—Negotiator with players in health care system
—Regular coordinator of medical and social services
—Advocate for new treatments and services
—Evaluator of interventions and outcomes
—Financial supporter
—Educator of patient and often provider, too
—"Cheerleader"—provider of hope

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1. Schlechte J, Walkner L, Kathol M: A longitudinal analysis of oremenopausal bone loss in healthy women and women with hyperprolactinemia. J Clin Endocrinol Metab 1992;75:698–703
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INDUSTRY-SUPPORTED SYMPOSIUM 22 (Part 1)—STRATEGIES AND TACTICS TO MANAGE DEPRESSED PATIENTS
Supported by Organon Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to tell whether: (1) baseline features predict who will respond; (2) symptomatic emission is critical or whether response is sufficient; (3) there are faster and lower responders to various treatments for depression; and (4) we can predict ultimate response from early symptom change patterns in those receiving antidepressants.

No. 22A
WHICH BASELINE SYMPTOM FEATURES PREDICT RESPONSE TO PARTICULAR ANTIDEPRESSANT MEDICATIONS?

A. John Rush, M.D., *Department of Psychiatry, University of Texas Southwestern Medical Center, 5959 Harry Hines Boulevard, Suite 9086, Dallas TX 75235-9070*

SUMMARY:

The efficient use of limited treatment resources would be increased substantially in the treatment of depressed patients *if* we could select the correct antidepressant medication at the onset for an individual patient. Ideally, some characteristics of either the patient or the illness would point strongly toward selecting one agent or class above others. As it stands, any one antidepressant medication benefits about 50% to 55% of patients who begin the treatment. If the first treatment fails, then another antidepressant, often from a different class, is tried (or an augmenting agent is added to the first if the latter produces some but not optimal benefits).

This presentation reviews published data and presents new findings to address the issue of selecting an agent based on the nature of cross-sectional symptom features present when treatment begins. For example, analyses to determine whether more "activating" antidepressants, such as desipramine or bupropion, are less effective in depressed patients with more anxiety, or whether more sedating agents are more effective in those with more anxiety will be presented. Obstacles and limitation to selecting among agents based on symptomatic presentation will be discussed.

No. 22B
RESPONSE VERSUS REMISSION: A DISTINCTION WITH A CLINICAL DIFFERENCE?

Madhukar H. Trivedi, M.D., *Department of Psychiatry, University of Texas Southwestern Medical Center, 5959 Harry Hines Boulevard, #520, Dallas TX 75235*

SUMMARY:

Major depressive disorder is not only highly prevalent, but also associated with significant morbidity and mortality. Yet not only is major depressive disorder underdiagnosed, even when it is properly identified it is often inadequately treated, especially in terms of residual symptoms and persistent functional impairments. The growing awareness of the chronicity and recurrence of depressive episodes has prompted the defining of response (symptom reduction) versus remission (no more than minimal symptoms with return of function). Further, remission is distinguished from recovery (several months of sustained remission). Evidence for efficacy of antidepressant medications is based on response (i.e., 50% symptomatic reduction) rather than on complete remission, indicating that optimal treatment

strategies remain to be determined. There is a strong correlation between the degree of response and the level of morbidity. For patients whose symptoms do fully remit, functioning usually returns to the premorbid level. It is this fact that dictates that the optimal goal of treatment be full remission. Studies reveal that too often patients do not get the correct medications, or at the correct dose, or in the right dose and combination for the time required for their illness to yield full response. A meta-analysis of randomized controlled trials found that with an intent-to-treat sample, response rates were approximately 50%, whereas full remission was found in only 30% to 35% of patients.

This presentation will address the rationale and techniques for achieving remission as opposed to response. It will also address the role of treatment algorithms for major depressive disorder.

No. 22C
ARE THERE FASTER AND SLOWER RESPONDERS TO ANTIDEPRESSANT MEDICATION AND WHO ARE THEY?

Andrew A. Nierenberg, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC 812, Boston MA 02114-3117;* Amy Farabaugh, M.A., Lindy E. Graham, B.A., Jonathan E. Alpert, M.D., Maurizio Fava, M.D., Jerrold F. Rosenbaum, M.D.

SUMMARY:

For reasons not yet clear, some patients appear to respond rapidly while others require more time. Pattern analysis suggests that rapid responders who have an acute, unstable course may be experiencing a placebo response, rather than a true drug response. In contrast, patients who respond quickly and maintain their response, i.e., an early, persistent response pattern, may have a true drug response. It is clinically important for physicians and their patients to know when to expect the onset of clinical improvement due to a true drug response. Speed of onset of a true drug response may also vary between antidepressants. This presentation will review evidence from multiple clinical trials to determine factors associated with early persistent, as compared with late, response to antidepressants. Also, available evidence will be evaluated to determine if different antidepressants are associated with faster onset of action. These data will be useful for physicians to be able to predict time of onset of response for their patients.

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INDUSTRY-SUPPORTED SYMPOSIUM 22 (Part 2)—STRATEGIES AND TACTICS TO MANAGE DEPRESSED PATIENTS
Supported by Organon Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

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No. 22A
ARE THERE FASTER AND SLOWER PSYCHOTHERAPY RESPONDERS?

John C. Markowitz, M.D., *Department of Psychiatry, Cornell University Medical College, 445 East 68th Street, Suite 3N, New York NY 10021*

SUMMARY:

Time-limited psychotherapies, particularly cognitive-behavioral therapy (CBT) and interpersonal psychotherapy (IPT), have demonstrated efficacy in treating depressive episodes. Clinical observation suggests that some patients show a symptomatic response early in these 12- to 20-week therapies, whereas other patients take longer to respond. At what point should the psychotherapist recognize that the patient is unlikely to respond and consider alternative treatments? Little research has formally addressed this important question of time to response and the clinical factors that might predict it.

This presentation will review data from large, recent treatment trials to assess whether there are significant differences in, and predictors of, time to psychotherapy response. Analyses will also compare time to response *across* psychotherapies from comparative trials of CBT and IPT.

No. 22B
EARLY ANTIDEPRESSANT RESPONSE AS A PREDICTOR

Lorrin M. Koran, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, RH2263, Stanford CA 94305*

SUMMARY:

Predicting whether a patient with unipolar major depression will respond to a specific medication remains a challenge. Predictors that have been found to be insufficiently accurate for clinical use include: duration and severity of illness; presence of melancholia, psychomotor retardation, decreased interest, emotional withdrawal, or substantial stressors; comorbid, chronic, debilitating medical disorder; and, biologic markers (e.g., neurotransmitter metabolites in cerebrospinal fluid, neuroendocrine test results, and sleep characteristics, such as short REM latency).

Can early response to an antidepressant accurately predict outcome after eight to 12 weeks of treatment? If so, this would allow more cost-effective and more clinically fruitful care. This presentation will review data from several controlled trials of antidepressant drugs regarding the clinical usefulness of early response in predicting longer term outcome. The utility of analyzing the sensitivity, specificity, false-positive rate, false-negative rate, and kappa statistic applied to early response will be explored.

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INDUSTRY-SUPPORTED SYMPOSIUM 23 (Part 1)—CONTROVERSIES AND TREATMENT STRATEGIES IN BIPOLAR DISORDERS
Supported by Abbott Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the critical issues in diagnosing and treating bipolar disorder, examine the risk and benefits of the newer atypical agents and combinations of agents in managing mood disorders, and recognize that compliance and safety are integral to the successful treatment of bipolar disorder.

No. 23A
BIPOLAR II: DIAGNOSTIC AND THERAPEUTIC CONTROVERSIES

Hagop S. Akiskal, M.D., *Department of Psychiatry, University of California at San Diego, 9500 Gilman Drive, La Jolla CA 92093-0603*

SUMMARY:

Bipolar II, a relatively new mood disorder construct that refers to major depressions with subthreshold or hypomanic features, is classified as a bipolar subtype. There are, however, unresolved diagnostic and therapeutic questions. These include: (1) How should hypomania be differentiated from mania? (2) What if duration is shorter than four days, the lower threshold in DSM-IV? (3) What about hypomania during antidepressant treatment? (4) What about major depression superimposed on cyclothymic disorder? (5) Is comorbidity with anxiety disorders differentially distributed between bipolar I, bipolar II, and unipolar disorders? (6) Are bipolar II depressions psychomotor retarded or labile? (7) What proportion of unipolars progress to bipolar II, and what proportion of the latter progress to bipolar I? (8) Are all antidepressants equally effective for bipolar II? (9) When mood stabilizers are indicated, does lithium work as well as in bipolar I? What dosages of anticonvulsants should be used? and (2) What about the utility of atypical antipsychotics? This presentation will critically assess data from the author's research and the literature bearing on these vital clinical questions.

No. 23B
PROMISES AND PREDICTIONS FOR THE ATYPICAL ANTIPSYCHOTICS IN BIPOLAR DISORDER

Robert N. Golden, M.D., *Department of Psychiatry, University of North Carolina at Chapel Hill, CB#7160, Neurosciences Hospital, Chapel Hill NC 27599*

SUMMARY:

Conventional neuroleptics have played important roles in the management of bipolar disorder for many years, but there are concerns and limitations regarding their use. The risk for development of tardive dyskinesia may be even greater in patients with mood disorders than for those with schizophrenia. Antipsychotic medication is often used in the treatment of acute mania. Many clinicians, however, believe that neuroleptics may have a "depressogenic" effect. A number of case reports and preliminary studies suggest that some of the atypical antipsychotics may have antidepressant activity in patients with schizophrenia and other psychotic illnesses. Thus, these medications may be particularly useful for the treatment of acute mania or for psychotic depression in bipolar patients. Rapid cycling and mixed episodes can be especially difficult to control, and the role of adjunctive atypical antipsychotic medications should be explored. An understanding of the pharmacological profile of each atypical antipsychotic medication and of the biochemistry of bipolar disorders can help guide the predictions of which agents are most likely to play a role in the treatment of bipolar disorder.

No. 23C
CURRENT UPDATE ON BIPOLAR DISORDER: WHERE DO WE GO FROM HERE?

Charles L. Bowden, M.D., *Department of Psychiatry, University of Texas Health Sciences Center, 7703 Floyd Curl Drive, San Antonio TX 78284-7792*

SUMMARY:

The pace of research activity in bipolar disorder in practically all domains has increased during this decade. The introduction of expanded treatment strategies has heightened interest in assessment of other drugs developed initially for epilepsy. Drugs employed for schizophrenia and depression act principally on membrane receptors and neurotransmitter uptake systems, whereas those mood stabilizers act on several sites within the neuron by modulating the transmission of signals between neurons that started with electrical or chemical activation on the surface of the neuron. Several of the newer drugs allow much improved tolerability of treatment regimens. This has renewed interest in the study of bipolar disorder in subsets of patients previously difficult to diagnose and treat. The cross-sectional, symptomatic, criterion-based DSM diagnostic system has both contributed to and impeded progress in bipolar research. Reliability is clearly enhanced, thereby improving the generalizability and clinical applicability of new findings. However, there is need for incorporation into the diagnostic process of more information on family history of mood disorder, illness course, treatment response, and biochemical measures. A dimensional approach to the identification of mental disorders that may benefit from mood stabilizing treatments may offer advantages over the current strictly syndromal approach to diagnosis.

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2. Sachs GS: Bipolar mood disorder: practical strategies for acute and maintenance phase treatment. J Clin Psychopharmacol 1996;16(suppl 1):32S–47S
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INDUSTRY-SUPPORTED SYMPOSIUM 23 (Part 2)—CONTROVERSIES AND TREATMENT STRATEGIES IN BIPOLAR DISORDERS
Supported by Abbott Laboratories

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No. 23A
COMPLIANCE AND SAFETY: ISSUES INTEGRAL TO SUCCESSFUL BIPOLAR THERAPY

Carlos A. Zarate, Jr., M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont MA 02178*

SUMMARY:

Optimal recovery and long-term stability in patients with bipolar disorder require adherence to treatment throughout the acute, continuation, and maintenance phases of therapy. The degree of treatment compliance is related to problems associated with the drug, the illness, the patient, and the physician. Factors related to noncompliance include comorbid substance abuse, complex medication schedules, psychosocial factors, and adverse events. A large percentage of patients fail maintenance treatment with a single agent. When monotherapy fails, physicians may use polypharmacy, which carries the risk of more side effects with each additional drug and drug-drug interactions, and increases the complexity of the treatment regimen, leading to more medication errors and noncompliance. Addressing the factors that may result in noncompliance as well as selecting better-tolerated medications is essential to a good long-term prognosis.

No. 23B
WHAT'S NEW IN PHARMACOECONOMIC TREATMENT OUTCOMES IN BIPOLAR DISORDER

Lisa B. Dixon, M.D., *Department of Psychiatry, University of Maryland, 701 West Pratt Street, Room 476, Baltimore MD 21201*

SUMMARY:

The development of new antipsychotic and antidepressant medications has spawned a substantive body of research on the costs and cost-effectiveness of the new medications. While these newer medications are more costly than older medications, these increased costs may be balanced by increased effectiveness and improved outcomes. Reduced side effects may mediate some of these improved outcomes. Most of the research on these new drugs has been conducted in populations of persons with depression, schizophrenia, and schizoaffective disorder. In the case of the antipsychotics, pharmacoeconomic studies suggest that the increased cost of these medications is frequently balanced by the reduced cost of hospitalizations. Pharmacoeconomic considerations have received less attention among persons with bipolar disorder. Both antidepressants and antipsychotic drugs are used in bipolar disorder, so that bipolar disorder could be considered in pharmacoeconomic studies of those drug classes. However, mood stabilizers are the mainstay of treatment of bipolar disorder and thus pharmacoeconomic studies of bipolar disorder must clearly focus on mood stabilizers. Important considerations include the costs of different drugs, the perspective of the study (mental health system only, medical care system, society), and the inclusion of indirect costs.

REFERENCES:

1. Tohen M, Zarate CA: Antipsychotic agents and bipolar disorder. J Clin Psychiatry 1998;59[supp 1]:38–48
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INDUSTRY-SUPPORTED SYMPOSIUM 24—ALZHEIMER'S DISEASE: TRANSLATING CLINICAL TRIALS INTO CLINICAL CARE
Supported by Bayer Corporation, Pharmaceutical Division

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to evaluate and interpret the increasing body of information from clinical trials with AD patients and translate these treatment results into meaningful improvements in their clinical practice.

No. 24A
ASSESSMENT TOOLS FOR GLOBAL FUNCTION

P. Murali Doraiswamy, M.D., *Department of Psychiatry, Duke University Hospital, Trent Drive, South Hospital #3547, Box 3018, Durham NC 27710*

SUMMARY:

Since draft guidelines were published by the Food and Drug Administration in 1990 for the design and conduct of anti-dementia drug clinical trials, global assessment of change have been required as primary outcome measures, in addition to the inclusion of performance-based objective test instruments. Global ratings are intended to provide an index of the clinical importance or relevance of change, information that cannot be obtained from quantitative assessment scales. Therefore, any agent considered for use as an anti-dementia drug must be evaluated through a clinician's global assessment scale as a primary outcome measure to help determine if a supposed effect is clinically meaningful. The Clinician's Interview-Based Impression of Change With Caregiver Input (CIBIC-Plus) is one such scale that assesses the status of the patient relative to baseline, but it is not a standardized instrument. Scales such as the Global Deterioration Scale (GDS) and the Clinical Dementia Rating (CDR) provide a rating of severity of dementia symptoms on a global scale at baseline and then at follow-up. These are standardized, validated severity rating scales. Global rating scales are comparable to the judgments made by clinicians when assessing drug effectiveness in practice situations.

No. 24B
SCALES USED TO ASSESS COGNITION

John C. Morris, M.D., *Department of Neurology, Washington University, 660 South Euclid, Campus Box 8111, MDC, St. Louis MO 63110*

SUMMARY:

Cognitive decline is the clinical hallmark of Alzheimer's disease (AD). Performance-based cognitive tests are essential tools in as-

sessing the efficacy of potential treatments, such as those aimed at improving the cholinergic deficits that contribute to cognitive impairment in AD. The current gold standard for assessing cognitive change is the Alzheimer's Disease Assessment Scale-Cognitive Subscale (ADAS-Cog), which is used as a primary outcome measure to comply with the Food and Drug Administration's dual outcome criteria for dementia clinical trials. The ADAS-Cog is a well-validated and reliable instrument that evaluates 11 cognitive subscales. Higher scores reflect poorer performance and positive changes from baseline scores represent worsening cognitive ability. Cognitive assessments reveal drug-related changes in memory, language, and visuospatial skills. Cognitive improvement or stabilization is the goal for limiting functional decline in AD.

No. 24C
ACTIVITIES OF DAILY LIVING: A KEY PARAMETER IN ALZHEIMER'S DISEASE

Linda Teri, Ph.D., *Psychosocial and Community Health, University of Washington, Box 357263, Seattle WA 98195-7263*

SUMMARY:

Activities of daily living (ADLs) are critically impaired in patients with Alzheimer's disease, affecting and being affected by both cognitive and affective status. The very term, activities of daily living, encompasses basic physical care needs, such as toileting, dressing, and eating as well as more complex care needs, such as shopping, meal preparation, and finances. Thus, ADLs necessitate an identifiable level of cognitive function and skill. Understanding the role of cognition and affect in ADL function may well facilitate accurate assessment and management. This presentation will provide state-of-the-art information about the nature of ADL impairment in patients with Alzheimer's disease and the association of such impairment to cognitive decline and affective health. It will begin by providing some basic definitions of ADL impairment common in patients with AD. It will discuss the importance of understanding the association of ADL impairment in day-to-day function and management. Data will then be presented from a large sample of patients with AD to demonstrate the relationship of cognitive, affective, and behavioral impairment and reduced ADLs. Recent studies emphasizing the association of ADL function, patient depression, cognitive decline, and collateral assessment will be discussed.

No. 24D
ASSESSMENT OF NEUROPSYCHIATRIC DISORDERS

Jeffrey L. Cummings, M.D., *Department of Neurology, University of California at Los Angeles, Reed Neurosciences Center, 710 Westwood Plaza, Los Angeles CA 90095*

SUMMARY:

The primary outcome measures for clinical trials of anti-dementia agents include global assessments such as the Clinician's Interview-Based Impression of Change (CIBIC) and alterations in cognitive function using the Alzheimer's Disease Assessment Scale-Cognitive Subscale (ADAS-Cog). Clinical trial study designs may target slowing disease progression or improving existing symptoms. Measurement of behavioral disturbances should be included when assessing the effects of anti-dementia agents. Apathy, agitation, psychosis, irritability, anxiety, mood changes, and purposeless behavior are common in Alzheimer's disease (AD). Some of these symptoms may be linked to the cholinergic deficiency of AD, and cholinergic therapy may reduce these behavioral disturbances. Patients symptomatic at baseline experience an improvement in many symptoms, and patients without symptoms at baseline are less likely to have new symptoms emerge in the course of the study. Assessment of behavioral changes in clinical trials of anti-dementia agents must include tools that are valid, reliable, multidimensional, and sensitive to change. Behavioral changes in AD are an important source of patient distress, caregiver burden, and disability; they often precipitate institutionalization. Reduction in behavioral abnormalities in AD is an important goal of anti-dementia drug therapy. The psychotropic effects of anti-dementia agents are of practical importance to clinicians.

No. 24E
ASSESSMENT OF DISEASE PROGRESSION

Mary Sano, Ph.D., *Sergievsky Center, PNS Box 16, Columbia University, 630 West 168th Street, New York NY 10032*

SUMMARY:

While attention is focused on the symptomatic treatment of Alzheimer's disease (AD)—improving cognition, minimizing neuropsychiatric problems, and/or increasing the ability to perform normal, daily activities—disease-modifying therapies that slow progress are also critically important. Clinical trial protocols, therefore, may focus on either measuring symptomatic changes or slowing disease progression. With the emergence of drugs designed to modify the course of illness, more clinical trials are measuring disease progression. Similar to the benefits of minimizing the symptoms of AD, slowing of disease progression has the potential to delay the use of costly medical services or reduce the amount of their use. Nursing home placement may be deferred. Substantial longitudinal evidence and different methodologic approaches are needed to support a finding that a drug may delay progression or modify disease. Antioxidants, anti-inflammatory agents, and estrogens may have disease modifying effects. A study of vitamin E treatment on AD sponsored by the National Institute on Aging is a model investigation of disease modifying therapy.

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INDUSTRY-SUPPORTED SYMPOSIUM 25—WHAT MAKES AN ANTIPSYCHOTIC ATYPICAL?
Supported by Watson Laboratories Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: (1) recognize the importance of serotonin 2 and dopamine 2 antagonism to the pharmacologic concept of "atypical antipsychotic"; (2) understand how atypical antipsychotics may therefore reduce extrapyramidal reactions, tardive dyskinesia, prolactin elevations, and negative symptoms of schizophrenia; (3) determine how this concept applies to risperidone, olanzapine, and quetiapine as well as to the older antipsychotic loxapine.

No. 25A
PHARMACOLOGICAL MECHANISM OF ATYPICAL ANTIPSYCHOTICS

Stephen M. Stahl, M.D., *Department of Psychiatry, University of California at San Diego, 8899 University Center Lane #130, San Diego CA 92122*

SUMMARY:

Typical antipsychotics are dopamine 2 (D2) antagonists, whereas atypical antipsychotics are serotonin (5HT)-2 as well as D2 antagonists (i.e., SDAs). Typical antipsychotics target positive symptoms of schizophrenia but cause EPRs, tardive dyskinesia, and elevated prolactin levels, whereas atypical antipsychotics target positive AND negative symptoms without such side effects. This explanation of the mechanism of action of antipsychotics is overly simplistic since atypical antipsychotics bind to more than a dozen other receptors, and no two drugs have identical binding properties. Also, the typical antipsychotics loxapine, thioridazine, and chlorpromazine bind to 5HT2A receptors, yet apparently lack atypical clinical features. Although SDA can explain in part atypical features, this does not explain why older SDAs lack clearly documented atypical clinical features. Study of these older SDAs began during the era of high doses, which can obscure atypical features even in the new drugs. Also, complex pharmacokinetics and the failure of chlorpromazine and thioridazine to bind 5HT2A receptors in vivo as well as they do in vitro could explain this. Careful analysis of these exceptions to the SDA rule of atypicality, coupled with better understanding of additional binding sites, should lead to improved understanding of the mechanism of atypical antipsychotic action.

No. 25B
SEROTONIN/DOPAMINE ANTAGONISM AND ATYPICALITY: *IN VIVO* EVIDENCE USING PET

Gary J. Remington, M.D., *Neuropsychiatric Research Unit, Clarke Institute of Psychiatry, 250 College Street, Toronto, ON, M5T 1R8, Canada;* Stephen M. Stahl, M.D., Peter F. Buckley, M.D., William M. Glazer, M.D.

SUMMARY:

Evidence with clozapine, the prototype of "atypical" antipsychotics, has suggested that its unique clinical properties may be at least partially related to its greater serotonin 5-HT_2 versus dopamine D_2 occupancy. *In vitro* findings have indicated that many novel antipsychotics share this feature, although it is noteworthy that other compounds, loxapine being one such example, also demonstrate this attribute.

Positron emission tomography (PET) has provided an opportunity to evaluate this hypothesis *in vivo,* and data are now available for a number of the newer antipsychotics, including clozapine, risperidone, olanzapine, and quetiapine, in addition to conventional agents such as haloperidol and loxapine.

At the most fundamental level, these findings have advanced our understanding regarding the relationship between D_2 occupancy and clinical response/side effects. Being able to evaluate 5-HT_2 occupancy as well has provided the opportunity to elucidate the model of shared 5-HT_2/D_2 antagonism and categorize compounds that share this particular feature.

This presentation will review the concept of "atypicality" based on PET evidence regarding the model of shared 5-HT_2/D_2 antagonism, with specific reference to the clinical implications of these findings.

No. 25C
MANAGEMENT OF AGITATION AND AGGRESSION: NEW PHARMACOLOGIC APPROACHES

Peter F. Buckley, M.D., *Case Western Reserve University, 2040 Abington Road, Cleveland OH 44106*

SUMMARY:

Although those who exhibit aggressive behavior are very much in the minority among patients with mental illness, aggression is a major contributory factor to stigma of mental illness. More effective management strategies could, therefore, have a broader impact beyond that of symptom control. A variety of psychotropics of varying classes have been tried. More recently, the use of novel antipsychotics has produced clinical and research evidence of efficacy in treating aggression, with some studies suggesting that these agents may possess a selective effect on aggression. At the same time, however, these drugs are not available in intramuscular form and, accordingly, typical antipsychotics continue to have a major role in acute management of aggression. This presentation will examine the relative merits of typical and atypical antipsychotics, as well as other agents and combinations, in an attempt to delineate a rationale and stepwise approach to the effective pharmacologic management of aggression.

No. 25D
IS THERE CLINICAL EVIDENCE FOR ATYPICAL EFFECTS OF LOXAPINE?

William M. Glazer, M.D., *Massachusetts General Hospital, Harvard Medical School, 260 West Broadway, #7D, New York NY 10013*

SUMMARY:

Loxapine is a tricyclic antipsychotic agent of the dibenzoxapine class, the same as clozapine. It is chemically distinct from the phenothiazines, indoles, thioxanthenes, and the butyrophenones. While loxapine is classified as a "typical" antipsychotic agent, its psychopharmacological profile is comparable to clozapine, e.g., 5-HT_2 and dopamine blockade, D4 binding affinity, etc. Since much of the *clinical research* with loxapine was performed before the concept of "atypicality" was fully articulated, potential atypical features of this compound may have been missed. For example, older studies were not designed to measure loxapine's efficacy for treating negative symptoms or refractory states in a manner consistent with today's standards. This presentation will review the clinical literature for evidence that loxapine's efficacy and safety profile is different from other typical antipsychotic agents. While it may not be appropriate to classify loxapine as an *atypical* antipsychotic agent, it is important for clinicians to understand potential treatment benefits that may be attributed to this compound.

No. 25E
USE OF INTRAMUSCULAR ANTIPSYCHOTICS IN ACUTE-CARE SETTINGS

Larry Ereshefsky, Pharm.D., *University of Texas, 7703 Floyd Curl Drive, San Antonio TX 78284-6220*

SUMMARY:

Perceived advantages in cognitive and social function, negative symptoms, and reductions in EPS and tardive dyskinesia have resulted in >60% of acute psychiatric admissions at San Antonio State Hospital receiving atypical therapy. However, rapid calming of agitated or aggressive patients is not clearly evident in many of our patients with orally administered atypical medications. Intramuscular therapy (IM) using benzodiazepines, e.g., lorazepam, neuroleptics, or combinations of both agents, are frequently needed during the short, acute-care admission. The need for coadministered typical neuroleptics for patients started on atypical medications is surprisingly frequent; lowest with risperidone (the most potent dopamine D2 receptor antagonist among the atypicals), and highest with quetiapine (the least potent D2 antagonist). IM or adjunctive loxapine might be a better choice for the acutely admitted patient started on atypical therapy. Loxapine is comparable to typical neuroleptics and lorazepam as measured by time till calm in the seclusion room. Moreover, its rate of EPS, especially acute dystonia, is appreciably lower than comparably effective doses of fluphenazine or haloperidol. Loxapine's pharmacologic profile (significant serotonin 5-HT2a antagonism) is less likely to cause a significant shift in the 5-HT2a:D2 receptor blocking ratio associated with many of the desirable features of the atypical antipsychotics.

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INDUSTRY-SUPPORTED SYMPOSIUM 26—UNMASKING DEPRESSION AND COMORBID CONDITIONS: CLINICAL CHALLENGES, SOLUTIONS AND UNANSWERED QUESTIONS
Supported by U.S. Pharmaceuticals, Pfizer Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to enhance recognition and treatment of depression by understanding the influence of comorbidity factors including medical illnesses, neurological illness, gender, and substance abuse; recognize how to diagnose depression as a comorbid psychiatric illness; and recognize how to assess treatment response and determine measurable patient outcomes.

No. 26A
UNDERSTANDING DEPRESSION AS A RISK FACTOR IN VASCULAR DISEASE

K. Ranga R. Krishnan, M.D., *Department of Psychiatry, Duke University Medical Center, 3018 South Hospital, Room 3352, Durham NC 27710*

SUMMARY:

Depression is a common problem in patients with cardiovascular and cerebrovascular disease. Epidemiological studies demonstrate that depression is a risk factor for the development of coronary artery disease and cerebrovascular disease. Depression following myocardial infarction or stroke also increases the risk of death and functional impairment. The clinical epidemiological data support the notion that depression is a significant risk factor for morbidity and mortality following vascular disease.

Recent data suggest that depression, when it originates late in life, is related to silent cerebrovascular disease. The advent of MRI clearly documents the frequent coexistence of ischemic changes in the brain and late onset depression. The term vascular depression has been used to describe this entity. Overall, these studies document the need to evaluate treatment strategies for depression in the context of vascular disease.

The clinical course and prognosis of vascular depression in the elderly is not as good as uncomplicated depression.

No. 26B
MOOD DISTURBANCE IN ALZHEIMER'S DISEASE AND OTHER NEUROLEPTIC ILLNESSES

Pierre N. Tariot, M.D., *Department of Psychiatry, University of Rochester, 435 East Henrietta Road, Rochester NY 14620*

SUMMARY:

Depressive signs and symptoms occur in 40% to 50% of patients with Alzheimer's disease (AD), and are severe enough to meet syndromal criteria in about 20% of patients. Theses clinical presentations will be described in detail, using case studies and examples of assessment tools. Manic syndromes occur less commonly. In some cases it appears that both depression and dementia co-occur, in others it appears that depression may represent either a risk factor or an early manifestation of AD. The evidence in support of each of these three hypotheses will be summarized, including data regarding epidemiology, course, and etiopathology. It is clear that depression significantly increases the morbidity of dementia. Pharmacologic and nonpharmacologic treatment studies indicate that both modalities can reduce symptoms. Current practice guidelines emphasize the use of SSRIs, while new evidence suggests a possible role for cholinesterase inhibitors as well. Key points regarding mood disturbances in cerebrovascular disease and Parkinson's disease will be reviewed, highlighting the similarly high prevalence of depressed mood in these patient groups as well.

No. 26C
MANAGEMENT OF DEPRESSION DURING PREGNANCY AND POSTPARTUM

Lori L. Altshuler, M.D., *Department of Psychiatry, VA Medical Center, 11301 Wilshire Boulevard, B116AA, Los Angeles CA 90073;*

Lee S. Cohen, M.D., Martin P. Szuba, M.D., Vivien K. Burt, M.D., Michael J. Gitlin, M.D.

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 presentation, 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. 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, will also be discussed. Decision-making guidelines regarding whether or not to discontinue medications during pregnancy will be presented. The risk for major depression in the postpartum period and the likelihood of postpartum recurrence after one postpartum event will be reviewed, and prophylactic strategies will be covered.

No. 26D
ADDICTIONS: SMOKING, ALCOHOL AND COCAINE

Barbara J. Mason, Ph.D., *Department of Psychiatry, University of Miami School of Medicine, 1400 NW 10th Avenue, Suite 314, Miami FL 33136*

SUMMARY:

An important association between depression and initiation of substance use, especially cigarette smoking, has been found in epidemiological studies. Greater MAO inhibition in smokers suggests smoking may have an antidepressant effect. Consequently, nicotine abstinence may unmask or increase depressive symptoms. Effectively treating depression has been associated with a lower rate of smoking relapse. The availability of the sustained release form of the antidepressant buproprion for smoking cessation may offer an important aid for smoking cessation in those at risk for depression.

Laboratory and clinical trial data suggest an association between untreated depression and drinking relapse in alcoholics. An inpatient cue reactivity study found both drinking and negative mood cues led to increased desire to drink, and this reported urge to drink predicted time to relapse after inpatient discharge. Controlled clinical trials of antidepressants in alcoholics who met criteria for major depressive disorder after at least one week of abstinence generally report lower rates of both depression and drinking in patients treated with active medication relative to placebo. Similarly, depressive symptoms were significantly associated with polydrug use involving cocaine in a survey of 570 inner-city blacks, and higher levels of depressive symptoms among cocaine addicts in treatment were associated with greater urges to use cocaine. Diagnosis and treatment of depression in adolescents and young adults may help prevent onset of substance use, and facilitate recovery in patients currently dependent on nicotine, alcohol, or cocaine.

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INDUSTRY-SUPPORTED SYMPOSIUM 27—GENDER ISSUES IN DIAGNOSIS AND RESPONSE TO TREATMENT
Supported by Glaxo Wellcome Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: (1) recognize symptoms of psychiatric illness more likely to occur in women, (2) establish what reproductive life events influence clinical symptoms, and (3) describe treatment considerations and the relationship to gender.

No. 27A
INCIDENCE AND TREATMENT OF MIGRAINE IN WOMEN

Anita L.H. Clayton, M.D., *Department of Psychiatry, University of Virginia, 2955 Ivy Road, Suite 210, Charlottesville VA 22903*

SUMMARY:

Migraine affects about 12% of the population, including 6% of men and 18% of women. Comorbidities include depressive illness, anxiety disorders, and cerebral vascular accidents. Complete migraine includes a prodrome, aura, headache, recovery, and postdrome. Menstrual migraine is migraine not associated with an aura, with rhythmical occurrence of symptoms between days –2 and +3 of the menstrual cycle. In women with migraine, 60% occur in the perimenstrual period mostly or exclusively, 67% disappear with pregnancy, 24% worsen on oral contraceptives, and 10% begin at menarche. Menstrual migraine appears related to the decline in estrogen levels that occurs during the late luteal phase of the menstrual cycle. This probably reflects an estrogen-mediated effect on serotonin with implications for the mechanism of action of medications used in acute and prophylactic treatment. Fluctuating and declining levels of estrogen seen in the perimenopause and with cyclic oral contraceptives and hormone replacement therapy may lead to exacerbation of migraine. Acute treatment of menstrual migraine is directed at the 5-HT1 receptor subtypes, and sc injection of sumatriptan is associated with a decrease in plasma levels of serotonin (5-HT) prior to relief of migraine. Prophylactic medications may include continuous hormonal replacement therapy, antidepressansts, antconvulsants, beta adrenergic antagonists, calcium channel blockers, nonsteroidal anti-inflammatory agents, and vitamin B supplements, with increased estrogen levels or 5-HT2 antagonism as the targeted effect.

No. 27B
GENDER ISSUES IN THE ASSESSMENT AND TREATMENT OF DEPRESSION

Susan G. Kornstein, M.D., *Department of Psychiatry, Medical College of Virginia, Box 980710, Richmond VA 23298*

SUMMARY:

Epidemiologic studies have consistently shown that both major depression and dysthymia are twice as common in women as in men. In addition to the difference in prevalence of depression, recent studies show gender differences in symptom presentation, course of illness, and treatment response to medications and psychotherapy. These findings suggest the need for a gender-specific approach to the management of depression.

This talk will increase awareness and understanding of gender considerations in the evaluation and treatment of depression. Data will be presented by gender from ongoing and recently completed chronic depression studies, including one evaluating relative responsivity to a tricyclic antidepressant versus a selective serotonin reuptake inhibitor and another examining the efficacy of pharmacotherapy or psychotherapy alone versus combined treatment. Emphasis will be placed on the clinical relevance of the data presented.

No. 27C
GENDER ISSUES IN DIAGNOSIS AND TREATMENT OF ANXIETY DISORDERS

Teresa A. Pigott, M.D., *Department of Psychiatry, University of Texas Medical Branch at Galveston, 4442 Graves Building, 301 University Boulevard, Galveston TX 77555*

SUMMARY:

Women have a substantially higher risk of developing anxiety disorders than men. Large-scale epidemiological studies suggest that women in comparison with men have a two- to three-fold increase in the occurrence of panic disorder, post-traumatic stress disorder or generalized anxiety disorder, as well as a 1.5-times greater risk of developing obsessive-compulsive disorder or social phobia. Elevated morbidity and mortality rates, frequent comorbid psychiatric diagnosis, and substantial psychosocial impairment are associated with the anxiety disorders. Pharmacotherapy is an important and highly effective treatment for anxiety. Significant gender differences in the metabolism of psychotropic medications have been identified. For example, significant increases in the expected plasma half-lives of various anxiolytic and antidepressant medications have been reported in women. Despite the fact that women are the greatest consumers of psychotropic medication, there are surprisingly little systematic data available concerning the clinical relevance of these differences. The potential effects of the menstrual cycle, pregnancy, exogenous estrogen, and menopause also are likely to have a substantial, and potentially significant impact on the course and treatment of women with anxiety disorders. This presentation will provide a brief overview of these important issues and their potential clinical relevance in the treatment of women with anxiety disorders.

No. 27D
TREATMENT OF WOMEN WITH BIPOLAR DISORDER

Ellen Leibenluft, M.D., *PDN Branch, National Institute of Mental Health, Building 10, Room 6N240, 10 Center Drive, MSC 1255, Bethesda MD 20892*

SUMMARY:

Two of the most difficult clinical situations that arise in the course of bipolar disorder—rapid cycling and severe postpartum episodes—commonly (or uniquely) affect women. Rapid cycling bipolar disorder is approximately three times more common in women than men, and data clearly indicate that bipolar women are at high risk for postpartum mood disorders and/or psychoses. This presentation will review current treatment approaches to these challenging clinical situations, including the use of mood stabilizers and atypical antipsychotic medications. The review will include a discussion of hyperprolactinemia secondary to antipsychotic medication, and the possible role that sleep-wake dysregulation may play in the pathophysiology of postpartum mood disorders. In addition, we will discuss several hypotheses that might explain why bipolar women are at high risk to develop rapid cycling and/or postpartum episodes. Topics to be discussed include the possible involvement of the hypothalamic-pituitary-gonadal and hypothalamaic-pituitary-thyroid axes in mood regulation.

No. 27E
SEXUAL DISORDERS IN WOMEN: DIAGNOSIS AND TREATMENT

Thomas N. Wise, M.D., *Department of Psychiatry, Inova Fairfax Hospital, 3300 Gallows Road, Falls Church VA 22042*

SUMMARY:

Recent surveys demonstrate that sexual problems in women are common. In addition, the recognition that medications such as serotonin reuptake inhibitors often lower libido and potentiate anorgasmia highlight the problem of female sexual dysfunction. Such dysfunctions are best delineated via the tripartite sexual response cycle characterized by drive, arousal, and release. Drive disorders include hypoactive sexual desire and sexual aversion disorder. Sexual aversion disorder differs from hypoactive drive disorder in that the essential element is aversion to sexual contact rather than lowered fantasy levels. The arousal phase disorder is characterized by inability to attain or maintain adequate vaginal lubrication and may be due to medication effects or menopause. Release phase disorders are characterized by the inability to achieve orgasm after adequate stimulation. This disorder is commonly found in women taking antidepressant medication. Finally the sexual pain disorders, vaginismus and dyspareunia, often have a physical component, such as vulvovestibulitis, to their etiology. Diagnosis involves pinpointing the presence of one or more such disorders and recognizing comorbid conditions such as mood disorders or physical conditions that could potentiate the sexual disorders. Rational treatments can then evolve from such diagnostic reasoning.

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INDUSTRY-SUPPORTED SYMPOSIUM 28—CLINICAL IMPLICATIONS OF NEW DEMENTIA RESEARCH

Supported by Novartis Pharmaceuticals Corporation

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: (1) describe the currently available tools to make a diagnosis of dementia, (2) demonstrate an understanding of how treatment research may aid psychiatrists in diagnosis and management of dementia, and (3) recognize imaging techniques that monitor the progression of dementia and response to treatment.

No. 28A
EARLY DETECTION AND PREVENTION OF DEMENTIA

Gary W. Small, M.D., *Department of Psychiatry, University of California at Los Angeles, Neuropsychiatic Institute, 760 Westwood Plaza, Los Angeles CA 90024-8300*

SUMMARY:

Several recent observations suggest that the common form of late-onset Alzheimer's disease (AD), beginning after age 65 years, may actually show subtle manifestations years earlier. Measures of brain function using positron emission tomography (PET) and genetic risk (apolipoprotein E-4 [APOE-4]) in middle-aged persons with mild memory complaints show significantly lower function in brain regions known to be affected by AD. Moreover, such metabolic patterns appear to predict future cognitive decline in people with age-related memory complaints. Structural images of medial temporal regions also show early atrophy as a predictor of future cognitive decline. Evidence of preclinical neuritic plaques and neurofibrillary tangles, the neuropathological hallmarks of AD, is consistent with very early and subtle preclinical changes. And, a study of the early autobiographies (mean age = 22 years) and the later (age 75–95) cognitive performances of 93 nuns found that low idea density and grammatical complexity in early life were associated with low cognitive test scores in later life. Thus this age-related, genetically-determined, gradually progressive disease may subtly begin decades before the patient manifests obvious symptoms. Discovering genetic causes and susceptibilities is likely to lead to clarification of underlying disease mechanisms and discovery of interventions that will alter pathogenesis. Early intervention may then delay AD onset and eventually prevent the disease in some people. This presentation will review new findings on predicting cognitive decline and current and future studies aimed at prevention.

No. 28B
TRANSLATING TREATMENT DATA TO THE REAL WORLD

Lon S. Schneider, M.D., *Department of Psychiatry, University of Southern California, 1975 Zonal Avenue, KAM-400, 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 two cholinesterase inhibitors are currently 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. Potential approaches to slowing the rate of cognitive decline or time to placement include the use of antioxidants and cholinergic drugs. The therapeutic options for physicians continue to expand. Considerations in pharmacological intervention, including the use of combination drug therapy, will be reviewed.

No. 28C
NEUROIMAGING TECHNIQUES AND APPLICATIONS

Steven G. Potkin, M.D., *Department of Psychiatry, University of California Irvine Medical Center, 101 City Drive South Route 88, Irvine CA 92717;* Ravi Anand, M.D., Joseph C. Wu, M.D., John Messina, Ph.D., Kirsten Fleming, Ph.D., David Keator, B.S., William E. Bunney, Jr., M.D.

SUMMARY:

Alzheimer's disease (AD) is a progressive dementia involving compromised cholinergic functioning. Cholinesterase inhibitors have demonstrated symptom and behavioral efficacy. In a pilot study, patients with mild to moderate probable AD (MMSE 10 to 26, inclusive) were enrolled in a double-blind, placebo-controlled comparison of three fixed daily doses of rivastigmine: (3 mg, 6 mg, 9 mg/day) or placebo for 26 weeks. Rivastigmine is a centrally selective acetylcholinesterase inhibitor of the carbamate type. FDG-PET scans were obtained on 27 patients at baseline and following 26 weeks of treatment during a Snodgrass picture naming activation task. Placebo-treated patients (N = 7) demonstrated a statistically significant decrease in hippocampal and frontal cortical metabolism, reflective of their deteriorating clinical status. Patients treated with rivastigmine (N = 20) showed statistically significant increases in absolute frontal and hippocampal metabolism. Clinical responders to rivastigmine (N = 15) increased their hippocampal metabolism by 28% compared with 9% for nonresponders and a decrease of 9.5% for the placebo patients. When technically possible each individual's hippocampus determined by MRI was co-registered with their PET scan. Responders (N = 12) increased their hippocampal metabolism by 18% ($t = 2.156$, $p = .05$) compared with 9% for nonresponders (n.s.). These results suggest that FDG PET can sensitively measure the progression of AD and its improvement with cholinesterase inhibitors.

No. 28D
RECENT FINDINGS IN BEHAVIORAL INTERVENTION

Jiska Cohen-Mansfield, Ph.D., *The Hebrew Home of Greater Washington, 6121 Montrose Road, Rockville MD 20852*

SUMMARY:

Behavioral interventions are used primarily to intervene with behavioral disturbances in dementia. Behavioral disturbances include four main subtypes: physically aggressive behaviors such as hitting or kicking, physically nonaggressive behaviors such as pacing and wandering, verbally aggressive behaviors such as cursing, and verbally nonaggressive behaviors such as repetitious vocalizations. In order to properly intervene, caregivers need to characterize the behaviors, understand their etiology, and match the treatment to the etiology as well as to the person's abilities, interests, and limitations.

Several theoretical frameworks can be utilized to understand the behaviors; namely, a neurobiological model, a behavioral model, and environmemtal vulnerability model, and an unmet needs model. Although these frameworks are not mutually exclusive, each provides different implications for treatment.

Research findings show that the different subtypes of behavioral disturbances are associated with different correlates, including health, mental health, demographic, and environmental. Based on these findings we have developed an intervention model that attributes the different behaviors to different unmet needs. This model, the Treatment Routes for Exploring Agitation (TREA), espouses and individualized approach for tailoring treatments to the specific behaviors manifested as well as to the person's identity and preserved abilities.

No. 28E
MANAGEMENT OF COMORBID CONDITIONS

George T. Grossberg, M.D., *Department of Psychiatry, St. Louis University, 1221 South Grand Boulevard, St Louis MO 63104–1016*

SUMMARY:

Behavioral or psychiatric symptoms in AD are quite common, with a recent study showing that nearly 80% of AD patients exhibit psychiatric symptoms sometime during the course of the illness. Psychiatric symptoms in AD are also the leading reason for nursing home admission in the U.S. Agitation is the most common behavioral symptom seen in AD, affecting up to 80% of patients. Overtly aggressive behaviors may affect up to 40% of patients. Psychotic symptoms are found in about 33 1/3% of patients, with delusions and visual hallucinations predominating. Depression affects 20% to 40% of patients with AD, can occur at any stage of the illness, and may be an early symptom as well as a potential marker. Wandering, day/night confusion, socially inappropriate behaviors, apathy/indifference are also frequent. Less commonly, sexual impulse control problems may be found.

Treatment of behavioral/psychiatric symptoms in AD starts with identifying potential triggers such as delirium, pain, or other syndromes. Psychosocial, environmental, as well as pharmacologic therapies all play a role. Particularly important is the behavioral diary, especially in the long-term care settings.

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3. Schneider LS, Tariot PN, Small G: Update on treatment for Alzheimer's disease. Psychiatric Clinics of North America: Annual of Drug Therapy, 1997

INDUSTRY-SUPPORTED SYMPOSIUM 29—MANAGING DEPRESSION ACROSS THE LIFE CYCLE
Supported by Forest Laboratories Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: recognize the heterogeneity of onset, antecedents, and course of major depressive disorder across the life cycle, with specialized focus on depression in children, women at critical biological milestones, the elderly, and adults in general; detail further clinical and diagnostic issues, as well as treatment considerations.

No. 29A
DEPRESSION IN CHILDREN AND ADOLESCENTS

Graham J. Emslie, M.D., *Department of Psychiatry, University of Texas Southwestern, 5323 Harry Hines Boulevard, Dallas TX 75235-7200*

SUMMARY:

Depression in children and adolescents causes substantial morbidity and mortality. Although adult criteria for major depressive disorder are the same for children and adolescents, some challenges exist in ascertaining the diagnosis. Children often have difficulty in providing information, and multiple informants (usually parents) must be used. In depressed children and adolescents, the most common symptoms include decreased concentration and fatigue. Comorbid diagnoses, particularly dysthymia, are also common. Information about newer antidepressants has substantially increased in recent years.

Two recently completed double-blind trials have provided data on the safety and efficacy of selective serotonin reuptake inhibitors (fluoxetine, paroxetine, setraline, and citalopram) in depressed children and adolescents. Despite the effectiveness of psychopharmacologic treatment of depression in children and adolescents, the disorder is often recurrent. In conclusion, early-onset depression is similar to depression in adults. As with adults selective serotonin reuptake inhibitors appear to be safe and effective in the treatment of children and adolescents with major depressive disorder. Although the majority of patients recover, recurrence is common, and further research regarding maintenance treatment in children is needed.

No. 29B
COURSE AND TREATMENT OF MOOD DISORDERS DURING PREGNANCY AND THE POSTPARTUM PERIOD

Zachary N. Stowe, M.D., *Department of Psychiatry, Emory University Medical School, 1639 Pierce Drive, Suite 4003, Atlanta GA 30322*

SUMMARY:

The treatment of psychiatric illness during pregnancy and lactation represents a complex clinical situation. In regard to the high incidence of mental illness in women during childbearing years, it is highly probable that the clinician will encounter such situations. The literature, while expanding rapidly, provides little definitive data to develop scientifically derived treatment guidelines. Collaborative efforts have demonstrated a high rate of relapse for pregnant women who discontinue medications. This information and new data on the daily medication dose in pregnancy and placental passage of selective serotonin reuptake inhibitors provide information for developing management guidelines. Similarly, the burgeoning database on breast

milk excretion of antidepressants and new information on time course provide mechanisms for minimizing infant exposure. To provide a comprehensive risk/benefit assessment, clinical interpretation of the available data on the potential teratogenic, toxic, and neurobehavioral effects of psychotropic medications should be scrutinized (e.g., confounds, assay sensitivity, etc.). An overview will be provided with an emphasis on the clinical utility of the literature, prevention strategies, predictors of treatment response, and the risk/benefit assessment.

No. 29C
DEPRESSION IN THE PERIMENOPAUSAL WOMAN

Peter J. Schmidt, M.D., *National Institute of Mental Health, 10 Center Drive, Building 10, 3N-238, Bethesda MD 20892;* Catherine A. Roca, M.D., David R. Rubinow, M.D.

SUMMARY:

The role of declining reproductive function in midlife-onset depression is the source of considerable contention. We have used several strategies to investigate the effects of the perimenopause, hypogonadism, and hormone replacement on mood and behavior. Two groups of subjects have been studied: women with depression occurring during the natural perimenopause and women with gonadotropin-releasing hormone agonist-induced hypogonadism. Perimenopausal women with depression did not differ from nondepressed controls regarding adverse life events, hot flushes, or basal measures of reproductive hormones. Estrogen replacement under double-blind, placebo-controlled conditions significantly improved measures of both mood and verbal memory in perimenopausal women with depression. In contrast, hypogonadism in younger women was not associated with changes in cognitive function, and hormone replacement in hypogonadal women with premenstrual syndrome but not in controls resulted in mood deterioration. Finally, women with premenstrual syndrome and normal controls had reductions in cognition-activated regional cerebral blood flow during gonadotropin-releasing hormone agonist-induced hypogonadism with the restoration of normal cerebral blood flow observed during replacement with estrogen or progesterone. The data suggest that gonadal steroids may regulate mood, cognitive performance, and neural physiology, but the effects are dependent on a number of contextual variables, including age.

No. 29D
LONG-TERM MANAGEMENT OF RECURRENT ADULT DEPRESSION

Jerrold F. Rosenbaum, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC 812, Boston MA 02114*

SUMMARY:

Research demonstrates that depression is a recurrent illness with a worsening or chronic course, particularly if left untreated. Some clinicians have speculated that treating depression episodically may actually predispose to recurrences and contribute to a poor prognosis for long-term outcome. In contrast, clinical research argues that patients with a history of recurrent depression who receive maintenance treatment (i.e., stay on the same dose used to treat them acutely) remain well longer and suffer fewer recurrences. With the introduction of the selective serotonin reuptake inhibitors (SSRIs) and the practice of keeping patients on medication longer following recovery from a depressive episode, several challenges have arisen in clinical practice. Specifically, these include how to enhance patient medication compliance and avoid the so-called "SSRI Discontinuation Syndrome," and how to change or augment pharmacotherapy for patients who lose benefit on long-term treatment. This presentation will emphasize the importance of maintenance therapy in the treatment of recurrent adult depression and will address strategies in clinical management that may optimize outcome for the patient with a history of recurrent depression.

No. 29E
LATE-LIFE DEPRESSION: BIOLOGIC VULNERABILITY, PHENOMENOLOGY AND COURSE

Barnett S. Meyers, M.D., *Department of Psychiatry, New York Hospital-Cornell, 21 Bloomingdale Road, White Plains NY 10605;* Robert C. Young, M.D., Balkrishna Kalayam, M.D., George S. Alexopoulos, M.D.

SUMMARY:

Elderly patients with major depression comprise individuals who had their first episode in young adulthood and those with a late age of onset (LO). Emerging evidence demonstrates important differences in pathogenesis, phenomenology, and course between these forms of geriatric depression. Depression with an early onset is associated with a greater family prevalence. Conversely, acquired biological factors play a greater role in the pathogenesis of LO depression. The relevance of pathologic brain changes to LO depression is demonstrated by the high frequency of subcortical hyperintensities on magnetic resonance imaging, indicating occult cerebral vascular disease in these patients. Furthermore, patients with LO depression who have vascular risk factors differ in clinical phenomenology and neuropsychological test performance. Patients with "vascular depression" differ in degree of guilt/insight and psychomotor disturbance and have greater disturbance in initiation/perseveration than do other patients with LO depression. This neuropsychological pattern has been linked to evidence of neurophysiologic dysfunction in prefrontal pathways and a more brittle clinical course. Late-life depression is also associated with vertriculomegaly, which, in turn, is associated with memory disturbances and diminished responsiveness to standard concentrations of nortriptyline. Thus, the multiple and interacting pathways to LO depression contribute to a poorer outcome and suggest the need for novel antidepressant treatment strategies.

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INDUSTRY-SUPPORTED SYMPOSIUM 30 (Part 1)—NOVEL APPROACHES TO THE TREATMENT OF IMPULSIVITY Supported by Solvay Pharmaceuticals, Inc. and Pharmacia & Upjohn Company, Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize how impulsivity cuts across a broad range of disorders, and to know how to appropriately treat disorders such as pathological gambling, compulsive shopping and sexual addictions, OCD, PTSD, and affective instability with impulsivity.

No. 30A
NOVEL APPROACHES TO THE TREATMENT OF PATHOLOGICAL GAMBLING

Eric Hollander, M.D., *Department of Psychiatry, Mt. Sinai Medical Center, 1 Gustave Levy Place, Box 1230, New York NY 10029;* Concetta M. DeCaria, Ph.D., Tomer Begaz, B.A., Jared Finkell, B.A., Sherie Novotny, M.D., Charles Cartwright, M.D.

SUMMARY:

Impulsivity is a symptom that cuts across a broad range of disorders, including the impulse control disorders, and contributes to considerable morbidity and mortality. Pathological gambling (PG), an emerging public health problem, shares features with other impulsive, compulsive, and addictive disorders, has a high comorbidity with bipolar spectrum, attention deficit (ADD), and substance abuse disorders, and is associated with a high rate of suicide.

Anecdotal case reports suggest efficacy of psychodynamic, cognitive-behavioral, self-help (Gambler's Anonymous), and inpatient rehab programs. Nevertheless, 92% of PG patients have relapsed at one-year follow-up in Gambler's Anonymous, so alternative treatments are needed.

We have completed two placebo-controlled, crossover trials with the selective serotonin reuptake inhibitor fluvoxamine, which both demonstrate statistically superior efficacy of fluvoxamine compared with placebo. Up to 70% of PG patients experienced remission of gambling behavior during acute fluvoxamine treatment, and there was a significant decrease in urge to gamble, ability to delay or inhibit acting on gambling impulses, and amount of money spent on gambling. Results from a controlled trial of lithium, sustained release lithium, and placebo in bipolar spectrum pathological gamblers will also be presented, as will pilot data in PG with the 5HT2 antagonist nefazadone.

No. 30B
TREATMENT OF COMPULSIVE SHOPPING AND SEX ADDICTION

Donald W. Black, M.D., *Department of Psychiatry, University of Iowa Hospital, Psychiatry Research, 2-203 MEB, Iowa City IA 52242-1000*

SUMMARY:

Compulsive buying is characterized by excessive and inappropriate shopping and spending behavior that causes impairment. It affects 2% to 3% of the population, has an onset in the late teens/early 20s, and appears chronic. It primarily affects women. Historically, treatment involved insight-oriented psychotherapy. Recent work suggests that cognitive-behavioral therapy and SSRIs may help to reduce its symptoms.

Compulsive sexual behavior (sex addiction) is characterized by excessive and/or poorly controlled sexual behavior that causes impairment. It is estimated to affect 5% of the population, begins in the late teens/early 20s, and is chronic or episodic. It primarily affects men. Treatment has consisted of insight-oriented psychotherapy and 12-step programs. Recent work has suggested a role for both antiandrogens and SSRIs in its treatment.

No. 30C
THE RELATIONSHIP BETWEEN OCD AND IMPULSIVITY

Joseph Zohar, M.D., *Department of Psychiatry, Chaim Sheba Medical Center, Tel Hashomer, 52621, Israel*

SUMMARY:

While compulsivity shares some characteristics of impulsivity, one of the main differences between the two is that impulsive behavior is usually pleasurable. Compulsive behavior often aims to prevent or reduce anxiety or distress and not to provide pleasure or gratification. In many cases of OCD, such as washing or checking, the impulsive part of the behavior is clothed in the straitjacket of a stereotypy of acts, which are performed according to rigid or elaborate rules. This is very different from what we usually perceive as an impulsive act, i.e., as a behavior free of rules and rigidity. However, if one considers this further, there are some important similarities between impulsivity and compulsivity. Both are irresistible, and many times the individuals afflicted know they would be better off if they could refrain from engaging in such activity, but the urge to do so persists. Sometimes, it can be quite difficult to differentiate between the process of what has been referred to as impulsive control disorder and OCD. It is not surprising, therefore, that many impulse control disorders are actually considered to be OCD-related disorders, since at the essence of both are common underlying features, i.e., failure to resist an impulse or drive to perform an act that may be harmful, coupled with the relief experienced after committing the act.

REFERENCES:

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INDUSTRY-SUPPORTED SYMPOSIUM 30 (Part 2)—NOVEL APPROACHES TO THE TREATMENT OF IMPULSIVITY Supported by Solvay Pharmaceuticals, and Pharmacia & Upjohn Company, Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize how impulsivity cuts across a broad range of disorders, and to know how to appropriately treat disorders such as pathological gambling, compulsive shopping and sexual addictions, OCD, PTSD, and affective instability with impulsivity.

No. 30A
TREATMENT OF IMPULSIVITY AND AGGRESSIVITY IN PTSD

Charles R. Marmar, M.D., *Department of Psychiatry, VA Medical Center, 4150 Clement Street (116-A), San Francisco CA 94143;* Frank B. Schoenfeld, M.D., Thomas Metzler, Daniel S. Weiss, Ph.D.

SUMMARY:

Post-traumatic stress disorder has a lifetime prevalence of 7.8% in the adult American population. Irritability and impulsive aggression are major problems in combat veterans with PTSD and are also present in sexual assault survivors with PTSD. Coccaro (1989) summarized data supporting central serotonergic system dysfunction as an important correlate of impulsive-aggressive behavior. Depression of central serotonergic function has also been implicated in increased startle reactions, one of the most disturbing symptoms in chronic PTSD. Primate studies also indicate that serotonin re-uptake inhibitors decrease vigilance and aggression. Taken together, these studies suggest a unique role for serotonin re-uptake inhibitors in alleviating irritability, impulsive aggression, and other arousal symptoms of PTSD, including sleep disturbances, concentration difficulties, and startle reactions.

Data will be presented on risk factors and course of PTSD in combat veterans and emergency services personnel. Novel psychopharmacological approaches to the treatment of PTSD will be presented, including new data on the role of fluvoxamine treatment of combat-related PTSD. Results from an open trial support the role of fluvoxamine in reducing hyperarousal symptoms as reported by patients and therapists. In addition, data will be presented on the role of fluvoxamine in reducing heart rate responses to auditory and visual trauma cues in male combat veterans.

No. 30B
THE RELATIONSHIP BETWEEN BIPOLAR SPECTRUM AND IMPULSE CONTROL DISORDERS

Concetta M. DeCaria, Ph.D., *Department of Psychiatry, Mt. Sinai Medical Center, 1 Gustave Levy Place, New York NY 10029;* Eric Hollander, M.D., Charles Cartwright, M.D., Sherie Novotny, M.D., Serge A. Mosovich, M.D., Jared Finkell, B.A.

SUMMARY:

Bipolar spectrum disorders and impulse control disorders frequently co-occur and overlap. For example, bipolar patients may manifest impulsivity, particularly in a manic phase, and impulse control disorder patients may have mood swings associated with their impulsivity. Also, bipolar spectrum disorders and impulse control disorders have similar comorbidity patterns including elevated rates of substance abuse and dependence, anxiety, and eating disorders. Pathological gambling (PG), an impulse control disorder, is highly comorbid with bipolar disorders, since 31% of PG patients have comorbid bipolar disorders. Lithium and other mood stabilizers have been used to treat bipolar disorders, mood instability, and impulsivity, all factors of PG. We hypothesize that mood stabilizers may be an effective treatment for PG patients with comorbid bipolar features and preliminary data in the literature support this hypothesis. Many pathological gamblers, as well as patients with other impulse control disorders, may have an untreated mood disorder, and require mood stabilizers for both their impulsivity and affective instability. Results from a 10-week, parallel, double-blind controlled trial of lithium carbonate, lithobid, and placebo for the treatment of PG with comorbid bipolar spectrum features will be presented. Implications for treatment will be discussed.

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INDUSTRY-SUPPORTED SYMPOSIUM 31 (Part 1)—MOOD AND PSYCHOTIC DISORDERS IN WOMEN: AN UPDATE ON TREATMENT
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to know the differential effects of gonadal steroid on CNS neutromodulation and critical clinical issues regarding course and treatment of illness during pregnancy, the puerperium, and perimenopause. New information regarding sex-based differences in response to antipsychotic therapy will also be presented.

No. 31A
EFFECTS OF GONADAL STEROIDS ON BRAIN AND BEHAVIOR

David R. Rubinow, M.D., *National Institute of Mental Health, 10 Center Drive, Building 10, MSC 1276, Bethesda MD 20892;* Peter J. Schmidt, M.D.

SUMMARY:

Gonadal steroids function as major neuroregulators and presumably underlie gender-related differences (sexual dimorphisms) in brain structure and function. In animals, gonadal steroids modulate neurotransmitter receptor ontogeny, distribution, and activity as well as create capacities for behaviors in adulthood. Further, recent studies have identified groups of persons who are differentially susceptible to mood destabilization by gonadal steroids. For example, estrogen administration precipitates depression in women with menstrual cycle-related mood disorders, has no effect on mood in women lacking a history of menstrual cycle-related mood disorders, and displays antidepressant efficacy in women with perimenopausal depression. Similarly, the beneficial effects of estrogen on verbal memory are far more apparent in perimenopausal women than in young women with experimentally-induced hypogonadism. Thus, while gonadal steroids create a context that shapes development, their activational/neuromodulatory effects are highly context dependent. These observations, culled from a variety of hormone manipulation studies in both male and female rats and humans (which will be described in this presentation), suggest that increased attention to the role of gonadal steroids in modulating human behavior will help elucidate a critical question in psychiatric research: Why do different individuals respond differently to what is ostensibly the same stimulus?

No. 31B
MOOD AND PSYCHOTIC DISORDERS IN WOMEN DURING THE CHILDBEARING YEARS

Lee S. Cohen, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC 815, Boston MA 02114*

SUMMARY:

Affective disorders and psychotic illness cluster in women during the childbearing years. Nonetheless, systematic data regarding the course and safest treatment of these disorders during reproductive life events such as pregnancy and the postpartum period are sparse. For example, pregnancy has frequently been viewed as a time of emotional well being for women, providing "protection" against emotional disturbance. A growing literature, however, suggests that pregnant women with recurrent major depression may be at significant risk for relapse during pregnancy following antidepressant discontinuation. In addition, the risk for postpartum depression in women with histories of major depression is well established.

This presentation will review course of mood disorder during pregnancy and the postpartum period. Teratagenic risk associated with antidepressant and/or antipsychotic use during pregnancy will also be reviewed. Data regarding potential for perinatal toxicity following antidepressant use during labor and delivery will be presented. Treatment guidelines for psychotropic drug use during pregnancy and the postpartum period and lactation will also be reviewed. Given the growing use of atypical neuroleptics in women suffering from mood and psychotic illness, special treatment considerations will be discussed with respect to (1) sex differences in response to therapy with atypical neuroleptics as well as (2) differential risk for treatment-emergent side effects such as hyperprolactinemia across the growing number of these agents.

No. 31C
COURSE AND TREATMENT OF BIPOLAR ILLNESS DURING PREGNANCY AND THE POSTPARTUM PERIOD

Adele C. Viguera, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC 815, Boston MA 02114*

SUMMARY:

While the postpartum period has typically been considered a period of risk for relapse of bipolar disorder, systematic data regarding the course of bipolar disorder during pregnancy are essentially unknown. The management of bipolar women who plan to conceive or who are pregnant poses significant challenges for clinicians who care for these patients. Recent data suggest that pregnancy is not protective and the risk for relapse after lithium discontinuation is similar in pregnant and nonpregnant women with 50 percent relapsing within six months. This presentation reviews the major clinical dilemmas in managing pregnant bipolar patients as well as recent data on the course of bipolar disorder during pregnancy and the postpartum period. Treatment guidelines for the management of bipolar illness during pregnancy and the postpartum period will also be presented.

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INDUSTRY-SUPPORTED SYMPOSIUM 31 (Part 2)—MOOD AND PSYCHOTIC DISORDERS IN WOMEN: AN UPDATE ON TREATMENT
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to know the differential effects of gonadal steroid on CNS neutromodulation and critical clinical issues regarding course and treatment of illness during pregnancy, the puerperium, and perimenopause. New information regarding sex-based differences in response to antipsychotic therapy will also be presented.

No. 31A
GENDER AND THE SECOND GENERATION OF ANTIPSYCHOTICS

Ruth A. Dickson, M.D., *Department of Psychiatry, University of Calgary, 3500 26th Avenue NE, Calgary, AB, T1Y 6J4, Canada*

SUMMARY:

With the introduction of the second generation of antipsychotic medications, there has been increased interest in gender-specific issues related to these drugs, including: (1) efficacy, (2) spectrum of symptoms treated, and (3) side effects.

As there were limited numbers of women, especially those of child-bearing age, included in clinical trials of these new medications, post-release research and clinical experience with the atypical antipsychotics provide information that is important for optimizing treatment of women.

Some, but not all, of the new antipsychotics are prolactin-sparing. This has implications for women's mental and physical health, given the impact of this pituitary hormone on sexual and reproductive functioning. Reversal of neuroleptic-induced neuroendocrine side effects, such as amenorrhea, may increase reproductive potential. Prevention and treatment of neuroendocrine side effects secondary to prolactin-sparing antipsychotic drugs have implications for individual patients, their families, and the mental health care delivery system.

No. 31B
ESTROGEN AND MOOD IN PERIMENOPAUSAL WOMEN

Catherine A. Roca, M.D., *BPB/SBE, National Institute of Mental Health, 10 Center Drive, MSC 1276, Bethesda MD 20892;* Peter J. Schmidt, M.D., David R. Rubinow, M.D.

SUMMARY:

Epidemiologic studies demonstrate that the majority of women do not experience depression during the perimenopause. However, evidence suggests that for a subgroup of women, the perimenopause *is* a time of increased risk for developing major or minor depression. While a number of factors may contribute to the etiology of perimenopause-related depression, a growing body of evidence supports the relevance of estrogen (or the withdrawal of estrogen) in the etiology of this disorder. We have examined the role of estrogen in mood regulation in several ways. First, we demonstrated that estradiol under

double-blind, placebo-controlled conditions, improved measures of mood in depressed perimenopausal women with and without hot flushes. Second, in an effort to identify potential mechanisms underlying estrogen's beneficial effects on mood, we showed that the serotonin receptor antagonist metergoline (but not placebo) reversed the efficacy of estradiol, suggesting that the beneficial effects of estradiol are mediated by the serotonin system. Finally, we have initiated studies of polymorphisms in candidate genes related to serotonergic function in an effort to clarify both the vulnerability of some women to experience mood disorders during the perimenopause and the role of the serotonergic system in the putative psychotropic effects of estrogen in these women.

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INDUSTRY-SUPPORTED SYMPOSIUM 32 (Part 1)—ANXIETY DISORDERS: FROM SCIENTIFIC RESEARCH TO CLINICAL PRACTICE

Supported by U.S. Pharmaceuticals, Pfizer Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to discuss the presentation and treatment of anxiety in childhood; explore new treatment options for panic disorder, social phobia, and post-traumatic stress disorder; and examine the impact of anxiety disorders and their treatment on patient's quality of life

No. 32A
RECOGNITION AND PREVENTION OF ANXIETY IN CHILDREN AND ADOLESCENTS

John S. March, M.D., *Department of Psychiatry, Duke University Medical Center, PO Box 3527, Durham NC 27710*

SUMMARY:

The child and adolescent anxiety disorders include separation anxiety disorder, generalized anxiety disorder, both generalized and specific social phobia, specific phobias, obsessive-compulsive disorder, and post-traumatic stress disorder. After attention-deficit hyperactivity disorder and oppositional-defiant disorder, these are the most common psychiatric illnesses in children and adolescents. Comorbidity with other conditions including ADD depression and learning disabilities, also is common. With the exception of PTSD where environmental trauma is primary, the principle risk factor for a childhood-onset anxiety disorder is having a parent with an anxiety or depressive-spectrum disorder. Thus, like other major psychiatric disturbances, the childhood anxiety disorders are usefully viewed as neurodevelopmental conditions in which genetic factors interact with environmental risk and protective factors to determine psychopathology. This presentation will address: (1) the presentation and diagnosis of the childhood-onset anxiety disorders, (2) theories of etiology, (3) relationship to comorbid conditions; (4) treatment with cognitive-behavioral psychotherapy and pharmacotherapy.

No. 32B
PANIC DISORDER: INITIAL TREATMENT STRATEGIES AND BEYOND

Mark H. Pollack, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC-815, Boston MA 02114*

SUMMARY:

The treatment of panic disorder has been the focus of increasing attention over the last decade. A number of pharmacologic and cognitive-behavioral interventions have demonstrated efficacy for this condition; however, though most treated patients clearly improve with treatment, many remain at least somewhat symptomatic. Thus, there is continued interest in the search for new and effective agents and treatment strategies for patients with panic disorder. Recently, the selective serotonin reuptake inhibitors (SSRIs) have emerged as first-line agents for the treatment of panic.

In this presentation, we will review the pharmacologic options for the treatment of panic disorder, discuss factors that may contribute to partial or nonresponse to treatment, and discuss options for the management of treatment-refractory patients.

No. 32C
MANAGEMENT STRATEGIES FOR PTSD

Kathleen T. Brady, M.D., *Department of Psychiatry, Medical University of South Carolina, 171 Ashley Avenue, Charleston SC 29425-0742*

SUMMARY:

Post-traumatic stress disorder has become increasingly recognized as a prevalent psychiatric disorder associated with significant distress, impairment, and disability in affected individuals. Recent survey data indicate that 60% to 70% of individuals in the United States have suffered a traumatic event and 5% to 10% meet current criteria for PTSD. PTSD is a heterogeneous disorder with a wide variety of clinical presentations. Diagnostic subtypes as well as the comorbidity of PTSD with other psychiatric disorders will be discussed. Risk factors for the development of PTSD will be reviewed.

There are a number of exciting developments in the pharmacotherapeutic and psychotherapeutic treatment of PTSD. Data addressing the use of exposure therapy and cognitive strategies for prevention of PTSD in individuals who have been traumatized as well as for treatment of PTSD will be presented. The pharmacotherapeutic treatment of PTSD has been an area of active investigation in the past several years. Promising data from controlled clinical trials investigating the use of sertraline, fluoxetine, and nefazadone will be presented. Pilot data addressing the use of other psychotropic agents will also be reviewed. A rationale for choosing a pharmacologic intervention based on patient subtype will be discussed.

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INDUSTRY-SUPPORTED SYMPOSIUM 32 (Part 2)—ANXIETY DISORDERS: FROM SCIENTIFIC RESEARCH TO CLINICAL PRACTICE
Supported by U.S. Pharmaceuticals, Pfizer Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to discuss the presentation and treatment of anxiety in childhood; explore new treatment options for panic disorder, social phobia, and post-traumatic stress disorder; and examine the impact of anxiety disorders and their treatment on patient's quality of life

No. 32A
SOCIAL PHOBIA: COURSE, COMPLICATIONS AND THERAPEUTICS

John H. Greist, M.D., *Madison Institute of Medicine, 7617 Mineral Point Road, Suite 300, Madison WI 53717*

SUMMARY:

Some social anxiety is salubrious as it stimulates practice, which produces better performance and greater rewards. Beyond some threshold, social anxiety interferes with performance and becomes a handicap. Social anxiety covers a spectrum from normal to performance and generalized social phobias and ends in avoidant personality disorder. Bimodel onset in early childhood or around puberty is common and late onset rare. Prevalence is remarkably high and recent studies have confirmed rates of clinically significant social phobia approaching 10%. Once begun, social phobia runs a chronic course, often with complicating comorbidities and substantial costs for sufferers and our communities.

Effective treatment is possible with MAOIs, benzodiazepines, SSRIs, and, for the performance type, beta blockers. For generalized social phobia, SSRIs are emerging as the treatment of choice because of their effectiveness, tolerability, and safety. Cognitive-behavior therapy is also effective although it is more difficult to design convenient exposure sessions for social phobia than for other anxiety disorders.

Common, chronic, fascinating, sometimes disabling, and imminently treatable, social phobia is emerging as another psychiatric disorder where careful diagnosis and straightforward treatment can relieve suffering and restore functioning.

No. 32B
UNDERSTANDING QUALITY OF LIFE IN ANXIETY DISORDERS

Mark H. Rapaport, M.D.,*Department of Psychiatry, University of California at San Diego School of Medicine, 8950 Villa Jolla Drive, #2243, La Jolla CA 92037;* Mark H. Pollack, M.D., Cathryn M. Clary, M.D., Robert Wolkow, M.D.

SUMMARY:

This paper investigates the cost and adverse impact of anxiety disorder on quality of life and health care utilization. Particular emphasis will be placed on the impact of panic disorder on quality of life and health care utilization. We will review data from both epidemiological and clinical studies of patients with panic disorder. We will then review the treatment trials suggesting that effective treatment is associated with decreased health care utilization and increased quality of life. However, the majority of this presentation focuses on new data demonstrating the interaction between true treatment response and improvement in quality of life. These data clearly demonstrate that the remediation of symptoms with pharmacotherapy leads to enhancement in quality of life that is distinctly different than observed in placebo responders. This finding has important implications not only for the researcher, but in particular for clinicians in their interaction with health care systems. These data suggest that true beneficial treatment response is clearly linked to quality of life improvement.

No. 32C
APPLYING COGNITIVE-BEHAVIOR THERAPY TO CLINICAL PHARMACOTHERAPY

Michael W. Otto, Ph.D., *Massachusetts General Hospital, 15 Parkman Street, WACC-815, Boston MA 02114*

SUMMARY:

Cognitive-behavior therapy (CBT), frequently characterized as an efficacious alternative to pharmacotherapy, is also an effective strategy for extending and maintaining treatment gains among patients undergoing medication treatment. This presentation will focus on the application of select cognitive-behavioral strategies to standard clinical pharmacotherapy. Greatest emphasis will be placed on the use of information and self-directed exposure assignments for the treatment of anxiety disorders. These strategies are used to compliment the anxiolysis provided by medication, and are designed to translate reductions in anxious affect into broader treatment gains. Informational interventions are used to provide patients with a model of self-perpetuating cycles between the thoughts, emotions, and avoidance behaviors that characterize each disorder. Information is followed by instruction in straightforward cognitive-restructuring, self-monitoring, and self-directed exposure interventions. Attention is placed on the application of these interventions within the context of brief (20 minute) pharmacotherapy visits. Minimal interventions are discussed specifically for panic disorder, social phobia, and PTSD.

REFERENCES:

1. Social Phobia. Diagnosis, Assessment and Treatment. RG Heimberg, MR Liebowitz, Edited by Hope DA, Schneier FR. The Guilford Press, NY, 1995
2. Rapaport MH, Cantor JJ: Panic disorder in a managed care environment. J Clin Psychiatry 1997;58 (suppl 2):51–55
3. Gould RG, Otto MW: Cognitive-behavioral treatment of social phobia and generalized anxiety disorder, in Challenges in Clinical Practice. Edited by Pollack MH, Otto MW, Rosenbaum JF. The Guilford Press, New York, 1996
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INDUSTRY-SUPPORTED SYMPOSIUM 33 (Part 1)—ASSESSMENT AND TREATMENT OF PSYCHIATRIC DISORDERS IN THE ELDERLY

Supported by Janssen Pharmaceutica and Research Foundation

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: (1) Identify the prevalence of mental disorders in the elderly; (2) Explain the benefits and side effects of conventional neuroleptics in the elderly; (3) Recognize the appropriate medication interventions among available pharmacotherapies as part of an interdisciplinary treatment plan; (4) Discuss the differential diagnosis of cognitive impairment and behavioral changes in the elderly; and (5) Identify treatment and diagnostic issues of late-life depression and dementia.

No. 33A
ADAPTATIONAL CHANGES IN LATE LIFE

W. Walter Menninger, M.D., *Menninger Clinic, P.O. Box 829, Topeka KS 66601*

SUMMARY:

Mental health problems affect a significant number of elderly persons, resulting in compromised personal functioning, increased use of health services, and an impaired quality of life. A clearer understanding of the conditions contributing to the adaptational challenges in the aging process will positively impact both the diagnostic accuracy and treatment precision for this population.

This symposium will address current issues in the assessment and treatment of the elderly from early detection mechanisms to advances in treatment approaches. A complete review of advances in pharmacotherapy for the elderly, particularly as it relates to depression, agitation, and dementia, and its role in an integrated treatment regime will be presented. The issue of comorbidity, common in this age group, will be discussed along with specific models for treating psychiatric disorders in a nursing home environment.

The educational significance of this program for mental health professionals is further emphasized by both the number of people affected and the changing dynamics of assessment and treatment.

No. 33B
ADVANCES IN THE TREATMENT OF AGITATION IN THE ELDERLY

Stuart C. Yudofsky, M.D., *Department of Psychiatry and Behavioral Sciences, Baylor College of Medicine, One Baylor Plaza, Houston TX 77030*

SUMMARY:

This presentation covers assessment and treatment strategies for agitation in older adults. It includes a review of epidemiology and differential diagnosis of agitation in elderly patients and presents the Overt Agitation Severity Scale, an objective rating scale for the assessment of agitation.

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, these behaviors are difficult to treat optimally while maintaining patient alertness and minimizing cognitive problems. Management with pharmacologic agents, including serotonin-specific drugs, anticonvulsants, and β-blockers, will be reviewed.

No. 33C
TREATING PSYCHIATRIC DISORDERS IN THE NURSING HOME

George T. Grossberg, M.D., *Department of Psychiatry, St. Louis University, 1221 South Grand Boulevard, St Louis MO 63104-1016*

SUMMARY:

Estimates are that 70% to 90% of all nursing home residents have one or more DSM-IV diagnosable psychiatric disorders. Most commonly encountered are the dementias with their secondary behavioral concomitants. Mood disorders are the second most commonly seen, with major depression affecting one in five nursing home residents. Delirium is often missed in the nursing home and accounts for 12% of psychiatric consultations.

The number one reason for psychiatric consultation is the presence of agitation and/or psychosis in the context of a dementing illness. Up to 80% of patients with probable Alzheimer's disease may develop agitation or more overtly aggressive behaviors.

This presentation will focus on diagnosis and treatment of mood disorders in the nursing home with an emphasis on the AMDA Consensus Conference recommendations. In addition, etiologies and nonpharmacologic treatment approaches to problem behaviors in demented patients will be emphasized.

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1. Aronson, SM: Cost-effectiveness and quality of life in psychosis: the pharmacoeconomics of risperidone. Clinical Therapeutics 1997;19:1;139–147
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3. Small GW: Neuroimaging and genetic assessment for early diagnosis of Alzheimer's disease. J Clin Psychiatry 1996:57 (Suppl 14)
4. Jeste DV, McClure FS: Psychosis: diagnosis and treatment in elderly. in: Updates in Geriatric Psychiatry. L Schneider (Ed.), Jossey-Bass, Chap. 4, 53–70, 1998
5. Menninger WW (Ed): Times of crisis: adolescence and aging. Bulletin of the Menninger Clinic 1988; Vol. 52(3):190–279
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INDUSTRY-SUPPORTED SYMPOSIUM 33 (Part 2)—ASSESSMENT AND TREATMENT OF PSYCHIATRIC DISORDERS IN THE ELDERLY

Supported by Janssen Pharmaceutica and Research Foundation

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: (1) Identify the prevalence of mental disorders in the elderly; (2) Explain the benefits and side effects of conventional neuroleptics in the elderly; (3) Recognize the appropriate medication interventions among available pharmacotherapies as part of an interdisciplinary treatment plan; (4) Discuss the differential diagnosis of cognitive

impairment and behavioral changes in the elderly; and (5) Identify treatment and diagnostic issues of late-life depression and dementia.

No. 33A
COPING WITH LATE LIFE

W. Walter Menninger, M.D., *Menninger Clinic, P.O. Box 829, Topeka KS 66601*

SUMMARY:

In the process of adapting to change in late life, individuals must address four major tasks, each of which represents loss and a change in the sense of self:

- Acceptance of a new, less potent sense of self, prompted by physical and mental changes inherent in the aging process.
- Acceptance of the loss of one's peers through death, including the loss of one's life partner.
- Losing one's independence with ultimately a role reversal of becoming dependent on one's children.
- Losing one's lifelong identity through retirement from work, and becoming oriented to the past as a means of rationalizing one's continued existence.

Ego defenses, ranging from primitive to mature, are utilized in coping with the aging challenge. These include retreating from reality in efforts to conserve energy, excluding distressing experiences from awareness, and seeking new ways to achieve mastery and control.

No. 33B
EARLY DETECTION AND COMORBIDITY ISSUES: DEMENTIA AND DEPRESSION IN THE ELDERLY

Stephen M. Aronson, M.D., *Medical Education, Oakwood Hospital, 18189 Oakwood Blvd, Suite 401, Dearborn MI 48124*

SUMMARY:

Mood disorders and dementing illnesses are common in elderly patients. Both have significant consequences in terms of suffering, comorbidity, outcome, and financial cost. It is often difficult to quickly and precisely differentiate between these syndromes because there is often significant symptom overlap between them. Patients with dementia (such as Alzheimer's disease or vascular dementia) may appear withdrawn, anergic, affectually flat, and amotivational without in fact being depressed. Elderly persons with a depressive disorder may present with a dementia-appearing vegetative syndrome so severe that they seem to have late-stage Alzheimer's disease.

This presentation will survey the characteristics of depressive and dementia syndromes in the elderly with emphasis on areas of overlap and potential diagnostic confound. A rational and cost-effective approach to diagnostic evaluation will be presented that may assist the clinician in diagnosing and treating these syndromes. The epidemiology of the disorders will be reviewed, and recent findings about the comorbidity of depression and dementia will be discussed, with attention to implications regarding prognosis. Treatment options are different for depressive disorders and dementing illnesses, yet they share the same goal of maximizing quality of life and functional independence for the elderly patient and her/his family.

No. 33C
TYPICAL VERSUS ATYPICAL ANTIPSYCHOTICS IN THE ELDERLY

Dilip V. Jeste, M.D., *Department of Psychiatry, University of California at San Diego, 3350 La Jolla Village Drive, San Diego CA 92161;* Jonathan P. Lacro, Pharm.D., M. Jackuelyn Harris, M.D., Hoang A. Nguyen, M.D., Enid Rockwell, M.D., Mihaela E. Petersen, M.D.

SUMMARY:

Pharmacologic treatment of geriatric patients presents a special challenge because of issues such as physical comorbidity, polypharmacy, altered pharmacokinetics, and pharmacodynamics, among others. The primary indications for neuroleptics in the elderly include psychotic disorders such as schizophrenia, and severe behavioral disturbances in patients with dementia. Elderly patients with psychotic symptoms or severe agitation respond to antipsychotic treatment, but are at an increased risk for side effects, particularly tardive dyskinesia, associated with conventional neuroleptics. New atypical antipsychotics, such as clozapine, risperidone, olanzapine, and quetiapine represent a significant advance over conventional ones. Data will be presented on the efficacy and safety of conventional versus atypical antipsychotics in the elderly. For example, studies have found that the risk of tardive dyskinesia is markedly lower with atypical compared with typical antipsychotics. Nonetheless, the newer agents too have side effects, especially when used in higher dosages in the geriatric population. Specific recommendations will be made regarding appropriate dosing of these drugs in the elderly.

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1. Aronson SM: Cost-effectiveness and quality of life in psychosis: the pharmacoeconomics of risperidone. Clinical Therapeutics 1997;19:1;139–147
2. Grossberg GT, Grossberg J: Epidemiology of psychotherapeutic drug use in older adults. Geriatric Medicine Clinics Feb., 1998
3. Small GW: Neuroimaging and genetic assessment for early diagnosis of Alzheimer's disease. J Clin. Psychiatry, 1996:57 (Suppl 14)
4. Jeste DV, McClure FS: Psychosis: diagnosis and treatment in elderly, In: Updates in Geriatric Psychiatry. Edited by Schneider L. Jossey-Bass, Chap. 4, 53–70, 1998
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7. Jeste DV, Rockwell E, Harris MJ, Lohr JB, Lacro J: Conventional versus newer antipsychotics. American Journal of Geriatric Psychiatry (in press, 1998)

INDUSTRY-SUPPORTED SYMPOSIUM 34 (Part 1)—ADVANCES IN THE TREATMENT OF GERIATRIC DEPRESSION
Supported by SmithKline Beecham Pharmaceuticals

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize the factors that make the diagnosis and treatment of depression different in late life.

No. 34A
PHARMACOLOGY OF ANTIDEPRESSANTS PERTINENT TO OLDER PATIENTS

Bruce G. Pollock, M.D., *Department of Psychiatry, Western Psychiatric Institute, 3811 O'Hara Street, Pittsburgh PA 15213-2593*

SUMMARY:

Patients older than age 65 represent 12% of the U.S. population, yet they receive from 25% to 35% of all prescription drugs and disproportionately suffer from drug interactions and adverse effects of medications. Over the last decade, physicians in the United States

who treat older psychiatric patients have gained access to eight new antidepressants. Age-associated physical comorbidity, cognitive impairment, and pharmacokinetic or pharmacodynamic changes prevent the "simple" extrapolation to the elderly of data acquired in younger patients. Hence, it is unfortunate that there is such a dearth of information regarding the use of these medications in older patients and in particular on their relative effectiveness in frail older patients when compared with older psychotropic medications. It is also important to appreciate that the side-effect profile of newer medications in the old may differ from younger, healthier patients typically included in regulatory clinical trials. The purpose of this lecture is to summarize features and available study data for these new agents relevant to their use in the old. Particular attention will be given to age-associated concerns with antidepressant use, such as effects on cognition, balance, inappropriate antidiuretic hormone secretion, anticholinergic burden, and drug-drug interactions.

No. 34B
TREATING SEVERE MELANCHOLIC DEPRESSION: NEW DATA

Benoit H. Mulsant, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh PA 15213-2593;* Bruce G. Pollock, M.D., Robert Nebes, Ph.D., Mark D. Miller, M.D., John T. Little, M.D., Jackie Stack, M.S.N., Charles F. Reynolds III, M.D.

SUMMARY:

Over the past decade, selective serotonin reuptake inhibitors (SSRIs) have replaced tricyclic antidepressants (TCAs) as first-line antidepressants for most depressed patients both in psychiatric and primary care practices. This shift in practice has been attributed to the ease of use of SSRIs (e.g., absence of need to monitor EKG or plasma levels) and their more benign side-effects profile. However, some studies have found a lower rate of acute response with SSRIs than with TCAs in inpatients with melancholic depression. These studies have raised concerns about a possible efficacy gap between SSRIs and TCAs, in particular in older patients with more severe depression. Data from two studies comparing the efficacy of TCAs and SSRIs (nortriptyline vs. fluoxetine, nortriptyline vs. paroxetine) in older patients with severe depression will be reviewed. Implications for current clinical practice will be discussed.

No. 34C
TREATING DEPRESSION IN THE OLDEST-OLD: FINDINGS FROM THE HARVARD/HRCA STUDY

Carl Salzman, M.D., *Department of Psychiatry, Harvard Medical School, 74 Fenwood Road, Boston MA 02115-6106*

SUMMARY:

Major depression and symptoms of nonmajor depression are common and potentially disabling in the very old (>75). Diagnostic criteria for MDD in the oldest old are the same as for other age groups. However, sleep disturbance, hopelessness, and thoughts of death are not necessarily signs of MDD. Significant increases in irritability and social withdrawal are more reliable indications of a depressive-spectrum disorder.

Treatment of depression in the oldest old follows the principle of "start low and go slow." TCAs are very effective, but side effects may limit their usefulness unless very low doses are used. Hydroxymetabolites of TCAs are potentially cardiotoxic. SSRIs are the first choice antidepressants for outpatient and milder depressions. Some data suggest that they are as useful for serious MDD as TCAs. Newer, atypical antidepressants each have their benefits and unique side-effect profiles; all are effective.

We report preliminary data comparing paroxetine and placebo in nursing home residents >80 with nonmajor depression. There was a very high PBO response rate: overall there were no significant differences after eight weeks of treatment. Subgroup analyses, however, significantly favored paroxetine over PBO, suggesting that this SSRI is effective in treating nonmajor depression in very elderly nursing home residents.

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1. Pollock BG: Drug interactions, in: Nelson JC, ed. Geriatric Psychopharmacology. New York: Marcel Dekker, 1997; pp 43–60
2. Roose S, Laghrissi-Thode F, Kennedy JS, Nelson JC, Bigger JT, Pollock BG, Gaffney A, Narayan M, Finkel M, McCafferty J, Gergel I: A comparison of paroxetine to nortriptyline in depressed patients with ischemic heart disease. JAMA 279:287–291, 1998
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INDUSTRY-SUPPORTED SYMPOSIUM 34 (Part 2)—ADVANCES IN THE TREATMENT OF GERIATRIC DEPRESSION
Supported by SmithKline Beecham Pharmaceuticals

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to recognize the factors that make the diagnosis and treatment of depression different in late life.

No. 34A
DEPRESSION IN THE OLDER PATIENT WITH COMORBID ISCHEMIC DISEASE

Steven P. Roose, M.D., *Clinical Psychopharmacology, New York State Psychiatric Institute, 722 West 168th Street, Unit 98, New York NY 10032*

SUMMARY:

An important link between depression and ischemic vascular disease has been established. There is strong evidence that patients with depression more frequently develop symptomatic and fatal ischemic heart disease and that patients with manifest ischemic heart disease who are also depressed have an increased mortality rate. Thus, major depression has emerged as an independent risk factor for the development of ischemic heart disease rather than simply a psychological response to its presence. Furthermore, it has been established that depressive disorders are common following stroke, and there is an association between the location of the lesion and the development of post-stroke depression. Data from a longitudinal study of hypertension in the elderly further indicate that depression and anxiety may be independent risk factors for the development of stroke as well.

The physiological underpinning to the relationship between ischemic disease and depressive disorders may be abnormalities in plate-

let function. Depressed patients exhibit greater platelet reactivity compared with nondepressed controls. Whereas inhibition of platelet function prevents vascular occlusion, increased platelet activation leads to thrombosis formation and acute vascular ischemia.

Treatment studies of depressed patients with ischemic heart disease or post-stroke depression report that the SSRIs are effective and well tolerated. Intriguingly, it has been established that the SSRIs also have a significant effect on reducing platelet activation. Therefore, SSRI treatment may be uniquely beneficial in the treatment of the depressed patient with ischemic vascular disease.

No. 34B
THE CURRENT ROLE OF ECT IN THE TREATMENT OF GERIATRIC DEPRESSION

Harold A. Sackeim, Ph.D., *Department of Psychiatry, New York State Psychiatric Institute, 722 West 168th Street, Room 422, New York NY 10032*

SUMMARY:

Advances in pharmacological treatment led to a sharp decline in electroconvulsive therapy (ECT) utilization in the general adult population during the 1970s and 1980s. During this period, ECT use remained stable among elderly psychiatric patients, and has shown a general increase in recent years. This presentation will review the factors that make ECT a frequent consideration among geriatric patients with major depression. Indeed, unlike other psychiatric interventions, with ECT there appears to be a positive relation between patient age and therapeutic outcome. However, use of ECT in the elderly often calls for alteration of treatment technique. Older patients have special needs with regard to stimulus dosing, and often display a greater vulnerability to adverse cognitive side effects. The choice of stimulus dosing strategy, electrode placement, and spacing of treatments will be discussed. In the absence of continuation treatment following ECT, virtually all patients will relapse within a six-month interval. Pharmacological strategies for relapse prevention need to consider the degree and type of medication resistance evidenced during the acute depressive episode. The role of pharmacotherapy and continuation ECT in relapse prevention in elderly patients will be discussed.

REFERENCES:

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INDUSTRY-SUPPORTED SYMPOSIUM 35—THE INTERFACE BETWEEN DEPRESSION AND DEMENTIA
Supported by Parke-Davis

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to review the phenomenology, treatment, and research dimensions of the depression-dementia interface. Clinical assessment, interventions, and prognosis will be emphasized.

No. 35A
CLINICAL ASSESSMENT: MOOD, COGNITION AND THEIR INTERACTION IN THE ELDERLY

David L. Sultzer, M.D., *Department of Psychiatry, University of California at Los Angeles, Neuropsychiatric Institute, 760 Westwood Plaza, Room 37-440, Los Angeles CA 90024-1759*

SUMMARY:

Elderly patients with major depression frequently have memory deficits and other signs of mild cognitive impairment. These deficits associated with a primary mood disorder usually improve with treatment, although recent evidence indicates that depression may be a risk factor for subsequent dementia. Moreover, dysphoria and irritability are common in patients with Alzheimer's disease and major depressive episodes are frequent in patients with vascular dementia.

The clouded boundary between mood disorders and dementia and the frequent co-occurrence of mood and cognitive symptoms in the elderly can present a clinical challenge. Thoughtful, yet efficient assessment strategies are critical. Specific clinical features and the longitudinal course can usually distinguish primary mood disorders from dementia syndromes. Rating scales can be used to measure the severity of depression or cognitive impairment, and neuroimaging or other laboratory studies may be indicated in some situations. In patients with established dementia, identifying a comorbid mood disorder can be difficult, although the clinical features that appear in the interview and input from the caregiver can improve detection. Overall, careful assessment can distinguish between mood disorders and dementia syndromes, reveal superimposed mood symptoms in patients with dementia, and provide the clinician with a diagnostic conceptual framework that points toward an effective treatment strategy.

No. 35B
DEPRESSED MOOD AND DEMENTIA IN ELDERLY PATIENTS IN THE COMMUNITY

Davangere P. Devanand, M.D., *Department of Psychiatry, New York State Psychiatric Institute, 722 West 168th Street, Box 72, New York NY 10032-2603;* Karen Marder, M.D., Richard Mayeux, M.D., Mary Sano, Ph.D., Yaakov Stern, Ph.D.

SUMMARY:

The interface between depression and dementia is complex. Earlier views about "pseudodementia" being a common problem have given way to concerns that the presence of significant cognitive impairment with depression may be a harbinger of dementia. To clarify these issues, elderly community-residing subjects were identified for a long-term follow-up study. In the 852 subjects without dementia at baseline evaluation, the prevalence of depression was higher in subjects with greater cognitive impairment. Of these 852 subjects, 478 (58.3%) were followed for an average of 2.54 (SD 1.12) years. Compared with subjects without baseline depressed mood, those with depressed mood had 2.94 times the risk of developing dementia during follow-up. This effect remained significant after covarying for age, gender, education, primary language, and cognitive and functional ability scores. These findings indicate that the presence of depression may be either a prodromal sign or an early manifestation of AD in many elderly subjects. The patient who is aware of declining cognition may become depressed as a psychological reaction to the growing deficits. Alternatively, degeneration of noradrenergic and serotonergic pathways early in the course of Alzheimer's

disease may present as concomitant depression and cognitive impairment. Regardless of the mechanism involved, these data support those from other recent studies that suggest that cognitive impairment in a depressed patient may be an early indicator of a dementing process.

No. 35C
TREATMENT OF DEPRESSION IN THE OLD-OLD

Steven P. Roose, M.D., *Clinical Psychopharmacology, New York State Psychiatric Institute, 722 West 168th Street, Unit 98, New York NY 10032*

SUMMARY:

Though the "old old," over age 75, are the most rapidly expanding segment of the population, this group has been the least studied in randomized, control trials (RCTs) of depression. To date the many studies of late-life depression (over age 60) include few patients 75 to 80 and fewer still over 85. Though unfortunate, the lack of data on treatment of the depressed old old is understandable; traditional narrow inclusion and exclusion criteria in RCTs excludes many older patients because of comorbid medical conditions or concominant medication use. Another critical issue is of cognitive impairment: most studies will exclude patients with MMSE scores below 23, based on the belief that a score lower than 23 indicates dementia. However, studies have shown that in older patients significant cognitive impairment resolves when depression is effectively treated. These data will be reviewed.

Recently a consortium of geriatric researchers has begun the largest RCT in the depressed old old to date. This study, which began in September 1998, enrolled 200 depressed patients over age 75, with MMSE scores as low as 18, and will compare citalopram with placebo.

No. 35D
PHARMACOTHERAPY OF THE COGNITIVELY IMPAIRED

Bruce G. Pollock, M.D., *Department of Psychiatry, Western Psychiatric Institute, 3811 O'Hara Street, Pittsburgh PA 15213-2593;* Meryl Butters, Ph.D., Robert Nebes, Ph.D.

SUMMARY:

Depression can be a major problem in demented patients, further degrading their quality of life, increasing mortality, and burdening patients and their caregivers with excess disability. To date, placebo-controlled data with the SSRIs fluoxetine and citalopram have demonstrated decreases in depressive symptoms, confusion, and disturbed behavior in patients suffering from dementia, randomized to active medication, in contrast with a placebo-controlled trial with imipramine. Preliminary findings from an ongoing study at our center indicate an association between effective antidepressant treatment and significantly improved Mattis Dementia Rating Scale scores as well as measures of conceptualization and initiation/perseveration. These data are consistent with models that emphasize the role of frontal-subcortical systems in mediating the effects of depression on cognition. Application of clinical pharmacological methods may substantially improve pharmacotherapy of these complicated patients. There is immense inter-individual variability in structural damage, medical and medication burden, and therapeutic drug concentrations observed in older patient populations. For example, work from our center has shown that even very low levels of serum anticholinergicity are associated with memory decrements. It is thus important to balance considerations of antidepressant effectiveness with potential cognitive toxicity arising from direct, additive, anticholinergic effects or indirectly from drug interactions.

No. 35E
CARDIOVASCULAR CHANGES IN DEPRESSION AND DEMENTIA

K. Ranga R. Krishnan, M.D., *Department of Psychiatry, Duke University Medical Center, 3018 South Hospital, Room 3352, Durham NC 27710*

SUMMARY:

Emerging epidemiological data suggest that silent infarcts are common in the aging population. In the Cardiovascular Health Study (CHS) over 3,000 subjects were studied using MRI. Infarcts were detected in 30% of patients. The lesions increase with age. Parallel with the epidemiological studies are a number of clinical studies demonstrating a relationship between these lesions and cognitive impairment as well as affective disorder, both unipolar and bipolar. Epidemiological studies have shown an association with and a decline over time in cognition and the occurrence of lesions.

The available data support the concept of an MRI-defined vascular depression. MRI-defined vascular depression and bipolar disorder appear to be a common syndrome in geropsychiatry services. The clinical manifestation, treatment response, and outcome of MRI-based vascular depression will be discussed.

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INDUSTRY-SUPPORTED SYMPOSIUM 36—ANTIDEPRESSANT COMBINATIONS FOR DRUG-RESISTANT AND INTOLERANT CASES
Supported by Wyeth-Ayerst Laboratories

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: (1) Understand the rationale for combining multiple synergistic pharmacologic mechanisms not only to enhance efficacy, but also to alleviate treatment intolerance in depressed and anxious patients. (2) Know several specific approaches and drug combinations, and be able to implement them in psychiatric practice.

No. 36A
CELLULAR MECHANISMS OF ANTIDEPRESSANT ACTION

Richard C. Shelton, M.D., *Department of Psychiatry, Vanderbilt University, 1500 21st Avenue South, Suite 2200, Nashville TN 37212*

SUMMARY:

We are in a period of rapid expansion of both the agents that are available to treat depression and our understanding of how these drugs are working. This presentation will review the fundamental subcellular targets of antidepressant drugs and relate these mechanisms to the effectiveness of these agents in practice. In particular, we will trace the impact of antidepressant drugs on the transductional cascade from cell surface receptors (noradrenergic and serotonergic) to transductional mechanisms like protein kinases, Cyclic AMP Response Element Binding protein (CREB), and immediate early genes, to the generation of specific gene products. These mechanisms are affected by antidepressant drugs, which activate these cascades. These mechanisms are likely to become targets of novel antidepressant agents. Current and future treatment decisions may be guided by an expanded understanding of these mechanisms.

No. 36B
HOW TO COMBINE TWO ANTIDEPRESSANTS FOR TREATMENT SYNERGY AND SIDE-EFFECT REDUCTIONS

Stephen M. Stahl, M.D., *Department of Psychiatry, University of California at San Diego, 8899 University Center Lane #130, San Diego CA 92122*

SUMMARY:

When patients fail to respond to a series of antidepressants, it may be that the necessary neurotransmitter-mediated transduction cascade cannot be converted into the generation of those specific gene products that cause antidepressant effects to occur. Combining synergistic pharmacologic mechanisms may provoke the desired gene response when single pharmacologic mechanisms cannot. However, unacceptable side effects may occur when the genetic products that mediate the development of tolerance fail to be activated. In this case, combining antagonistic pharmacologic mechanisms may reduce such side effects. Understanding how more than two dozen antidepressants work by at least seven distinct mechanisms can assist the clinician in selecting agents that combine either synergistic actions, antagonistic actions, or both. Some agents, such as venlafaxine and mirtazapine, have dual actions themselves. Clever combinations of agents, which pair different actions at the same neurotransmitter system, or the same actions at different neurotransmitter systems, can often solve the problems of treatment resistance and treatment intolerance. Several specific examples will be discussed and their actions demonstrated in a multimedia presentation.

No. 36C
WHEN IS POLYPHARMACY GOOD IN TREATING MAJOR DEPRESSION?

Jeffrey E. Kelsey, M.D., *Department of Psychiatry, Emory University, 1639 Pierce Drive, Suite 4000, Atlanta GA 30322*

SUMMARY:

The armamentarium of medications that have antidepressant properties directly, or in combination with other agents, has been growing at a rapid pace. We also recognize that the contemporary practice of psychiatry is finding increased numbers of patients with major depression who may not achieve remission with monotherapy. Older medications, such as the tricyclic antidepressants, tend to have multiple pharmacological effects, often a mix of both presumed therapeutic activity, and properties that produce undesirable side effects. The resistant/intolerant patient challenges us to utilize our full knowledge of pharmacotherapy for utilizing medications as a component of treatment. Unfortunately, the rational use of multiple medications, when necessary to achieve remission, is a field that is more populated by case reports and open-label trials than the more direct "one drug" treatment approach. This presentation will review the use of more than one medication for treatment of major depression, based on a presumptive understanding of mechanism of action including stimulating release, inhibiting reuptake, occupancy of pre- and/or postsynaptic receptors, or inhibiting degradation. Data from clinical trials, retrospective reports, and patient examples will be used. Relevant pharmacokinetic and pharmacodynamic interactions will be addressed.

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INDUSTRY-SUPPORTED SYMPOSIUM 37—RECENT ADVANCES IN PSYCHOPHARMACOLOGY
The American Society of Clinical Psychopharmacology
Supported by Bristol-Myers Squibb

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to use new treatments for schizophrenia and bipolar disorder, should be able to treat chronic depression, and treat comorbid anxiety and substance abuse, and will be familiar with drug interactions important in psychiatry.

No. 37A
NEW TREATMENTS FOR SCHIZOPHRENIA

Stephen R. Marder, M.D., *Department of Psychiatry, West Los Angeles VA Medical Center, 11301 Wilshire Blvd. (116A), Los Angeles CA 90073*

SUMMARY:

This presentation will review recent advances in the pharmacological treatment of schizophrenia. The data supporting the effectiveness of approved new agents (currently clozapine, risperidone, olanzapine, and quetiapine) will be reviewed, with a focus on their effects on negative as well as cognitive symptoms. Both short-term and long-term trials will be reviewed as well as studies in special populations including the elderly and children. The adverse-effect profiles of these agents will be reviewed and recommendations will be made regarding which older or newer agent is appropriate for different individuals with schizophrenia. The status of drugs that are under study and not approved will be reviewed.

No. 37B
NEW TREATMENTS FOR BIPOLAR DISORDER

Lori L. Altshuler, M.D., *Department of Psychiatry, VA Medical Center, 11301 Wilshire Blvd, B116AA, Los Angeles CA 90073*

SUMMARY:

This lecture will present an overview of the course and epidemiology of bipolar disorder. Treatment goals, differential diagnosis, and the spectrum and precipitants of bipolar disorders will also be discussed. Several new anticonvulsants—lamotrigine, gabapentin, tiagabine, and topiramate—are currently undergoing trials as add-on treatment for mania. The literature will be reviewed and optimal clinical usage discussed. These new treatments will be compared with current treatment regimens. The discussion will include guidelines for incorporating the new treatments into a patient's current regimen. Timing (when is it appropriate to use a new anticonvulsant?), safety and efficacy issues, and suggested titration schedules will be reviewed.

No. 37C
REMOVING THE CHRONICITY FROM CHRONIC DEPRESSION

James H. Kocsis, M.D., *Department of Psychiatry, New York Hospital, PO Box 147, New York NY 10021–0012*

SUMMARY:

"Chronic depression" refers to a depressive syndrome persisting two or more years. *Pure dysthymia* is a mild chronic depression. *Chronic major depression* is a more severe chronic depression. When dysthymia is punctuated by episodes of major depression, it is termed *double depression.* Because of their frequent early age of onset and chronicity, chronic depressions are often misdiagnosed as personality disorders. *Even* in its mild form chronic depression is characterized by marked impairments in social and vocational function. Recent clinical research has focused attention on the treatment of these disorders.

The main purpose of this presentation will be to review and discuss the implication of studies of the treatment of chronic depression. The following issues will be addressed:

(1) Are antidepressant medications effective for the treatment of chronic depression? (2) Do classes of antidepressant medication vary in their effectiveness for chronic depression? (3) How long does effective treatment need to continue? Is long-term treatment effective? (4) What happens to psychosocial deficits during antidepressant therapy? (5) What are the implications of comorbidity of anxiety, personality, or substance abuse disorders? (6) Is there evidence that psychotherapies, either alone or in combination with antidepressant medications, are useful for treating chronic depression?

No. 37D
TREATMENT OF COMORBID ANXIETY AND SUBSTANCE ABUSE

Kathleen T. Brady, M.D., *Department of Psychiatry, Medical University of South Carolina, 171 Ashley Avenue, Charleston SC 29425–0742*

SUMMARY:

In this presentation, the prevalence of comorbid anxiety disorders with drug and alcohol use disorders in both epidemiologic and treatment-seeking samples will be reviewed. The relationship between anxiety symptoms and drug and alcohol use and withdrawal is likely to differ for each anxiety disorder. These relationships will be reviewed. Models for the etiologic relationship between substance use disorders and anxiety disorders will be presented. The effect of substance use on the presentation of symptoms, course of illness, and treatment of anxiety disorders will be discussed. Projects exploring the use of combined psychotherapy for substance use disorder with psychotherapy for PTSD and social phobia will be described. In addition, promising preliminary data from these trials will be presented.

The pharmacologic treatment of comorbid anxiety disorder and substance use disorders is an area of active investigation. Controlled clinical trials have demonstrated the efficacy of an anxolytic agent, buspirone, in alcoholics with generalized anxiety disorder. The use of benzodiazepines in this population will be discussed. Finally, there have been several recent pharmacotherapeutic trials exploring the use of various classes of antidepressant agents in the treatment of comorbid alcoholism and panic disorder or PTSD. The results of these trials will be reviewed. New avenues of investigation in the pharmacotherapy of comorbid anxiety and substance abuse will be discussed.

No. 37E
DRUG INTERACTIONS: A PRACTICAL PRIMER FOR CLINICIANS

James W. Jefferson, M.D., *Madison Institute of Medicine, 7617 Mineral Point Road, Suite 300, Madison WI 53717*

SUMMARY:

Drug interactions continue to challenge clinicians who are intent on providing the most effective and safest treatments for their patients. Avoiding or at least minimizing the risks of adverse interactions is best achieved by a general understanding of how drugs are metabolized (including a working knowledge of the cytochrome P450 system) coupled with more specific information about individual psychiatric drugs, how their metabolism is affected by other drugs and by genetic and nonpharmacologic environmental factors, and how, in turn, they influence the metabolism of other medications.

Emphasis will be placed on both antidepressant and antipsychotic drugs and their roles as substrates, inhibitors, and inducers of P450 enzymes. Examples will be provided of clinically important drug/drug and drug/diet interactions—interactions that could result in treatment-limiting toxicity or loss of therapeutic efficacy. The demystification of drug interactions should be of immediate practical utility to clinicians.

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INDUSTRY-SUPPORTED SYMPOSIUM 38—TREATING DEPRESSION: EFFECTIVENESS WITHOUT EXTRAVAGANCE

Supported by Healthcare Technology Systems

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to: (1) Recognize that practical cost-effective depression treatment programs exist that substantially improve patient outcomes; (2) Compare and contrast the depression treatment programs; and (3) Understand how each of the depression treatment models may impact the practice of psychiatry and primary care in the future.

No. 38A
THE BURDEN OF UNTREATED DEPRESSIONS

Ronald C. Kessler, Ph.D., *Department of Health Policy, Harvard Medical School, 180 Longwood Avenue, Boston MA 02215*

SUMMARY:

Depression in primary care patients is underrecognized, undertreated, and a major health problem. Epidemiologic studies consistently demonstrate that about 10% of primary care patients suffer from significant depressive disorders. Depressed primary care patients report poorer quality of life, greater impairment of daily functioning, reduced productivity, and more disability due to illness. Use of general medical services by depressed primary care patients is 50% to 100% higher than utilization by similar patients without depressive illness. The annual economic cost of depression in the U.S. was estimated to total nearly $44 billion, equivalent to the cost of heart disease. The Global Burden of Disease Study, completed by the World Health Organization, found that major depression is the fourth leading cause of disability throughout the world and the second leading cause of disability in developed regions.

The prevalence rate of depression is even greater in high utilizers of general medical services, nonpsychiatric inpatients, those with multiple somatic complaints and/or chronic pain. In the CARE study 20% of depressed high utilizers screened positive for current unrecognized or unsuccessfully treated depression. The depressed high utilizers had lower global health perception and more office visits and hospital days than nondepressed high utilizers.

The economic burden of depression vastly exceeds the resources currently devoted to treatment. Cost-effective treatment programs are needed to decrease the enormous burden of depression for individuals, families, employers, and our communities.

No. 38B
CAN PRIMARY CARE DELIVER QUALITY TREATMENT OF DEPRESSION?

Elizabeth H.B. Lin, M.D., *Department of Psychiatry, Clarke Institute, 250 College Street, Toronto, ONT, M5T 1R8, Canada;* David J. Katzelnick, M.D., Gregory E. Simon, M.D., Steven D. Pearson, M.D., Wayne J. Katon, M.D.

SUMMARY:

Mental health specialists (MHS) and primary care physicians (PCPs) have traditionally worked in isolation from each other, with rare interchange about patients. Research over the last decade has demonstrated improved patient outcomes, satisfaction, and adherence when MHS and PCP collaborate to treat depressed primary care patients. This presentation will describe: (1) Challenges in the primary care setting; (2) What has not worked: efforts to improve care for depression such as screening for depression and didactics by psychiatrists to educate PCPs on antidepressant treatment have not significantly improved outcomes for depressed patients in the general health care setting; (3) What has worked: a summary of essential elements in successful interventions that integrated MHS into primary care; and (4) The strategy of "Individualized Stepped Care for the Treatment of Depression" evolved, based on lessons and evidence from recent randomized clinical trials. This approach monitors patient outcomes after initiation of treatment and matches additional mental treatment with patients at high risk of persistent depression or relapse.

No. 38C
CLINICAL OUTCOMES CARE STUDY

David J. Katzelnick, M.D., *Madison Institute of Medicine, 7617 Mineral Point Road, Madison WI 53717;* Gregory E. Simon, M.D., Steven D. Pearson, M.D., Willard G. Manning, Ph.D., Cindy P. Helstad, Ph.D., Henry J. Henks, M.S.

SUMMARY:

The CARE study is a 12-month, randomized, cost-effectiveness evaluation of the Depression Management Program (DMP) compared with Usual Care (UC). We identified patients with depression by administering the SCID, via telephone interview, to high utilizers of ambulatory services in three large HMOs. Patients screening positive for major depression or depression in partial remission received a HAMD assessment two weeks later. Patients meeting study eligibility criteria, including a HAMD score of 15 or higher, were asked to complete four follow-up telephone interviews over the next year. We randomized 407 consenting patients, 218 to the DMP and 189 to UC. DMP patients initiated treatment with their primary care physicians and nonresponders received increasing levels of psychiatric care. DMP patients received the Rhythms patient education program at the first visit. DMP follow-up visits and prescription refills were also tracked to improve compliance. UC patients received the care available without the DMP. The clinical data are for the entire 12 months of treatment and are based upon intent to treat. Baseline HAMDs were 19.1 for DMP and 19.2 for UC. Improvements in HAMD scores were significantly greater in the DMP group at six weeks and all later assessments ($p < 0.05$). Twelve-month HAMD scores were 9.9 for DMP vs. 13.6 for usual care. At 12 months DMP patients reported better mental health and general health perceptions than UC on the SF-20 ($p < 0.05$). At least three antidepressant prescriptions were filled in the first six months by 69.3% of DMP patients vs. 18.5% in UC ($p < 0.001$). There were three or more mental health visits in the first six months by 13.3% of DMP patients vs. 9.5% in UC ($p < 0.05$).

No. 38D
COST-EFFECTIVENESS OF DEPRESSION TREATMENT PROGRAMS

Gregory E. Simon, M.D., *Group Health Cooperation, Center for Health Studies, 1730 Minor Avenue, Suite 1600, Seattle WA 98101-1404*

SUMMARY:

Several recent studies have demonstrated that organized treatment of depression can significantly improve outcomes. While these programs all require modest increases in expenditures for mental health treatment, more effective treatment of depression could yield significant economic benefits to the health care system and the larger society. This presentation will discuss two important general issues

in the economic evaluation of depression treatment programs: (1) cost-offset vs. cost-effectiveness, and (2) consideration of cost from multiple perspectives (costs of depression treatment, costs to the health care system, and costs to the employer). Data from the "Collaborative Care" studies in Seattle demonstrate that improved treatment of depression requires only modest increases in depression treatment costs. These organized treatment programs nearly doubled the probability of a successful treatment response (73% vs 40%) at a cost of approximately $500 per patient treated. "High utilizers" of general medical care are an ideal population in which to study the effects of improved depression treatment on use of general medical services and disability. The CARE study has demonstrated that an organized depression treatment program in this population significantly improves clinical and functional outcomes. This presentation will use CARE study data to examine the economic impact of organized depression treatment.

No. 38E
"DIVIDING THE PIE" BETWEEN PRIMARY CARE PHYSICIANS AND PSYCHIATRISTS

Jonathan F. Borus, M.D., *Department of Psychiatry, Brigham and Women's Hospital, 75 Francis Street, Boston MA 02115-6195*

SUMMARY:

Primary care physicians (PCPs) are this country's major casefinders and treaters of, as well as gatekeepers for, patients with mental disorders. The CARE study demonstrates that identification of "hidden" depression and treatment by PCPs can be effective. What are the implications for how psychiatrists and PCPs divide/share responsibility for such patients? Although current financial incentives tend to "split" them and some psychiatrists may feel financially threatened when PCPs treat mental disorders, psychiatrists and PCPs must learn to collaborate, with psychiatrists available to educate PCPs about psychiatric diagnosis, psychopharmacology, and supportive treatments; consult with them in their treatment of mental disorders; and accept referral and provide rapid feedback on how specialized psychiatric care will impact medical care. Through Primary Care Psychiatry/Outpatient C-L rotations, psychiatry residents can learn to work alongside PCPs and better understand the different ways patients with mental disorders present in primary care settings, the roles of and constraints and stresses on the PCP, and ways to most helpfully collaborate. Psychiatrists who know how to work with PCPs are both likely to thrive with abundant consultations and referrals, and to benefit large numbers of patients with mental disorders.

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INDUSTRY-SUPPORTED SYMPOSIUM 39—TIME AND DEPRESSION
Supported by Organon Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of this symposium, the participant should be able to understand the complex relationship between time, antidepressants, and the development of depression.

No. 39A
DEPRESSIVE SPECTRUM DISORDER AND TREATMENT

Mark H. Rapaport, M.D., *Department of Psychiatry, University of California at San Diego School of Medicine, 8950 Villa Jolla Drive, #2243, La Jolla CA 92037*

SUMMARY:

This presentation will describe the stability and cost associated with depressive spectrum disorders. However, the primary focus of this presentation is a review of data describing effective treatments for minor depression and depressive symptoms. Both focused psychotherapies and pharmacotherapies will be discussed. The majority of the talk will focus on the presentation of new data from a large national multisite trial of acute and continuation pharmacotherapy for minor depression. Both the efficacy and the potential effectiveness of such treatment will be discussed in detail. The ramifications of these findings for clinicians and patients will be presented. Particular emphasis will be placed on how these findings impact our conceptualization of these conditions and treatment in the era of managed care.

No. 39B
DEPRESSED CHILDREN: GROWING AND GROWN-UP

Neal D. Ryan, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh PA 15217;* Lewis L. Judd, M.D.

SUMMARY:

The question of continuity from child and adolescent depression to adult depression is scientifically important. It is also important for understanding the treatment response of this disorder. It appears that the clinical picture of depression is quite similar through the lifespan. Psychobiologic correlates of depression show strong continuities as well as some age-related maturational effects. Available follow-up studies similarly support continuity and will be reviewed. This has important implications for understanding the apparent maturational-related changes in antidepressant response.

No. 39C
WHEN DO DEPRESSED PATIENTS START TO RESPOND TO ANTIDEPRESSANTS?

Alan J. Gelenberg, M.D., *Department of Psychiatry, University of Arizona Health Science Center, PO Box 245002, 1501 North Campbell, Tuczon AZ 85724-5002*

SUMMARY:

Soon after the introduction of the first two classes of antidepressants in the 1950s, doctors recognized that there was a several-week delay between initiation of drug therapy and the onset of antidepressant effects. Antidepressants have been typically described as taking two to three weeks to achieve efficacy, yet there are many confounding factors. Some patients appear to respond earlier than others, and periodically there have been suggestions that certain antidepressants take effect earlier than others. In addition, from the beginning of symptomatic benefit to the achievement of maximal efficacy often requires several weeks and is further confounded by dose and observer effects. Some investigators have recently paid attention to pattern analyses of responses, particularly attempting to distinguish placebo from "true-drug" effects. This paper will review the growing literature on this topic.

No. 39D
PERSONALITY AND DEPRESSION OVER TIME

M. Tracie Shea, Ph.D., *Department of Psychiatry, Brown University, 700 Butler Drive, Providence RI 02906;* Andrew C. Leon, Ph.D., David A. Solomon, M.D., Robert M.A. Hirschfeld, M.D., Martin B. Keller, M.D.

SUMMARY:

While it is clear from clinical and empirical work that personality features and depression are related, how they are related is less apparent. Causal relationships have frequently been hypothesized: most commonly that certain personality features or traits are a vulnerability that increases risk for depression, but also that episodes of depression may leave lasting influences in the form of pathological personality traits. Whether or not certain personality traits represent a cause or consequence of depression, they have been shown to influence the course of depression, although the extent of this influence is unclear. Longitudinal studies, with repeated assessments of personality and depression over time, are required to examine the validity of these various hypothesized relationships and their clinical implications. This presentation will summarize findings regarding the reciprocal influences of personality traits and depression over time, with particular emphasis on findings from the NIMH Psychobiology of Depression Collaborative Study. Implications of these findings for the treatment and course of depression over time will be discussed.

No. 39E
RESIDUAL SYMPTOMS AFTER RESPONSE TO ANTIDEPRESSANTS

Andrew A. Nierenberg, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC 812, Boston MA 02114-3117*

SUMMARY:

After successful antidepressant treatment, patients with major depression frequently experience residual symptoms and other stubbornly persistent problems. These symptoms include mildly depressed mood, absence of a sense of well-being, lack of motivation and enthusiasm, irritability, anxiety, fatigue, and depressive cognitions. Those with residual depressive symptoms experience persistent impairments in social and occupational functioning. Patients who improve substantially and no longer meet criteria for DSM-IV major depression, may instead meet criteria for either minor or subsyndromal depression. Residual symptoms could be caused or exacerbated by comorbid conditions such as social phobia, personality disorders, and substance abuse. What is the best approach to managing residual symptoms? Do different antidepressant treatments result in different residual symptoms? What is the role of psychotherapy for residual symptoms? This presentation will cover the neglected area of residual depressive symptoms and their management, an important long-term outcome of major depression.

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INDUSTRY-SUPPORTED SYMPOSIUM 40—NOREPINEPHRINE: NEUROTRANSMITTER FOR THE MILLENNIUM

Supported by Pharmacia & Upjohn Company, Inc.

EDUCATIONAL OBJECTIVES FOR THIS SYMPOSIUM:

At the conclusion of the symposium, the participant should be able to review the problems of the currently available antidepressant pharmacopoeia, discuss the role of norepinephrine-containing neural circuits in the pathophysiology of depression, and review the data on the treatment of depression with selective norepinephrine reuptake inhibitors (NRIs).

No. 40A
PROBLEMS WITH CURRENTLY AVAILABLE ANTIDEPRESSANTS

Charles B. Nemeroff, M.D., *Department of Psychiatry, Emory University, 1639 Pierce Drive, Suite 4000, Atlanta GA 30322*

SUMMARY:

Although the availability of a wide variety of new antidepressants has clearly improved the treatment of major depression, there is unquestionably room for further advancements in our pharmacopoeia. The selective serotonin reuptake inhibitors (SSRIs), the mixed reuptake inhibitors (venlafaxine), and the selective receptor antagonists (nefazodone and mirtazapine) all represent clear advances over the tricyclic antidepressants (TCAs) and the monoamine oxidase inhibitors (MAOIs). These advantages include a much improved therapeutic index and side-effect profile. The efficacy of these newer agents is considered equal to the TCAs, although there is some controversy on this matter. The hope for improvement in antidepressant pharmacotherapy lies in two major areas: improved efficacy and a better side-effect profile. In terms of efficacy, many patients treated with monotherapy exhibit only a partial response to any of the drugs in the classes of antidepressants listed above;, moreover approximately 20%-40% of patients are treatment resistant or do not respond at all, depending on the definition of response. In terms of tolerability, side effects of treatment remain the major cause of noncompliance. These side effects include sexual dysfunction, sedation, headache, and persistent sleep disturbances. In addition to better efficacy and tolerability, a rapid onset of action remains a major goal of new antidepressant drug development.

No. 40B
NOREPINEPHRINE INVOLVEMENT IN ANTIDEPRESSANT ACTION

Alan Frazer, Ph.D., *Department of Pharmacology, University of Texas Health Sciences, 7703 Floyd Curl Drive, San Antonio TX 78284*

SUMMARY:

With the introduction of selective serotonin reuptake inhibitors (SSRIs) norepinephrine has become the "forgotten" monoamine with respect to the mechanism of action of antidepressants. This is an unfortunate situation as it is clear that drugs that acutely alter norepinephrine function *selectively* can be antidepressants, (e.g., desipramine). It is not clear whether these drugs maintain their selectivity for norepinephrine systems on repeated administration, or, in addition, affect serotonergic function. Preclinical and clinical data will be presented that are relevant to these points. For example, repeated administration of norepinephrine reuptake inhibitors (NRIs) to rats does not affect certain serotonergic parameters, (e.g., 5-HT_{1A} receptor sensitivity). Also, the clinical efficacy of NRIs does not seem to be dependent on the presence of 5-HT. By contrast, new *in vivo* voltammetric data have demonstrating that NE reuptake inhibitors alter the clearance of 5-HT in certain brain areas. Also, administering desipramine to patients with depression over time causes a reduction of the concentration of serotonin in their platelets. These data will be presented in the context of the general behavioral functions thought to be associated with the activation of norepinephrine or serotonin neurons in brain.

No. 40C
NOREPINEPHRINE DYSFUNCTION IN DEPRESSION

Dennis S. Charney, M.D., *Department of Psychiatry, Yale University, 25 Park Street, New Haven CT 06519*

SUMMARY:

There is abundant clinical evidence suggesting a role for norepinephrine (NE) in the pathophysiology and treatment of depression. Recently, we have studied the behavioral effects of reducing NE and dopamine (DA) levels in patients with depression. NE and DA levels are lowered by administering a tyrosine hydroxylase inhibitor, alpha-methylparatyrosine (AMPT). We have found that in patients whose depression has remitted on a norepinephrine reuptake inhibitor(NRI) (i.e., desipramine, mazindol), AMPTproduces a transient return of depressive symptoms. In a similar group of patients whose depressive symptoms have remitted on a selective serotonin reuptake inhibitor (SSRI), this phenomenon does not occur. Further, in drug-free, remitted, depressed patients, AMPT produces a brief return of depressive symptoms, and effect not seen in healthy subjects. These findings suggest that the integrity of the NE neuronal systems is critical to the mechanism of antidepressant drugs with prominent NE reuptake properties. Further, thay suggest that the vulnerability to AMPT-induced depressive symptoms may reflect a trait disturbance in NE function in patients with depression.

No. 40D
CLINICAL EFFICACY OF REBOXETINE IN MAJOR DEPRESSION

Alan F. Schatzberg, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, MC: 5717, Stanford CA 94305-5548*

SUMMARY:

The past decade has witnessed the advent of selective serotonin reuptake inhibitors (SSRIs) as first-line treatments for major depression. Still, there is considerable debate as to whether these agents are as effective or as potent as the first-generation tricyclic antidepressants (TCAs) or the mixed reuptake inhibitor, venlafaxine, all of which exert considerable effect on norepinephrine (NE) reuptake. Recently, reboxetine, a selective NE reuptake inhibitor (NRI) has been introduced in Europe. This drug has only a minimal affinity for muscarinic acetylcholine receptors and thus causes less dry mouth, constipation, urinary retention, or other such effects than to the TCAs. Reboxetine does not block serotonin reuptake or alpha-1 receptors and, thus, does not appear to produce significant nausea, diarrhea, or hypotension. Unlike other antidepressants, reboxetine appears to be nonsedating. Data on clinical efficacy and safety from double-blind comparison studies with reboxetine will be presented. These studies indicate reboxetine is significantly more effective than placebo and as effective as fluoxetine in reducing depressive symptoms. Improvements in social adjustments were reported to be more favorable with reboxetine than fluoxetine. Further, data from controlled clinical trials have shown that the side-effect profile for reboxetine is extremely benign. The Clinical implications of studies on reboxetine will be discussed with an eye toward defining the role NE regulation may play in affecting optimal clinical responses in patients with major depression.

No. 40E
GENETIC ABLATION OF THE NOREPINEPHRINE TRANSPORTER IN MICE

Marc G. Caron, Ph.D., *HHMI, Duke University, Research Drive, Carl Building, Durham NC 27710*

SUMMARY:

The norepinepherine transporter (NET), a member of the Na^+/Cl^- dependent transporter family, which includes the dopamine (DA) and serotonin (5-HT) transporters, is the target of antidepressants (E.G., desipramine) and drugs of abuse (e.g., cocaine and amphetamine). Using homologous recombination techniques, we have generated a NET knockout (NET KO) mouse line in which exon 2 of NET is fused in frame with the green fluorescent protein gene followed by the neomycin resistance gene. Southern analysis and ^{3}H-desipramine/nisoxetine-binding assays demonstrate that the NET gene has been disrupted and the functional NET is absent in the NET KO mice.

The homozygous NET KO mice live into adulthood but display lower body weights than mice with intact NET function. Relative to mice with intact NET function, NET KO mice adjust faster in a novel environment and display lower body temperature in a cold tolerance test, an impairment that is consistent with the regulatory role NE plays in thermoregulation. Interestingly, similar to wild-type mice treated with desipramine, the NET KO mice exhibit prolonged escape attempts in an automated tail-suspension test, a model what is widely used as a behavioral screen for antidepressants. In addition, both cocaine and amphetamine produce enhanced locomotion in the NET KO mice. Moreover, NET KO mice show significantly more "behavioral reward" in the cocaine-conditioned place-preference test than mice with intact NET function. Further, the deletion of the NET gene appears to produce alterations in the striatal dopaminergic system of these mice. Levels of (DA) and its metabolites, 3,4-dihydroxyphenylacetic acid (DOPAC) and homovanillic acid (HVA), were also decreased in the striatal tissue of NET KO mice. Low-perfusion-rate microdialysis also reveals decreased extracellular levels of DA, DOPAC, and HVA in the striatum of freely moving NET KO mice. Thus, the behavioral and functional phenotypes observed in the NET KO mice may implicate changes in several of the monoaminergic neurotransmission pathways. Understanding the biochemical basis of these effects in mice lacking the functional NET as well as other transporters may help to delineate the mechanisms underlying the involvement of the monoaminergic pathways in the biological responses to psychoactive drugs and stress.

REFERENCES:

1. Nemeroff CB, Schatzberg AF: Pharmacological treatment of unipolar depression, in Treatments of DSM IV Disorders. Edited by Nathan PE, Gorman JM. New York, Oxford University Press, 1997, pp 210–223
2. Frazer A: Antidepressants. J. Clin. Psychiatry 1997;58(Suppl 6):9–25
3. Miller HL, Delgado PL, Salomon RM, et al: Effects of alpha-methyl-para-tyrosine (AMPT) in drug-free depressed patients. Neuropsychopharmacol 1996;14:151–157
4. Heninger GR, Delgado PL, Charney DS: The revised monoamine theory of depression: a modulatory role for monoamines, based on new findings from monoamine depletion experiments in humans. Pharmacopsychiaty 1996;19:2–11
5. Ban TA, Gaszner P. Aguglia E, et al: Clinical efficacy of reboxetine: a comparative study with desipramine–with methodological considerations. Hum Psychopharmacol 1997;13:S29–S39

LECTURES

LECTURE 1
APA/APPL MANFRED S. GUTTMACHER AWARD FALSE MEMORY LAWSUITS: THE WEIGHT OF THE SCIENTIFIC AND LEGAL EVIDENCE

Daniel Brown, Ph.D., *75 Cambridge Parkway, Cambridge, MA 02142*; Alan W. Scheflin, J.D., *3045 21st Avenue, San Francisco, CA 94132*; D. Corydon Hammond, Ph.D., *University of Utah Health Service Center, 50 North Medical Drive, Salt Lake City, UT 84132*

SUMMARY:

Recently, several hundred malpractice lawsuits have been filed by former patients or third parties against therapists for allegedly implanting false memories of abuse. Over a thousand are pending. The architecture of these malpractice complaints all contain similar features, including relatively standard malpractice allegations such as misdiagnosis, failure to use appropriate informed consent, conducting treatment that is below the standard of care, fostering undue dependency, and causing harm to the patient and/or third parties. The unique feature of these suits is their allegation that an "experimental treatment" has been rendered. Regardless of the nature of the psychotherapy offered, the treatment is characterized or mischaracterized as "memory recovery therapy." Despite the obvious weakness in both the scientific evidence and forensic fact pattern used in support of many of these malpractice cases, many of these cases have been successful against therapists in the courts. Therefore, we recommend identification of risk factors and specific practice guidelines for those treating patients who report abuse in an effort to avoid malpractice litigation and evolve the standard of care in trauma treatment.

REFERENCE:

1. Brown D, Scheflin AW, Hammond DC: *Memory, Trauma Treatment and the Law.* Norton, New York, NY, 1998.

LECTURE 2
APA'S SOLOMON CARTER FULLER AWARD To Be Announced

LECTURE 3
CHILDHOOD ONSET SCHIZOPHRENIA: WHAT HAS IT TAUGHT US?

Judith L. Rapoport, M.D., *Chief, Child Psychiatry Branch, NIMH, Building 10, Room 3N202, 10 Center Drive, MSC 1600, Bethesda, MD 20892*

SUMMARY:

Childhood onset schizophrenia has been recognized since the earliest descriptions of the illness. Because the study of very early onset cases has been so instructive across all of medicine, an ongoing NIMH study has been examining these rare severely ill cases since 1991. These patients resemble adult onset poor outcome cases having insidious onset and are often refractory. Clinical and neurobiological measures for the probands show continuity with the adult onset disorder. Similarly, the pattern of risk factors including premorbid developmental abnormalities and cytogenetic abnormalities in the proband, familial schizophrenia and schizophrenia spectrum disorder, as well as abnormal smooth pursuit eye movements in the close relatives all resemble the risk pattern seen in adult patients. In contrast, there was no evidence for increased obstetrical abnormalities for these patients compared to healthy full siblings. Of particular interest is the differential progression of brain MRI abnormalities for these patients which is seen during their adolescence, but which dissipates when they reach early adult years. Thus, adolescence provides a window of opportunity to observe some late development trajectories which we believe is characteristic of the illness.

REFERENCE:

1. Jacobsen LK, Rapoport JL: Research Update: Childhood-Onset Schizophrenia: Implications of Clinical and Neurobiological Research. *J Child Psychol Psych* 39(1):101–113. Cambridge University Press, 1998.

LECTURE 4
APA'S BENJAMIN RUSH AWARD SOCIAL AND NEUROBIOLOGICAL DIMENSIONS OF THE COMPULSION TO FORGET AND REPEAT TRAUMA

Bessel A. van der Kolk, M.D., *16 Braddock Park, Boston, MA 02116*

SUMMARY:

Since the time of Homer, people have been aware that exposure to overwhelming terror can lead to troubling memories, arousal and avoidance. However, psychiatry, as a profession, has had a very troubled relationship with the idea that reality can profoundly and permanently alter people's psychology and biology. Mirroring the intrusions, confusion and disbelief of victims whose lives are shattered by traumatic experiences, our profession periodically has been fascinated by trauma, followed by collective amnesia, in which well established knowledge was abruptly forgotten and the psychological impact of overwhelming experiences ascribed to constitutional or intrapsychic factors alone. This lecture will examine how psychiatrists during the past century and a half have attempted over and over again to come to terms with the complex issues surrounding the treatment of traumatized individuals, such as nature versus nurture, body versus mind, amnesias and fragmented memories, dissociation and somatization, treatment versus advocacy. The historical antecedents of contemporary studies demonstrate how fragile the unbiased study of trauma is and how a multitude of social and political factors have always interfered with honest scientific and clinical observations. Today, accurate scientific observation of the role of trauma in our patient's lives continues to be as problematic as in the past, although large scale epidemiological studies and a greater understanding of the neurobiology of trauma makes it more difficult to ignore the effects of reality in shaping our patients' brain and behavior.

REFERENCE:

1. van der Kolk BA, McFarlane AC: *When Time Does Not Heal: Memory, Trauma and the Integration of Experience.* Guilford Press, In press.

LECTURE 5
BEYOND MEDICINE: EDUCATION, ADVOCACY, HELP AND HOPE

Rosalynn Carter, *P.O. Box 350, Plains, GA 31780-0350*

LECTURE 6
APA'S KUN-PO SOO AWARD EAST INDIAN POPULATION AND THEIR MENTAL HEALTH

Jambur V. Ananth, M.D., *2709 Via Pacheco, Palos Verdes Estates, CA 90274*

SUMMARY:

Over a million Indians live in America. Therefore, it is important to assess the mental health of this population. Delusions, hallucinations, self-esteem and expectation differ in the four different castes. Indian

schizophrenic patients have a better prognosis, and Indian patients manifested depression differently. In our study, 84 percent of the North Americans had guilt compared to 62 percent of the Indians. Belief in God and reincarnation had significant relationship to guilt. Treating Indian patients need special skills with cultural sensitivity. Obtaining the family history or discussing sex are difficult issues to address. An exclusive relationship with the therapist and exuberant emotional expression are not ideal. The therapist ideally assumes the role of a guru guiding the patient by modeling and by imparting knowledge. Patients harmony with the family and significant others is the goal. The patients do accept medications as it meets the cultural expectation. Side effects are not acceptable. The significance of these findings is that they are helpful to treat the Indian patients; the finding that schizophrenic patients in India have a better prognosis requires careful consideration; and lower incidence of depression in females in the rural India deserves further investigation.

REFERENCE:

1. Ananth J: Treatment of Indian Immigrant Indian patients. *Canadian J Psych* 29:490–493, 1984.

LECTURE 7
WILLIAM C. MENNINGER MEMORIAL CONVOCATION LECTURE
To Be Announced

LECTURE 8
PSYCHIATRY'S SHIFTING FOUNDATION: RESEARCH UP, REIMBURSEMENT DOWN, MANAGED CARE CHALLENGED

Herbert Pardes, M.D., *Vice President for Health Sciences and Dean of the Faculty of Medicine, Columbia University Health Sciences Center, 630 West 168th Street, Room 2-401, New York, NY 10032*

SUMMARY:

Psychiatry has come a long way from the first half of the 20th Century when its focus was inpatient care, heavy use of state hospitals, almost exclusive focus on psychoanalysis and psychoanalytic treatment as therapeutics and scant attention to diagnosis and psychopharmacology. From the 50s through the late 90s waves of interest included deinstitutionalization, community mental health, DSM, psychopharmacology and neuroscience. What can one say about psychiatry today as a basic discipline? What should be its primary precepts, its education, and its treatment focus? What should a graduate of psychiatry residency program be expected to know and do? How much does psychiatry have to compromise its code of principles by virtue of the managed care focus? How will psychiatry change as its current research potential is realized? How should psychiatry work with patients, family, advocates and critics? In this presentation, the presenter will trace the evolution of psychiatry, examine the main lines of research likely to influence psychiatry and offer a template for psychiatry going forward.

REFERENCE:

1. Yudofsky SC, Hales RE: *The American Psychiatric Press Textbook of Neuropsychiatry.* American Psychiatric Press, Inc., Washington, DC, 1997.

LECTURE 9
HOW NEUROSCIENCE CONTINUES TO CHANGE PSYCHIATRY

Steven E. Hyman, M.D., *NIMH, Parklawn Bldg., Room 17-99, 5600 Fishers Lane, Rockville, MD 20857*

SUMMARY:

Neuroscience is a vital discipline that is fundamentally altering our concepts of mental illness and which will provide better treatments, and eventually preventive strategies. Mental illnesses are disorders of the brain. All mental illnesses investigated to date appear to be "complex disorders," i.e., resulting from the interaction of multiple vulnerability genes with nongenetic factors, whether during development or, for some disorders, after maturity. Genetics as well as molecular and cellular neuroscience are providing critical tools to understand brain function and illness from the "bottom up." At the same time, "top down" approaches such as cognitive and integrative neuroscience are helping us to understand how the brain works, and what may go awry in mental illness. Both types of approaches will be discussed, as will the challenges that face psychiatry as it incorporates the full range of modern neuroscience into its confrontations with mental illness.

REFERENCE:

1. Hyman SE: Brain Neurocircuitry of Anxiety and Fear: Implications for Clinical Research and Practice. *Biological Psychiatry* 44:1201–1203, 1998.

LECTURE 10
CHILDHOOD MALTREATMENT AND ADVERSE OUTCOMES: A PROSPECTIVE DEVELOPMENTAL APPROACH

Frank W. Putnam, M.D., *10210 Summit Avenue, Kensington, MD 20893*

SUMMARY:

Childhood maltreatment, with an incidence of over one million cases per year is increasingly associated with a host of negative outcomes. These range from psychiatric disorders such as PTSD, Dissociative Disorders, BPD and Somatization Disorder to symptoms such as depression, suicidality, and self-mutilation. Recent epidemiologic studies strongly implicate child abuse as a major risk factor for substance abuse, HIV risk and high rates of medical care utilization. Annual economic costs of child abuse are estimated to exceed 50 billion dollars and are of the same order of magnitude as major public health problems such as Cancer, AIDS and Heart Disease. Yet, the very heterogeneity of outcomes raises questions about the specificity of maltreatment as a contributing factor. Drawing on a decade of prospective longitudinal data on the effects of sexual abuse, this lecture examines the complex psychologic, biologic and social developmental pathways leading to this diverse array of negative outcomes. Tracing developmental trajectories for both psychopathology and competence reveals clinical and social opportunities for early interventions that can restore health, order and function to the lives of children victimized by maltreatment.

REFERENCE:

1. Putnam FW, Trickett PK: The psychobiological effects of sexual abuse. A longitudinal study. Annals of the New York Academy Science 821:150–159, 1997.

LECTURE 11
EARLY INTERVENTION STRATEGIES IN DIFFERENT PHASES OF SCHIZOPHRENIA: HOW EFFECTIVE?

Marvin I. Herz, M.D., *Department of Psychiatry, University of Rochester, 300 Crittenden Blvd., Rochester, NY 1642-1018*

SUMMARY:

The term, "early intervention," has been used to characterize treatment interventions at various stages in the development and

course of schizophrenia. These include early intervention during the prodromal phase which aims to prevent the onset of schizophrenia (primary prevention); treatment intervention during the early phases of a first schizophrenic episode (secondary prevention), and treatment intervention during the prodromal phase of relapse for patients who have had prior psychotic episodes (tertiary prevention). This presentation will review studies of early intervention at various stages of the disorder and present the results of these studies.

REFERENCE:

1. Herz MI: Early Intervention in Schizophrenia. In: *Psychosocial Treatment of Schizophrenia, Vol. 4,* Herz MI, Keith S, Docherty J (eds). Elsevier Science Publishers, Amsterdam, 1990.

LECTURE 12
APA's GEORGE TARJAN AWARD
DOCTOR WHERE ARE YOU FROM? THE INTERNATIONAL MEDICAL GRADUATE IN THE U.S.

Silvia W. Olarte, M.D., F.A.P.A., *37 East 83rd Street, Apt. 1, New York, NY 10028*

SUMMARY:

International medical graduates (IMG) encompass twenty percent of the physician workforce in this country, twenty-five percent of the total number of resident physicians in the Accreditation Council for Graduates Medical Education accredited programs and twenty-three percent of the APA. IMG psychiatrists' patterns of practice when compared with American medical graduate psychiatrists show that IMGs are over-represented in city, county and state psychiatric hospitals, are underrepresented in solo office practice, group office practices and medical schools and universities. To further study the profile of IMGs practicing psychiatry in the US, a randomized sample of 900 IMG APA members were sent a questionnaire inquiring about pertinent demographic information, graduate medical specialization in the country of origin, specialization and subspecialization in this country, current patterns of practice, board certification, academic involvement and research participation. In this presentation, the results of this survey and its implication for the future of IMGs in American psychiatry will be discussed.

REFERENCES:

1. Dunn MR, Miller RS: US Graduate Medical Education. *JAMA* 278: 750–754, 1997.
2. Balon R, Munoz RA: International Medical Graduates in Psychiatric Manpower Calculations (letter). *Am J Psych* 53(2): 296, 1996.

LECTURE 13
APA'S ADMINISTRATIVE PSYCHIATRY AWARD
WOMEN IN MEDICAL LEADERSHIP: HOW FAR BABY?

Carolyn B. Robinowitz, M.D., *Associate Dean, Georgetown University School of Medicine, 3900 Reservoir Road, Washington, DC 20007*

SUMMARY:

The increased number of women in medicine has not been reflected by a proportional increase in their representation in higher levels of medical management, even when years since training are considered. Further, when women attain more senior status, they often are in the second tier or subordinate position in which they tend to remain without advancement. A review of business literature discloses particular issues for women wishing to become leaders, as well as how their leadership styles impact their work. The presentation will address the factors that relate to women's attainment of leadership positions and their successful function using examples from current medical leadership.

REFERENCES:

1. Kanter RM: Restoring People to the Heart of the Organization of the Future. IN: The Organization of the Future, Hesselbein F, Goldsmith M, Beckhard (eds). Jossey-Bass, San Francisco, 1997.
2. Heim P, Golant S: Hardball for Women: Winning at the Game of Business. Plume Books, Los Angeles, 1993.

LECTURE 14
APA'S SEYMOUR D. VESTERMARK AWARD
QUO VADIS PSYCHIATRY?

G. Alan Stoudemire, M.D., *Department of Psychiatry, Emory University, 1355 Clifton Road, NE, 5th Floor, Atlanta, GA 30322*

SUMMARY:

This presentation will focus on the status of psychiatric education "fin de siecle." Psychiatric education occupies a low status level at most academic departments of psychiatry. The reasons for this relegation to the lower echelons of academic prestige are complex, but relate in part to the fact that educators rarely generate external grants and represent "cost centers" on the budgets of departmental chairs. There is ample evidence that educators are undervalued in academia with excellence in teaching rarely a seriously considered qualification for tenure and promotion in traditional tenure-track lines of advancement. What is prized and highly valued in academia is proficiency in procuring external financial resources through federal government grants and the pharmaceutical industry. This presentation will call on academic psychiatry to critically examine its fundamental values as well as the support and valuation of psychiatric education and psychiatric educators. Broader issues in the American philosophy of education as it relates to psychiatry will be examined in this context in light of the pragmatic American philosophers John Dewey and Elbert Hubbard. A primary focus on the presentation will be recommendations for the further development and advancement of medical student education, psychiatric and non-psychiatric residency training education, and the psychiatric education of the general public in the 21st century.

REFERENCE:

1. *An American Bible: Foundations of the American Character.* Eds: Alice Hubbard; Compiled by Elbert Hubbart; New Introduction by G. Alan Stoudemire, M.D. R. Bemis Publisher Limited, Atlanta, 1998.

LECTURE 15
CRIMINAL PROFILING: USING THE TOOLS OF THE PAST TODAY

Caleb Carr, *8854 Horner Street, Los Angeles, CA 90035*

LECTURE 16
APA'S ALEXANDRA SYMONDS AWARD WOMEN, MENTAL HEALTH AND PRODUCTIVITY

Mary Jane England, M.D., *Washington Business Group on Health, 777 North Capitol Street, NW, #800, Washington, DC 20002-4239*

SUMMARY:

Women and their mental health are major factors in the health and productivity of the nation. The leadership of women psychiatrists in uncharted areas of government and business will be presented. DALY's (Disability Adjusted Life Years) has identified women's depression as a major predictor of the economic vitality of a country. The changing demographics of women working and the remarkable

increase of women physicians provides opportunities to improve the health and productivity of all.

REFERENCE:

1. Murray C: *The Global Burden of Disease.* Harvard University Press, Massachusetts, 1994.

LECTURE 17
FRAMING AND REFRAMING BATTERED WOMEN IN MENTAL HEALTH SETTINGS: NEW APPROACHES TO UNDERSTANDING AND TREATMENT

Evan Stark, Ph.D., M.S.W., *201 W. Park Avenue, New Haven, CT 06511*

SUMMARY:

The goal of this talk is to enhance psychiatry's response to victims and perpetrators of women battering by presenting a critical review of what is known about the dimensions, dynamics, causes, and consequences of the problem and the most appropriate intervention and treatment strategies in mental health settings. A summary of research in the field will be supported by case material drawn from the presenter's clinical and forensic practice. Emphasis will be placed on describing the scope and consequences of the problem; identifying the dynamics of coercive control in battering relationships; assessing risks to all parties involved, including children; weighing theories of etiology; reformulating traumatization theory; evaluating current approaches to diagnosis and treatment; delineating therapeutic dilemmas in work with victims and perpetrators; and challenging treating individuals to become involved in community-based prevention efforts. Particular attention will be paid to special needs populations of adolescents, substance abusers and women who attempt suicide.

REFERENCE:

1. Stark E, Flitcraft A: *Women at Risk: Domestic Violence and Women's Health.* Sage, 1996.

LECTURE 18
PERSONALITY DISORDERS ARE PERSONALITY DISORDERS

Juan Lopez-Ibor, Jr., Ph.D., *Clinica Lopez Ibor, Nueva Zelanda, 44, Madrid 28035, Spain*

SUMMARY:

Psychiatry has had many problems to conceptualize the disorders of the personality. Every culture has had individuals unable to live according to prevailing social norms. In 1575 Huarte de San Juan for the first time considered that some of this abnormal behaviors were pathological. In 1809 Pinel described cases of extreme impulsive behavior without delusional or hallucinatory symptoms (manie sans delire). Cleckley in 1942 considered that such behaviors were masks of insanity. Traditional psychopathology separates brain diseases from extreme variants of behaviors, which are diseases only in a metaphorical sense. Schneider considered that only psychoses were real disorders due to the fact that they originate from brain disturbances. Nevertheless, there is sufficient clinical psychopathological and biological data to consider the disorders of personality under a broader perspective which includes both psychological and biological aspects. Models of personality that correlate with neurobiological functions allow to understand biological basis of behavior and to differentiate pathological forms from normal ones. Disorders of personality should be differentiated from variants of personality and life styles in order to interpret data of studies that correlate dimensions of the personality with biological variables.

REFERENCE:

1. Lopez-Ibor, Jr. JJ: The Concept and Boundaries of Personality Disorders. *Am J Psych* 154:6, June, 1997.

LECTURE 19
THE PERSISTENT NEUROBIOLOGICAL CONSEQUENCES OF EARLY UNTOWARD LIFE EVENTS: TREATMENT IMPLICATIONS

Charles B. Nemeroff, M.D., *1639 Pierce Drive, Suite 4000, Atlanta, GA 30322*

SUMMARY:

There is considerable evidence that early untoward life stress, including child abuse and/or neglect, is associated with an increase in the prevalence rate of depression in adulthood. This presentation will summarize a series of preclinical studies and a pilot clinical study, which all provide congruent results suggesting that CRF-containing neurons are rendered persistently supersensitive to stress after exposure to neonatal stress. Previous studies have clearly documented CRF neuronal hyperactivity in drug-free depressed patients as evidenced by hypothalamic-pituitary-adrenal (HPA) axis hyperactivity and increased cerebrospinal fluid (CSF) CRF concentrations. These CRF alterations are reduced by successful treatment of depression with ECT or fluoxetine. In an animal model of early untoward life stress in rats, maternal separation, we have repeatedly demonstrated long lasting hyperactivity of the HPA axis, as well as increases in CRF mRNA expression in the PVN, central nucleus of the amygdala and bed nucleus of the stria terminals, CSF CRS concentrations and behavioral alterations reminiscent of depression. Similar findings were found in a bonnet macaque model of early stress. Treatment of adult rats exposed to neonatal maternal deprivation with paroxetine, the SSRI antidepressant, reverses these measures of HPA axis hyperactivity and CRF neuronal hyperactivity. Clinical studies in depressed women with a history of sexual abuse in childhood or adolescence reveals an increased HPA axis response to stress. These data, taken together, support the CRF hypotheses of depression and suggest that alterations in CRF neurons mediate the effects of early trauma in increasing an individual's vulnerability to depression. The therapeutic implications of these findings will be discussed.

REFERENCE:

1. Nemeroff CB: The Neurobiology of Depression. *Scientific American* 278(6): 28–35. Scientific American, Inc., June, 1998.

LECTURE 20
APA'S SIMON BOLIVAR AWARD HISPANIC PSYCHIATRY: FROM MARGIN TO MAINSTREAM

Renato D. Alarcon, M.D., *Department of Psychiatry, Emory University School of Medicine, 1670 Clairmont Road, Atlanta, GA 30033*

SUMMARY:

The advent of the 21st century offers a unique opportunity for a reassessment of the epistemological bases of American psychiatry and its diverse components. The case of Hispanic/Latino Psychiatry in the U.S. exemplifies the complexities of this process in terms of a reaffirmation of singular characteristics (at the workforce and the general population levels), and a struggle to gain recognition from and full acceptance into the so-called "mainstream" psychiatry. This presentation attempts to describe the process through the examination of three complementary issues: the shaping of a true mestizo identity, a documented series of accomplishments in practice, clinical care, and research areas, and Hispanic psychiatry's extraordinary potential as a setting for the in-depth study of bio-cultural linkages in a variety of clinical phenomena. It is asserted that, given the contemporary

trends toward globalization of knowledge. Hispanic psychiatry may serve both as a natural laboratory and as a model for an ultimate - and inevitable - mestization process of American psychiatry as a whole.

REFERENCE:

1. Eisenberg L.: The Social Construction of the Human Brain. *Am J Psych* 152:1563–1575, 1995.

LECTURE 21
APA'S OSKAR PFISTER AWARD
INTERNISTS OF THE MIND OR DOCTORS OF THE SOUL?

Donald S. Browning, Ph.D., *5513 South Kenwood Avenue, Chicago, IL 60637*

SUMMARY:

Every profession must communicate to the public that it serves. It must be able to explain its primary responsibilities. But it also should be able to identify its role within the context of wider cultural understandings of human nature and society. Psychiatry has this dual responsibility as well.

In recent decades, technical advances in psychiatry have made it more precise in treating major mental illnesses. If our friends or loved ones are suffering from mental difficulties, they are today far more likely to receive the care they need. At the same time, psychiatry has become more precise; it has become more narrow. On the whole, psychiatrists no longer try to tell us how to live the good life. This too can be seen as good. One can argue that psychiatry in limiting its scope of responsibilities has also become more humble.

But there is another danger lurking in the background of psychiatry. This is the possibility that it can unwittingly feed the belief that there are no principles or truths governing the good life and that health is strictly a matter of the mechanics of the mind. There is also the danger of subtly undermining the institutions, traditions and moral and religious beliefs by which humans traditionally have achieved the good life. This lecture will investigate psychiatry's twin responsibilities to cure illness and cherish the cultural sources of the good life.

REFERENCE:

1. Browning D et al: *Does Psychiatry Need a Public Philosophy?* Nelson Hall, Chicago, IL, 1991.

LECTURE 22
Title to be Announced

Nelba Chavez, Ph.D., *Administrator, SAMHSA, 5600 Fishers Lane, Rockville, MD 20857*

LECTURE 23
TECHNOLOGICAL ADVANCES IN INFERTILITY THERAPY: IMPACT ON BIOLOGY AND PATIENTS

Grace M. Couchman, M.D., *Division of Reproductive Endocrinology and Infertility, Duke University Medical Center, Box 3143, Durham, NC 27710*

SUMMARY:

With the birth of Louise Brown twenty years ago, the field of reproductive medicine has made tremendous advances in the past two decades. Infertility, or subfertility, affects ten to fifteen percent of reproductive age couples. Patients are now faced with many more options to pursue conceptions that are complex and expensive, but often successful. This seminar will focus on the newest technology in reproductive medicine such as in vitro fertilization, intracytoplasmic sperm injection, blastocyst transfers, and donor gametes. We will briefly review infertility investigation but will spend the majority of time on clinic and lab procedures, expected pregnancy outcomes for these therapies and explore the impact on biology and patients.

REFERENCE:

1. Kempers RD, Cohen J, Haney AF, Younger JB (eds): *Fertility and Reproductive Medicine.* Proceedings of the XVI World Congress on Fertility and Sterility. Elsevier, San Francisco, 1998.

MEDIA PROGRAMS

1. IN THE COMPANY OF MEN

PROGRAM DESCRIPTION:

In the Company of Men (1997) won several awards at the Sundance Film Festival. It was written and directed by Neil LaBute, who has been referred to as the Mormon version of David Mamet. It is rated R for language and emotional abuse. It is not a film for the kids.

The plot summary is that two junior executives, Chad (Aaron Eckhart) and Howard (Matt Malloy), are on a six-week business trip. The women in their lives have recently hurt both of them. To get even they devise a plan whereby they will find a vulnerable woman, romance her, and then when the time is right, dump her. They find Christine, an attractive and deaf office assistant (played by Stacy Edwards of TV's, "Chicago Hope." They set their plan into motion but everything does not go exactly as planned.

Roger Ebert, of the *Chicago Sun Times,* gave this film four stars saying: "Now there is true evil."

Alona Wartofsky, of the *Washington Post* wrote, "couples who see this film walk in the theater hand-in-hand . . . when they leave they are no longer touching. The women's arms are grimly folded across their chests. The men slink out of the theater." Bring someone that you love (or hate) to see this film.

2. THE LAST EMPEROR

PROGRAM DESCRIPTION:

Bernardo Bertolucci's epic film tells the dramatic history of Pu Yi, the last of the Emperors of China. Placed on the throne at age three, he reigned briefly in the Forbidden City before becoming a puppet emperor of Japan's Manchukuo. Imprisoned by the Communist government, he was released to die as an obscure gardener. The discussion will focus on the psychological, political and cinematic themes in the *Last Emperor* drawn from the recent book Bertolucci's *The Last Emperor: Multiple Takes.* It won nine Academy Awards including Best Picture for 1987.

3. CONFESSIONS OF A RABID DOG

PROGRAM DESCRIPTION:

What's the heroin scene really like? Why do people start to use it? Can they ever stop?

Confessions of a Rabid Dog delves into questions like these with the directness you'd expect from someone who's been there. The documentary's guide is director John L'Ecuyer, who spent seven years on the streets of Montreal as a junkie and sex-trade worker. Six heroin addicts in recovery, ranging in age from 20 to early 40s, share their experiences with him in a frank and unsentimental way. Interwoven with their interviews are evocative black-and-white scenes that recreate, in words and images, the emotional landscape of the drug-addicted.

L'Ecuyer doesn't hide behind the camera. He tracks his own introduction to the drug scene in Montreal, his recovery in Ottawa and his new life in Toronto. His life may dispel the "once a junkie, always a junkie" myth, but, as *Confessions* shows, L'Ecuyer isn't hooked on self-deception. Recovery, he makes clear, is a lifelong process. Warning: This film contains explicit language and subject matter and some footage of drug preparation.

4. ONE FOR THE ROAD

PROGRAM DESCRIPTION:

The physical and mental devastation of lifelong alcohol abuse effects not only the drinker but also his or her friends and family. *One for the Road* focuses on this deadly web of alcoholism.

Medical experts describe the physiological effects of long-term addiction, while recovering alcoholics such as musician Doc Severinsen and baseball great Don Newcombe offer more personal perspectives. The loved ones of drunk-driving victims tell their stories, and celebrities such as Chuck Norris, Carol Burnett, and Suzanne Somers provide a glimpse of how growing up with an alcoholic has affected the course of their lives.

Despite its frank depiction of the ravages of alcohol addiction, *One for the Road* points the way towards the long but attainable road to rehabilitation and recovery that an abuser must undergo to survive.

SESSION 5 HANDS-ON WEB WORK APA Committee on Information Systems

EDUCATIONAL OBJECTIVES:

By the conclusion of this workshop participants will be able to use a keyboard and mouse in a Windows environment, will be able to navigate the Web using a standard browser, will know how to use Internet technology to meet individual needs, and will understand the basic format and structure of the APA Web site.

PROGRAM DESCRIPTION:

Presentations and materials will include introduction to Windows technology, Web history and design, and navigation of the Web including specifically APA's site. Information will be presented in a hands-on format and will include: how to use the Windows environment; exercises to become familiar with a mouse (for the beginning sections); how to use the Web navigation tools; and how to find the information you want when you don't know exactly who or what you are looking for. Skill development will include: how to familiarize yourself with the Web environment; how to find useful sites, using search engines; how to find a site again that you like; how to handle searches that are taking too long; how to respond when you get error messages (e.g., can't find this server); how to set preferences; how to download and print from the Web.

5. APARAJITO (Part II of the Apu Trilogy)

PROGRAM DESCRIPTION:

This is Part II of the cinematic masterpiece *The Apu Trilogy* (1955-1958) by the great Indian director Satyajit Ray, shown in the restored print. It shows 10-year Apu completing school and eventually going to college in Calcutta. His mother loves her son very much and wants him to succeed, but she does not want to be left alone. Ray's cinematic style reveals profound humanism amidst existential and cultural despair. Part I, *Pather Panchali,* was shown at the APA Annual Meeting in San Diego.

6. VIOLENCE AND VIDEO GAMES

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize different types of video games and demonstrate

an awareness of the literature on how violent video games may affect child and adolescent functioning.

PROGRAM DESCRIPTION:

As American society has watched its youngest members become increasingly more violent, the controversy over what precipitates violent behavior has grown. An easy focal point is violence portrayed in the media. Instead of the passive experience of television and movies, video games make children active participants in fantasy worlds, which can often include representations of extremely violent behavior. This presentation will review research on the effects violent video games have on children and adolescents, and will feature a demonstration of violent video games like *Carmageddon, Doom,* and *Duke Nukem.* While the majority of studies suggest a short-term connection between violent video games and aggressive behavior, long-term studies have not been conducted. However, research has shown that violent television imagery has three effects: it models aggressive behaviors, it can cause emotional desensitization, and can increase fear in children (the "mean world" effect). Much consideration should be given to how vulnerable children may understand the basic assumption of violence as a positive activity in many video games.

7. BREAKING THE RULE OF THUMB

PROGRAM DESCRIPTION:

Combining powerful interviews with documentary footage, this timely and compelling videotape takes a comprehensive look at the issues still confronting battered women 20 years after the beginning of the domestic violence movement. Featuring the stories of three women, one a police officer who went through the Philadelphia family courts to ensure their safety, *Breaking the Rule of Thumb* examines contemporary domestic violence in terms of changing historical definitions of abuse. Incorporating individual stories into a strong argument for legal reform, filmmaker Andrea Elovson exposes how domestic violence's seemingly personal gender issues are inextricably tied to flawed ideas of civil justice.

8. UNDERSTANDING VIOLENCE

PROGRAM DESCRIPTION:

This program features Dr. Carl Bell, one of the country's leading psychiatrists, who focuses on children who have witnessed violent acts, committed violence, or been the victims of violence. In this program, Dr. Bell argues that the cycle of violence in children's lives can be broken if we act early to deal with their trauma. Children capable of violence must be taught to empathize with the pain in someone else's life, allowing them to see the painful consequences of violence.

9. COMING APART: FILM AND GENERATION

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be aware of various parameters and the course of psychiatric illness in colleagues; and understand the specific sociocultural influences of the 1960s–1970s, which background the protagonist's breakdown.

PROGRAM DESCRIPTION:

Milton Moses Ginsberg's 1969 feature film, *Coming Apart,* not only is a searing portrait of the psychological disintegration (and articulated boundary violations) of a talented mental health professional, it affords insights into the social ferment of the 1960s and 1970s. Finally, it represents an impressive experiment in depicting disordered subjective states through radically novel cinema rhetoric.

The hero is a Manhattan psychoanalyst who has abandoned his family and moved into a luxury apartment to pursue the illusion of a "free" lifestyle centered around pharmacological and sexual experimentation. He sets up a hidden camera; through its frame, and only through its frame, the viewer perceives a dizzying succession of patients, lovers, friends, and relatives. Some "takes" last five to 10 minutes, others only a few seconds. The film culminates when a former patient, now enraged exlover, hurls a chair through the one-way mirror and destroys the camera.

Coming Apart initially received excellent reviews, until a savagely critical piece by Andrew Sarris of the *Village Voice* essentially ended its run. It went on to attain cult status over the succeeding theatrical exhibition. Within the past year, interest in the film has suddenly escalated, not only because of its exceptional merit, but also because of its "signifying" status vis-à-vis 1960s and 1970s culture. It formed the basis for a recent Manhattan *Coming Apart* film festival; both film and director were subjects of several overviews, (by the *New York Times,* inter alia).

10. FIRST BREAK

PROGRAM DESCRIPTION:

For the majority of people diagnosed with a mental illness, the first episode occurs in their late teens or early twenties. It can be a terrifying, disorienting experience.

For the making of *First Break,* three young adults and their families courageously come forward and illuminate, with compelling candor, their personal experiences. Over the course of a year, Simon, Ariadne, and Shely allow us to share in the ongoing challenge of living with a diagnosis of mental illness, and its impact on their self-identities and family relationships. As a result, we are provided with a valuable perspective on the hopes, frustrations, and achievements of three young adults whose lives have been dramatically changed by a first break.

Engaging, honest, and compassionate, this film dispels the myths and questions the stigma attached to mental illness, while offering a very human portrait of coping.

Bronze, National Health Information Awards.

11. THE BONNIE TAPES: RECOVERING FROM MENTAL ILLNESS

PROGRAM DESCRIPTION:

Bonnie talks with social worker Andrea Blodgett about the experience of having schizophrenia and what she has learned about coping with this illness. The discussions include the reality of the voices, the need to trust people, checking one's own perceptions, and accepting the illness as part of recovery. Bonnie, her parents, and Andrea discuss the role of medications, and they try to answer the question, "How much can one expect?" Finally, they explore the nature of recovery and the importance of not giving up hope.

Bonnie is a delightful young woman who suffers from paranoid schizophrenia. The love that she and her family members share is clearly apparent in their frank and respectful discussions of their individual perspectives.

Bonnie's struggle to recover offers a model of hope for patients, families, and professionals. Her ability to articulate her feelings and thoughts opens a window to how it feels to have this dreadful disease.

It is instructive as well to listen to Bonnie's sister describe her own reactions to the illness that took up so much of her family's emotional energy for so long.

Since the completion of taping, Bonnie has graduated from college with a degree in psychology and found full-time employment as a

counselor in a group home. She has moved into her own apartment. She hopes her widening circle of friends will sustain her through further rough periods in her illness.

The other *Bonnie Tapes:* Other tapes in the series include *Mental Illness in the Family,* and *My Sister Is Mentally Ill.*

12. PARTNERSHIP IN RECOVERY: MEDICINE, MANAGEMENT, MOTIVATION

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: demonstrate how patients with comorbid psychiatric illness and substance abuse/dependence are the most difficult patients to treat, and how integrated treatment tailored to accommodate patients' strengths and weaknesses can be successful in this population.

PROGRAM DESCRIPTION:

Patients with a history of violence who have comorbid chronic mental illness and substance abuse/dependence disorders are among the most challenging to treat and manage. Preliminary outcome studies of this population suggest that programs, that integrate substance abuse treatment with mental health care are the most effective in reducing psychiatric morbidity and antisocial recidivism. Integrated programs, whose staffs are cross-trained in substance abuse treatment and mental health care, reduce the patient's burden of negotiating multiple, often uncoordinated systems of care. This video presents an overview of a revolutionary integrated program in Little Rock, Arkansas, which offers a true continuum of care from residential to assertive community treatment.

The program is presented through the eyes of three patients who provide frank accounts of their histories and treatment experience. The video follows the patients through the program's essential components, namely, targeted psychotherapy, modern psychopharmacology, and community reintegration. Psychotherapy is individually tailored to the patient's abilities and follows a cognitive-behavioral model promoting engagement, persuasion, treatment and prevention. Medication management features the use of newer agents, which reduce the risk of cognitive impairment, extrapyramidal side effects, and obtundation, thereby increasing the likelihood of CBT effectiveness. Another important part of this component is psychoeducation designed to increase the patient's understanding of his or her mental illness and the role of medications in recovery.

Assertive community reintegration includes continuing, assertive medication management, which increases the likelihood of abstinence from substance abuse and promotes prosocial behaviors. The seamless, assertive continuum-of-care approach helps to ensure implementation in the community setting of skills learned in the residential setting. The three patients featured in this video represent a population of individuals who tend to be the most impaired clients in treatment systems. Their success, after a lifetime of defeat, reflects the effectiveness of this novel program.

13. AT WHAT COST? APA Tennessee Psychiatric Association

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be able to: recognize the pitfalls involved in a state's attempting to replace Medicaid with a health care system managed by private companies and applying managed care principles to mental health and substance abuse benefits.

PROGRAM DESCRIPTION:

This year-long video project produced by the Tennessee Psychiatric Association, a District Branch of the American Psychiatric Association, was designed to document the problems with the TennCare Partners Program. This is the part of Tennessee's Medicaid Waiver Program that is responsible for the mental health and substance abuse benefits. TennCare is a bold attempt to replace Medicaid with a health care system managed by private companies. The program covers 800,000 Medicaid-eligible and an additional 400,000 uninsured or uninsurable Tennesseans. TennCare Partners, the mental health carveout, was implemented July 1, 1996.

The tape features an array of providers and consumers who provide a close look at TennCare Partners. Many examples are given of cuts in service to the mentally ill because of underfunding, poor planning, and mismanagement of public sector managed care principles. Although the tape is one-year old, and despite HCFA site visits, problems remain. The tape alerts planners to the pitfalls in this type of undertaking.

14. MA VIE EN ROSE (my life in pink)

PROGRAM DESCRIPTION:

Ma Vie En Rose is the first cinematic exploration of gender identity in young children. It is about Ludovic, a 7-year-old French boy who is convinced he is meant to be a girl. The Belgian-born director, Alain Berliner, was present to introduce the film at its Boston Film Festival premiere. He modestly informed us that this was his first full-length feature, as it was for all of the other principals on the production side. And then, with a sense of moral urgency unusual in filmmakers, he said that he had concluded that a film like this needed to be made. Many in Hollywood might share his sentiments, but it is unlikely that such a film could have been made in our bottom-line America.

Producer Carole Scotta selected the story (by Chris Vander Stappens) and chose Berliner to direct it because she saw "*son audace et sa poesie*" as indispensable for realizing the story's fragile nature. By film industry standards, Scotta's audacity in producing the film is even more impressive. *Ma Vie En Rose* has no action, no violence, no romance, no aliens, and no natural disasters, not even a recognizable star. It is certainly no comedy and, though it is a film about children, many conventional parents will not want their children to see it. In sum, it has no targeted audience. Yet in a world that genuinely prized and did not just tolerate difference, this film would have been made by Disney. It marks a new, truthful departure in cinematic understanding of difference in human sexuality and gender identity in children.

Gay and lesbian themes are now commonplace in films, and audiences seem to take them in stride. It is difficult to know what to make of this. Are we now more tolerant, more emphatic, more able to respond emotionally to the gay and lesbian erotica? Or is it, that audiences, though more tolerant, have also become as inured to these images as they have to violence? Film has the capacity to deepen and purify the emotions or deaden the sensibilities. The outcome depends on both the filmmaker and his audience. Gay issues pose problems for both.

15. THE WAY HOME

PROGRAM DESCRIPTION:

World Trust is a nonprofit organization that in 1994 launched Heart-to-Heart Conversations, a national program of public dialogue designed to help people share deep feelings about race and culture. Through these conversations, participants are encouraged to look deeply within themselves, to discover and recognize their embedded assumptions, and to challenge them as part of the process of transformation.

In 1996, World Trust initiated The Women's Video Project. Over the course of eight months, 64 women, representing a cross-section of cultures in America, came together to share their experiences of

oppression through the lens of race. Separated into eight ethnic councils, (Indigenous, African-American, Arab, Asian, European-American, Jewish, Latina, and multiracial) the women explore their stories of identity, oppression, and resistance. It is the intention of World Trust to use this video as a catalyst for powerful learning, healing, and transformation.

16. COMPUTERIZED MEDICAL RECORDS FOR A LARGE OUTPATIENT DIVISION

Steven E. Hyler, M.D., *New York State Psychiatric Institute, Unit #112, WHCS, 722 West 168th St., New York, NY 10032*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to relate the experience of implementing a computerized medical records system into a large, urban, psychiatric outpatient clinic.

PROGRAM DESCRIPTION:

The acute out-patient division of the St. Luke's-Roosevelt Hospital edical Center covers much of the west side of Manhattan in New York City. The clinic includes an access center for all new evaluations, an outpatient Center for ongoing treatment, and a transitional day hospital. There are some 1,200 plus patients who are treated there by 50-plus different clinicians. Each week some 20-plus new patients are evaluated and referred for treatment. The amount of paperwork generated by the clinic to clinically manage the patients, keep track of staff activity, satisfy government agencies, third party payers, and managed care organizations, ensure accreditation by JCAHO, etc., is overwhelming.

This presentation will focus on the implementation of a new computerized medical records system at the clinic from the perspective of: 1) the department chairman, 2) the chief financial officer, 3) the clinic director, and 4) the clinician. This presentation will include a demonstration of the TIER system, by Sequest Technologies, which was chosen by the medical center for the task of computerizing the medical records of, first, the clinic, then the whole department.

17. WITHDRAWN

18. COMPUTER-ASSISTED ASSESSMENT, PSYCHOTHERAPY, EDUCATION AND RESEARCH (CAPER) TREATMENT PLANNER

Peter F. Fore, M.D., *VA Chicago HCS WS, Department of Psychiatry, P.O. Box 8195 MC116A1, Chicago, IL 60680*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize: 1) the usefulness of computer assistance in developing treatment plans; 2) the benefits to clinicians, patients and administrators through simplifying and standardizing this task, and 3) understand how the CAPER treatment planner generates treatment plans.

PROGRAM DESCRIPTION:

Development of written plans is a complex and time-consuming task for clinicians. Assuring that treatment plans are prepared according to Joint Commission standards is complex and time-consuming problem for administrators. The CAPER Treatment Planner eases these tasks.

The CAPER Treatment Planner is PC-based software that the clinician uses to generate individual treatment plans. The clinician selects from a menu of preset phrases in four categories: 1. problems, (diagnoses and behavioral manifestations), 2. long-term goals, 3. short-term goals, and 4. interventions. Each phrase can be edited by the clinician. The pre-set phrases can be modified by the system operator or the clinician. Efforts have been made to write the preset phrases to satisfy the Joint Commission requirement for measurable goals.

The system can run on an individual personal computer or a network. It is highly customizable and can be used for both inpatients and outpatients. A large urban VA medical center has recently satisfied JCAHO standards with this system. This medical center integrated the PC-generated plans with the VA's computer system (DHCP) by uploading the plans to the VA's computer system for permanent storage and wide access in patient's electronic records.

19. CITY LIGHTS

PROGRAM DESCRIPTION:

City Lights is Charlie Chaplin's great masterpiece about the power of courage and compassion in the healing process. It tells the story of the Tramp's love for a blind flower girl, whose sight he eventually restores. Yet in one of the cinemas's greatest moments, the heart of compassion emerges from the veils of illusionary daily life to show the power of caring and gratitude. The laser disc version to be shown will bring together an archive print with a 1992 recording of the original soundtrack by Chaplin.

20. CRIMES AGAINST HUMANITY: THE SEARCH FOR JUSTICE

PROGRAM DESCRIPTION:

The program featured from this series is *Justice Pursued.* Rwanda, Argentina, East Germany, and Bosnia have been the locus for the most heinous acts of the last 20 years. In this program, Gerald Gahima, Rwanda's Minister of Justice, has the unenviable job of tracking down hundreds of Rwandans accused of perpetrating hideous atrocities against their neighbors during that country's recent civil war. We follow Gahima to Israel where, in an emotional meeting with a former Nazi-hunter, Gahima receives advice on how to proceed. A survivor details the torture and murder of thousands of young Argentines. In East Germany, newly discovered Stasi training tapes paint a brutal portrait of political repression behind the Berlin Wall, while in Bosnia, efforts to track down the perpetrators of ethnic cleansing are ongoing.

21. SECRETS OF S-21: LEGACY OF A CAMBODIAN PRISON

PROGRAM DESCRIPTION:

In the Cambodian city of Phnom Penh stands a compound that once served as a high school. During the bloody rule of the Khmer Rouge, it was a prison where 17,000 men, women, and children were incarcerated, and only four emerged alive. In this documentary, two American photographers painstakingly piece together the details of the genocide that took place at S-21 through thousands of photos left behind by prison officials. The photos and interviews with former prison guards and prisoners reveal a world built on power, fear, and total disregard for human life and dignity. A BBC production.

22. WHEN HELPING HURTS: SUSTAINING TRAUMA WORKERS

PROGRAM DESCRIPTION:

This video was produced for trauma workers, international relief workers, and those exposed to trauma due to their professions or

volunteer work. It outlines the symptoms of secondary traumatization and compassion fatigue and what organizations and supervisors can do to prevent or reduce their effects on trauma workers. Noted therapists discuss ways of recognizing these conditions in yourself and others, plus the means of treatment and prevention.

23. SMOKE SIGNALS

PROGRAM DESCRIPTION:

This Sundance Film Festival award-winning film shows in rich, humorous detail the cultural identity and cultural relations issues faced by young American Indians today. The first film ever produced, directed and acted by American Indians, it is a refreshing and amusing portrayal breaking many stereotypes. Two Coeur d'Alene Indians, tough, brooding Victor and likable, nerdy Thomas, travel from their Idaho reservation to Phoenix to retrieve the remains of Victor's dead father and discover some truths about themselves along the way. Through the help of Thomas and his father's final friend Suzu, Victor is able to find resolution and peace.

24. WHOSE DEATH IS IT ANYWAY?

PROGRAM DESCRIPTION:

Using segments from the videotape, *Whose Death Is It Anyway?* and video material depicting several family situations, this presentation will provide the opportunity to discuss guidelines to help families cope with the painful ambiguities of threatened loss during an illness. Using a systems model that integrates different kinds of illnesses with the family denial, psychological/physical loss, difficulties surrounding end-of-life decisions and transgenerational experiences will be discussed. Various issues highlighted in the video will be examined, and the group will interact with one another in sharing their expertise and experience.

25. WHEN ALL IS SAID AND DONE: AN INTRODUCTION TO THE FAMILY MEETING

PROGRAM DESCRIPTION:

This video is devoted to the terminally ill and their family members, demonstrating ways in which dying can become a time for forgiveness, letting go, and connectedness. The viewer has the opportunity to witness several family meetings between family members and the individuals who are dying. During this sacred time, family members share openly issues that have rarely been spoken of before and say goodbye to each other. The stories shared are powerful examples of encouragement and support that will help professionals in their work with the dying and their families.

26. WHEN PHYSICIANS COMMIT SUICIDE: REFLECTIONS OF THOSE THEY LEAVE BEHIND

Michael F. Myers, M.D., *St. Paul's Hospital, Department of Psychiatry, 1081 Burrard Street, Vancouver, BC, Canada V6Z 1Y6*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to treat survivors of physician suicide with respect and dignity and be able to examine his or her personal feelings of loss when physicians commit suicide.

PROGRAM DESCRIPTION:

When physicians kill themselves the heartache for family, work colleagues, friends, and their patients are profound. Many "survivors" struggle with feelings of disbelief, guilt, remorse, and anger. Shame and a conspiracy of silence often preclude an open discussion of the physician's life and legacy.

In this videotape, survivors of physician loved ones who have committed suicide talk about their loss, their journey of healing, and the reactions of physician colleagues, friends, and family, and make wise suggestions to us in the health professions who treat physicians and their families. Also included are the poignant works of a physician who, struggling with major depression, attempted suicide during her residency. Grateful to be alive, she explains not only the pain of depression but that it is a treatable illness. Her message is full of compassion and hope for physicians who live with depression.

This videotape should further diminish the stigma associated with mental illness in physicians. The target audience is medical students and physicians (and their families), medical school deans, directors of training programs, medical licensing board personnel, physician well-being committees, hospital administrators, all professionals who treat ill physicians, and the countless survivors who have lost loved ones to suicide.

SESSION 17. UP-TO-DATE PSYCHIATRY THROUGH THE INTERNET

27. GERIATRICS: WOMEN'S/MEN'S HEALTH

28. PSYCHOPHARMACOLOGY TIPS

29. FORENSIC PSYCHIATRY

Rima Styra, M.D., *The Toronto Hospital, Department of Psychiatry, 8 EN-235, 200 Elizabeth Street, Toronto, ON, Canada M5G 2C4*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants will be able to utilize the Internet as an educational and reference tool in the areas of psychopharmacology, women's/men's health, and geriatric and forensic psychiatry.

PROGRAM DESCRIPTION FOR THE ABOVE THREE PRESENTATIONS:

The Internet lends itself to being an ever-expanding resource of up-to-date information for the practicing psychiatrist. In this presentation, we will cover several categories of Web sites: women's/men's health, geriatrics, psychopharmacology, and forensics.

Information on aging from preventative aspects to treatment considerations for the public and the health care professional has been provided by numerous sites. Women's health issues on the WWW have been linked to such major resources as the American Medical Association; however, men's health resources tend to be more scattered throughout the Web.

Psychopharmacology will be covered by exploring Psychopharmacology Tips, which is an innovative resource on the WWW. Practical suggestions are submitted by members, then selected, edited, indexed, and adapted for the Web by the presenter. The ease-of-use and the utility of Psychopharmacology Tips and the role of such a resource, including clinical, ethical, legal, and technical issues, will be discussed.

The Web has become a valuable research tool as well as a gateway for interdisciplinary access to psychiatry. We will explain the uses

of the Web to collaborate with medial professionals and other medical specialties around forensic psychiatry issues. Moreover, a review and analysis will be made of how to make psychiatric knowledge accessible to non health care professionals such as attorneys and risk managers.

30. THE TREATMENT OF DEPRESSION IN LONG-TERM CARE: INTERACTIVE CD-ROM TRAINING

Jules Rosen, M.D., *University of Pittsburgh, Division of Geriatrics and Neuropyschiatry, 3811 O'Hara Street, Pittsburgh, PA 15213-2593*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation the participant should be able to understand the behavioral approach to treating nursing home depression.

PROGRAM DESCRIPTION:

An interactive video CD-ROM titled "The Treatment of Depression" will be demonstrated. This is one of a series of 12 computer-based training modules designed to educate the staff of nursing homes. Using the latest interactive, computer-based video technology, you will see nursing home residents, their families and caregivers tell their stories in a documentary-style format that demonstrates key principles of caring for the elderly in nursing homes.

Nursing home staff participates in decision-making and assessments through the use of interactive technology. In this module, the nonpharmacological principles of treatment for depression are presented through the stories of two residents. Aunt Ginny was near death from her depression until she began treatment of her depression after being put in a nursing home. Through the special efforts of a treatment team and one special relationship with an employee, Ginny experienced a total recovery. A second story is about Gertrude. Through the words of her son Paul, the staff learned who Gertrude was for the 95 years of her life prior to coming to the nursing home. Through this understanding (assessment), they were able to construct a behavioral treatment plan that contributed to her recovery. The third vignette includes an interactive exercise in which the viewer conducts an assessment and constructs a treatment plan for Delores based on her on-camera interview.

31. A WORLD WIDE WEB SURVEY OF PHYSICIAN KNOWLEDGE OF ALZHEIMER'S DISEASE

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation the participant should be able to recognize the potential advantages and limitations of conducting research surveys on the Internet.

PROGRAM DESCRIPTION:

Determining current physician knowledge of Alzheimer's disease (AD) is the first step towards identifying what information needs to be more effectively disseminated to physicians. To accomplish this objective we are conducting a survey using the Internet, a powerful new research tool. With University of British Columbia Ethics Committee's approval, physicians can now view a WWW site concerning the clinical diagnosis of AD. (http://www.alzheimerdrsvy.com) and submit their results online to 32 self-evaluation questions. Twelve of these questions are based on short videos depicting simulated clinical interactions. Demographics of the responding physicians are also elicited and include gender, age, medical specialty, type of practice, years in professional practice, country of practice, and percentage of clinical practice related to geriatrics and AD. Since the site's launch on June 15, 1998, 30 physicians from eight countries have participated in the survey. The mean percentage of correct responses is 79%. Only 33% of the respondents viewed the entire survey, with a significant drop-off occurring when the first question with a video was introduced. Implications for future survey design will be discussed, as will the general advantages (timeliness, minimal cost, wide distribution) and disadvantages (biased subject response, malicious data) of conducting health research on the Internet.

32. BETTY BLUE

PROGRAM DESCRIPTION:

First a precautionary note: *Betty Blue* is in French with English subtitles. It is R rated, containing explicit scenes of nudity, sex, and violence. Anyone who feels that they might be offended should please consider not viewing this film. Children under 16 should definitely not attend.

Betty Blue was adapted from the book titled: *37 degrees 2 Le Matin.* It was made in 1986. The screenplay was written by Jean-Jacques Beineix and Philippe Djian, who wrote the original novel. Jean-Jacques Beineix, who is better known for his direction of the film *Diva,* directed it. Jean-Hughes Anglade plays the role of Zorg, and Beatrice Dalle plays Betty.

Zorg is a handyman who is working at a bungalow colony on the French Riviera. He is a slovenly housekeeper but diligent worker who writes in his spare time. Into his life walks Betty. A young and beautiful woman who is wild and unpredictable. After an argument with Zorg's employer they leave and Betty gets a job at a restaurant. She keeps after Zorg to get his books published, but all he gets are rejection letters. This makes Betty fly into a rage. She gets more and more out of control. Zorg watches helplessly as the woman he loves goes slowly insane. Can love conquer all?

The film was wildly popular in France but received mixed reviews in the United States. For teachers of psychopathology and diagnosis, Betty presents a textbook (*DSM-IV*) example of borderline personality disorder.

33. ODÔ YÁ! LIFE WITH AIDS

PROGRAM DESCRIPTION:

This is the affirming story of how Candomble, a Brazilian religion of African origin, has become a source of strength and power for a group of AIDS sufferers. Shot in Rio de Janeiro, São Paulo and Bahia, it shows the rituals of Candomble and the celebration of carnival. It features the personal struggles and words of wisdom from those whose faith has brought endurance and pride. Rather than denying the sexuality of this African-descendant population, innovative education programs have been developed for its followers. Where other religions preach abstinence, Candomble advocates the use of condoms so that sexuality need not be repressed.

This beautifully shot documentary puts the epidemic in a cultural context, showing how this joyful religion helps it followers cope with the illness. An important film for classes in medical anthropology, folklore and religion, and Latin American culture.

34. RAINMAKERS THAILAND

PROGRAM DESCRIPTION:

Jongsada Suwanchondee kicked her heroin habit only to discover she was HIV-positive. Through support groups, Jongsada has found

new hope and now helps others understand the disease and its impact. A moving portrayal of HIV illness in Thailand.

35. WOMEN AND HIV: FOUR STORIES

PROGRAM DESCRIPTION:

Women and HIV: Four Stories is a documentary that chronicles how four Los Angeles women of different ages and ethnicity approach life after learning they are HIV-positive. They each have a unique story to tell, and through their stories, we are educated and touched by the daily challenge of living with a life-threatening illness.

Jennifer: Infected in her teens, Jennifer now has two children and a new relationship. She is the typical young woman of today, except that she has HIV. She is Vietnamese and openly shares how difficult it has been to be young, Asian and living with the virus. Christine: Christine never had the experience of just being HIV-positive. When she was diagnosed in 1989, she already had AIDS. Despite her many medical challenges, she has continued to work, and poignantly shares her feelings about her life. Martha: Martha found out when was diagnosed after she was married. She and her husband, both dealing with HIV, also face language barriers and discrimination, which add to the burden of living with the virus. Charlon: Charlon is a single mother with a household of six. She cares for her children, her grandchildren, and others who come to her for help. She has been clean and sober for 10 years, and with that sobriety, started a new life.

36. REGENERATION: A DOCTOR AND A POET TRANSFORMED BY WAR

PROGRAM DESCRIPTION:

A fascinating, beautifully acted and little seen film directed by Gillies MacKinnon (*The Playboys, Small Faces*) that provides an unforgettable and haunting examination of war and compassion. The film centers on the interaction of a sensitive psychiatrist (Jonathan Pryce) and the shell-shocked soldiers who are his patients (James Wilby, Jonny Lee Miller, and Stuart Bunce) at a Scottish military hospital, a castle just outside of Edinburgh. But Dr. Rivers begins to question the value of his work when he is told to treat Lt. Siegfried Sassoon, a war hero and poet whose experiences on the front have turned him into a staunch opponent of the war. Another patient, Wilfred Owen, becomes close to both men. Based on the Booker Prize-winning novel, the film takes its inspiration from actual facts. Rivers was a pioneer in treating shell shock, and he did treat Sassoon and Owen who became the best known of the "War Poets."

37. ALTERNATIVE MEDICINE

PROGRAM DESCRIPTION:

Alternative, or complimentary, health systems are being integrated into American culture. From Chinese medicine to homeopathy to chiropractic, many features and systems can now be found in our physicians' offices. This video provides an overview of Chinese medicine, acupuncture, ayurveda, homeopathy, herbalism, naturopathy, osteopathy, massage, and chiropractic. People explain how they're using one or more of these in their health care. We hear from some of the leading practitioners in the field of alternative medicine: Andrew Weil, M.D., Christiane Northrup, M.D., Fredi Kronenberg, M.D., and Nancy Lonsdorf, M.D.

38. THE FAITH FACTOR

This videotaped lecture presents a review of the empirical research and literature correlating religion/spirituality with physical and mental health as well as quality of life. Given by master lecturer Dale A. Matthews, M.D., Associate Professor of Medicine at Georgetown University School of Medicine, the presentation focuses on an aspect of caring for the total person which is becoming increasingly important in both clinical care and medical school education. Addressing a medical student class, Dr. Matthews combines his knowledge of the scientific literature with a heartfelt passion for this previously neglected area.

39. ALGORITHM FOR THE PHARMACOTHERAPY OF SCHIZOPHRENIA

David N. Osser, M.D., *150 Winding River Road, Needham, MA 02492-1025*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation the participant will be able to demonstrate Internet software that offers psychopharmacology consultation on patients with schizophrenia in a variety of contexts, e.g. acute, relapsing, partial response, with noncompliance, 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 Internet expert system for advising psychiatrists in strategies to optimize the pharmacotherapy of schizophrenia. It covers first-onset patients, relapse management, unsatisfactory response, and when to use depot medications.

A panel of seven Massachusetts psychopharmacologists and a subcommittee of the Alliance for the Mentally Ill of Massachusetts reviewed an earlier text version and provided detailed editorial commentary, which has been incorporated into the 266 files of this program.

This application is 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 diagnoses, or related advice. "Comment" screens appear at crucial points with additional explanations. The evidence basis of the clinical pathways is provided in context-sensitive references, which support all critical questions and recommendations. Other features include links to accessory prescribing information, capacity to store and retrieve consultation data on specific patients, potential to aggregate data on patient outcomes at each decision point, feedback system for users to send comments to the developers at any time, and function to view recently added material.

As Internet access increases, disease management systems like this may become increasingly valuable to psychiatrists.

40. BOOTING UP YOUR PRACTICE

Theron C. Bowers, Jr., M.D., *10600 Foundren 217, Houston, TX 77096*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be able to recognize barriers in 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 or most psychiatric practices, its use remains confined to primarily administrative jobs such as billing and scheduling. As 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 practice.

This program will examine potential barriers and challenges in 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 in tracking a patient's progress and monitoring medication side effects. Finally, there will be instructions on implementing a computerized record-keeping system in private practice with a focus on effectively utilizing data in a variety of clinical reports.

41. THE STORY OF ADELE H

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation the participant should be able to recognize the development of obsessive love and gain an understanding of possible etiological factors. The association of obsessive and unrequired love and delusional depression will be elaborated.

PROGRAM DESCRIPTION:

The Story of Adele H is a poignant and realistic portrayal of obsessive and unrequited love. The film is based on the diaries of Adele Hugo, the youngest daughter of the great novelist Victor Hugo. The film is true to life and portrays Adele's inability to form sustained loving attachments. She was consumed with the obsessive pursuit of an unavailable man who did not return her attentions. Adele most likely was severely depressed. Francois Truffaut portrays Adele's melancholy and her obsessive quests to secure the attention, love, and promise of marriage from Lt. Pinson, and English soldier. Lt. Pinson, however, has no interest in her. In spite of repeated rejections. Adele is unrelenting and obsessively stalks him. Her fixation on this hopeless relationship never yields to the reality of the situation, and loss of reality extends to disorientation and psychosis. Adele kept a diary for many years and described her passions and longings. The diary was not discovered until this century. It was in code and not deciphered until modern times. Adele Hugo's life and diary are of literary importance. Truffaut's film, based on these diaries, stimulated interest in the Hugo family and in the tragic life of Adele.

42. KAMIKAZE SUMMER

Starting from San Francisco, a gay and a lesbian individual take an extended tour around the states in the West, where anti-gay sentiment has been active, politically, and where there is an attempt to limit and deprive gay and lesbian citizens of political power. The couple interview many different groups who have an anti-gay and anti-lesbian agenda and through this exposure, demonstrate the political power of the anti-gay movement. A powerful portrayal of the impact of homophobia on America's cultural landscape.

43. PRIDE DIVIDE

PROGRAM DESCRIPTION:

From the producers of the award winning *Last Call at Maud's* comes this groundbreaking exploration of the gender gap between gays and lesbians. Politically united against global homophobia, they are poles apart on many life issues. Oddly enough, their struggle of male versus female mirrors many traditional conflicts inherent in straight relationships. The gay and lesbian community is not immune to gender conditioning. Here is the classic battle of the sexes from a new perspective, leavened with humor.

The film looks at the issues around male domination versus female submission: promiscuousness versus commitment, exaltation of the body versus the spirit, AIDS support versus breast cancer support. We hear about the subtle chauvinism by gay activists who excluded lesbians from their political and social life, especially in the conformist 1950s. Now, however, both sides seem willing to discuss these differences openly.

Individuals involved in this dialogue include Martin Duberman, Barney Frank, Barbara Gittings, Simon Le Vay, Camille Paglia, and others. This lively film is sure to rouse discussion.

44. BEHIND THE MASK: TEACHING SPONTANEOUS THEATER

Ferruccio A. Di Cori, M.D., c/o Ian E. Alger, M.D., *500 East 77th Street, New York, NY 10162*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation the participant should be able to understand the complex nature of role play, psychodrama, and therapeutic theater, and to begin to apply these principles in therapeutic settings.

PROGRAM DESCRIPTION:

This video presentation is a collage of six discrete examples of the teaching of spontaneous therapeutic theater. This method promotes the enactment through role play of emotional conflicts and fosters the expansion of an individual's repertoire in actual life. In other applications of this method, special hats and special puppets are used in acting and reenacting feelings with emotional and social depth, paying special attention to plays and spontaneous creations evoked during the sessions.

Dr. Ferruccio DiCori is a psychiatrist who has practiced in both the United States and Italy and who currently presents an intense course in his methods at the University of Rome, where he is professor of psychiatry, in the department of literature.

In its six segments, the tape shows a monologue by a girl who experiences sleep-walking; two people struggling to unravel misinterpretations; a young woman expressing various aspects of herself through her vocal intonations; two girls enacting their mutual narcissism in pantomime; symbolic drawings and the attempts to interpret them; and the power of musical background in affecting free association.

The audience at the presentation will be engaged in discussion by the presenter, and exploration of ways in which these techniques can be applied to their own clinical milieu and work will be explored.

45. ROBERT ALTMAN'S JAZZ 34: REMEMBRANCES OF KANSAS CITY SWING

PROGRAM DESCRIPTION:

This tribute to Kansas City's great 1930's scene brings together more than 20 of today's finest musicians for an extended jam session. With Joshua Redman, James Carter et al.

46. MY COUNTRY

PROGRAM DESCRIPTION:

By telling the stories of three people with disabilities and their struggle for equal rights under the law, this film draws a powerful parallel between the efforts of disability rights activists and the civil rights struggle of the 1960s. It will be great for disability awareness programs and for discussions of disability rights issues. It should be

a part of every curriculum on the legal and psychological issues involving disabilities.

47. BEST MAN: BEST BOY AND ALL OF US TWENTY YEARS LATER

PROGRAM DESCRIPTION:

Filmmaker and psychotherapist Ira Wohl revisits his developmentally disabled cousin, Philly. Twenty years ago the two collaborated on the Oscar-winning film, *Best Boy.* Now, at age 70, Philly gets ready for his bar mitzvah. *Best Boy* charts Philly's move out of his parent's home into a group residence and followes him as he achieves greater independence. The first film did not simply record Philly's story, but actually contributed to his development. In *Best Man,* Wohl looks at Philly's life 20 years later and plants the idea of having a bar mitzvah. The first person documentary examines Philly's relationship with Ira, with his peers at the residence, and the death of their parents. Wohl offers a warm portrait of the extended family and reveals the importance of family and tradition. *Best Man* is a celebration of loving kindness in the face of life's inevitable changes and challenges.

48. THE AD AND THE EGO

PROGRAM DESCRIPTION:

You'll never look at an ad in the same way after screening *The Ad and the Ego,* the first comprehensive examination of advertising's impact on our culture of consumption. The film artfully combines clips from over 1200 familiar television ads with insights from some of our most astute media critics, resulting in a cultural psychoanalysis of late 20th century America and its principal inhabitants, Consumer Man and Woman.

The average American is exposed to 1500 ads a day. This constant stream of messages sells us not just products but values, identities, our sense of what is "normal." Media theorist Stuart Ewen argues that advertising creates a "psychology of need," generating a boundless hunger for things; one thing you'll never hear in an ad is, "You're OK."

The Ad and the Ego demonstrates the critical connections between consumerism, our debased public discourse, environmental degradation, and our blind faith in economic growth at any cost. This film will cause every viewer to take more seriously the central role of advertising in our society and our psyche.

49. BARBIE NATION: AN UNAUTHORIZED TOUR

PROGRAM DESCRIPTION:

The Barbie doll is not just the world's most popular toy; she's a Rorschach test for our times and us. And the woman who created the Barbie doll is just as controversial as her creation.

Barbie Nation is an investigation into the Barbie fad. It tells the story of the rise and fall of Ruth Handler, the woman who invented Barbie and co-founded Mattel, Inc., the world's largest toy company. *Barbie Nation* also visits Barbie conventions and anti-Barbie demonstration; girls' play dates and Barbie Web pages. Everybody has a Barbie story, and the stories are about sexuality and sex roles, body image, breast cancer, anorexia, childhood development, and the changing role of women in society.

50. LETTERS TO THIEN

On the morning of January 29th 1996, a janitor discovered the body of a young Asian male on the tennis courts of Tustin High School in Southern California. He had been stabbed multiple times, his throat was slashed from side to side, and his head had been stomped on.

Thien Minh Ly, eldest son, beloved brother, community leader, and recent graduate from UCLA and Georgetown University in Washington, D.C., was 24 years old at the time of his death. *Letters to Thien* attempts to restore the humanity so coldly denied him by his brutal murder. Thien's character is memorialized through anecdotes, tributes, and letters from his family and friends, who address him one year after his death. Full of humor, love, and an abiding, bewildering grief, these stories painstakingly conjure Thien's willingness to try new things, his broad interests, ranging from biology and Shakespeare to Vietnamese culture, and, above all, his strong impact on those who knew him. In this context, director Trac Vu shows us how the discovery of a letter commencing with the boast "Oh, I killed a jap [sic] a while ago," led to the arrest of Thien's young murderers, and he covers the community's struggle to get the district attorney of Orange County, California, and the city of Tustin to declare Thien's murder a hate crime.

51. FORGOTTEN FIRES

Forgotten Fires is a powerful exploration of the devastating consequences of prejudice. Filmed over one year in Manning, South Carolina following the Ku Klux Klan burning of two local African-American churches, the film is a frightening testimony to the emotional and physical violence perpetrated by the KKK. Historically the churches were the emblem of the fight for freedom and equality. Today, their active role in the community makes them a vulnerable target for racial hatred. But surprisingly, out of this painful story emerges a moving portrait of a community's ability to forgive and to heal itself. Claiming to stand for the rights of white people, the Klan proclaims that blacks are responsible for the disenfranchisement of whites. One Timothy Welch, a white man, got caught up in these twisted beliefs and set fire to the Macedonian Baptist Church. From the vantagepoint of prison, Welch reflects upon how his involvement with the Klan led him to racial violence. As a racist he is a hateful figure, but his remorse and desire for forgiveness are genuine and heartfelt. Through interviews with members of both the African-American community and the KKK, *Forgotten Fires* tells the moving story of Welch's forgiveness and acceptance by the black community in a message of hope for the future of racial harmony.

52. A LIFE APART: HASIDISM IN AMERICAN Mesorah Society for Traditonal Judaism and Psychiatry

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be able to 1. understand the historical development of modern-day Hasidism in America; 2. identify some of the distinguishing characteristics of Hasidic life; 3. recognize the religious and spiritual values that hold them together and separate them from the rest of society; and 4. appreciate the strains modern Western life creates for an isolated community.

PROGRAM DESCRIPTION:

Hasidim often provoke controversy and arouse remarkably intense feelings among outsiders. On one hand, some condemn the insularity of the Hasidic people as "racist" and their strict division of gender roles as "sexist." Their way of life is derided as "fundamentalist," and their defiant refusal to join the rest of society is perceived as "un-American." Certain Jews criticize the Hasidim for "spiritual arrogance" and are offended by the flagrant demonstration of "differentness" in Hasidic dress and behavior at a time when Jews have assimilated into American society.

On the other hand, many Jews feel reassured that Jewish customs, faith, and traditions will be perpetuated. They cherish authenticity and steadfastness in the face of temptation. They perceive that Hasidim are freed from the moral complexities and ambiguities they have to face. Others are merely curious about a group of many thousands of people who have been able to survive for more than two centuries without conforming.

This film relates the dramatic story of the creation of the post-Holocaust Hasidic communities in the United States, a country that had been labeled "trayfina medina" (impure land) by earlier rabbinical leaders. After the film, a psychiatrist will lead a discussion of Hasidic life from the perspective of three decades of experience with the Hasidic population. Hasid featured in the film will join him.

53. SILENCE

PROGRAM DESCRIPTION:

A little girl named Tana survived Teresienstadt concentration camp thanks to her resourceful grandmother. After liberation, she lived a comfortable and cultured life with relatives in Sweden. No one spoke of her ordeal. "Forget the Past," she was told. Tana knew how to keep silent.

This haunting animated film captures the surreal world of a child survivor whose pain has not been recognized or shared. At 20, when Tana left Sweden, she was given letters written by her mother before she was sent to Auschwitz where she perished. Tana now had a bridge to the past, but still couldn't speak of it. It took 50 years for her to break the silence.

54. THE LAST TRANSFER

Elizur Avner, M.D., *Abarbanel Hospital, 15 Keren Kayemet Blv., Bat Yam Israel 59100*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation the participant should be able to recognize the interaction between massive psychic trauma, the Holocaust, and chronic deteriorating course of psychotic illness in a subgroup of survivors.

PROGRAM DESCRIPTION:

Fifteen to 45 years in a mental institution? For many Holocaust survivors World War II is not over yet. *The Last Transfer* follows a group of patients in the psycho-geriatric ward of the Abarbanel Mental Health Center in Israel who cannot escape from their memories. Robot-like G., cannot stop working, H. continues cleaning toilets as she did in the concentration camp over 50 years ago. A. continues looking for her dead child oblivious to the time that has passed.

The Last Transfer attempts to examine why these people broke down and were unable to rebuild their lives. Why did mental collapse become their refuge? The film questions whetherlong hospitalization is the result of the trauma, the war, or the neglect of the Israeli society. The interaction between the massive psychic disintegration due to the holocaust and a chronic, deteriorating course of illness in survivors is discussed.

55. THREE STORIES

Krakow, Poland was the birthplace of Henryk Vogler, writer and holocaust survivor, his son Pavel, an artist, and his 11-year-old granddaughter, Sara. Pavel never questioned his father directly about his war experiences, yet he sensed his father's pain. Pavel and Sara immigrated to America to get Sara the medical treatment she needed. Here, half a world away, Sara questions her father about why her grandfather remained in Krakow after the war. In Jewish day school she had learned that most Jewish survivors left Europe after the war.

This led Pavel to bring his daughter, a budding artist herself, back to Krakow to learn her grandfather's story. Grandfather Henryk tells her of the beauty of the medieval city and its cultural past. He recalls that in September 1939 he was the "happiest man in the world," newly married and about to publish his first novel. War tore his life apart. He recounts the loss of everything he held dear and his own miraculous survival in the concentration camp. With the defeat of the Germans, Henryk returned to his beloved Krakow, the only place where, as a writer, he could express himself in his native language. His literary career flourished. The birth of his son gave life new meaning.

This is beautiful story, filmed with artistry, about the renewal of life and hope.

56. STILL MISSING

PROGRAM DESCRIPTION:

It's every parent's worst nightmare. It's law enforcement's most implacable challenge. Almost every day in America, a non-family member, most often a child molester kidnaps a child. Most of these abducted children never return to their families. *Still Missing* is an extremely important documentary, and a very human one. It deals head-on with the terrifying facts of child abduction and gives us information and tools to help prevent these crimes.

Still Missing hears from four parents of young children, Jacob Wetterling, Megan Garner, Kevin Collins and Monique Burnett, who were taken from their families. The case studies of the kidnapping are instructive; the deeply personal stories of the parents, their remembrances, and photos and home videos of their lost children make denial impossible. As the video makes clear, far from being the family's fault, child abduction is something that can happen to any family. One of the revelations of *Still Missing* is that most child molesters are ordinary-looking people who pass unnoticed within society. Yet this video gives concrete ways to protect children from these predators.

Still Missing is essential viewing for parents, teachers, law enforcement personnel, criminologists, psychologists, social workers, and all who care about the safety of our children.

57. SACRIFICE: THE STORY OF CHILD PROSTITUTES FROM BURMA

PROGRAM DESCRIPTION:

Each year thousands of girls are recruited from rural Burmese villages to work in brothels in Thailand. Held for years in debt bondage, they suffer extreme abuse by pimps, clients, and the police.

The trafficking in Burmese girls has soared in recent years as a direct result of political repression in Burma. Human rights abuses, war, and ethnic discrimination have displaced thousands of families, leaving families with no means of livelihood. An offer of employment in Thailand is a rare chance for many families to escape extreme poverty.

Sacrifice examines the social, cultural, and economic forces at work in the selling of Burmese girls into prostitution. It is the story of the valuation and sale of human beings and the efforts of teenage girls to survive a crisis born of economic and political repression.

58. TRYING TO GET SOME DIGNITY

Their stories are empowering, sensitively told, challenging, difficult, and ultimately validating and reassuring. They are true stories, which will speak to anyone touched by and concerned with issues of child abuse. Particularly intended for therapists and for those struggling to come to terms with similar experiences in their lives. *Trying to Get Some Dignity* is also a call to action; a reminder to

us that unspeakable events should never have happened in the past and should not be allowed to continue today.

59. INTERVIEWING FOR CHILD SEXUAL ABUSE: A FORENSIC GUIDE

PROGRAM DESCRIPTION:

Professionals called upon to interview children about alleged sexual abuse face a complex task. Safeguarding the welfare of these young clients demands a solid understanding of both clinical and legal issues. What are the most critical clinical and legal issues? What are the most appropriate techniques for eliciting reliable accounts of children's experience? How should evaluators structure the interview to avoid legal challenges to their findings? And, without losing sight of forensic considerations, how can the process be made as comfortable as possible for the child? Featuring Kathleen Faller, noted expert in child abuse evaluations, this informative video offers much-needed guidance for mental health and child protection professionals. It is also recommended viewing for lawyers, judges, and law enforcement personnel.

MEDICAL UPDATES

1. MODERN MANAGEMENT OF MENOPAUSE

Diana L. Dell, M.D., F.A.C.O.G., *10 Yonge Street, #3313, Toronto, ON M5E 1R4, Canada* and Donna E. Stewart, M.D., F.R.C.P.C., *The Toronto Hospital, Women's Health, 200 Elizabeth Street, EN-122, Toronto, ON M5G 2C4, Canada*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will understand the general physiologic changes surrounding the menopause; be able to differentiate perimenopausal symptoms from long-term changes secondary to the climacteric; understand the medication regimens which are commonly used to treat symptoms in the perimenopausal and menopausal periods; and understand perimenopausal mood symptoms, contrasting community-based samples to clinic populations.

SUMMARY:

Perimenopausal and menopausal health issues have become prominent, mainstream medicine as the baby-boomers have aged. Over the past ten years, there have been significant changes both in medical philosophy and available regimens for the treatment of perimenopausal and menopausal symptoms.

This medical update will review general physiologic changes associated with the menopause. It will outline the various forms of hormone therapy that are currently used, including the new class of drugs called "Selective Estrogen Receptor Modulators" (SERMs). Complementary-Alternative therapies that are widely used by menopausal women will also be included.

An overview of mood disorders seen during the climacteric will emphasize the differences seen in community-based and clinic-based samples. Treatment of mood symptoms occurring during the climacteric will also be thoroughly explored. Adequate time has been reserved for questions, and questions about difficult perimenopausal cases are welcome.

REFERENCES:

1. Stewart DE, Robinson GE: *A Clinician's Guide to Menopause.* American Psychiatric Press, Inc., Washington, DC, 1997.
2. Chez RA, Jonas WB: Complementary and Alternative Medicine: Part II. Clinical Studies in Gynecology (Review). *Obstetrical & Gynecological Survey* 52(111):709–716, 1997.

2. ADVANCES IN THE TREATMENT OF HIV INFECTION

Gary L. Simon, M.D., GW *Department of Medicine, Division of Infectious Disease, 2150 Pennsylvania Avenue, 54–11, Washington, DC 20037*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, partifipants will have knowledge of the current approach to the management of HIV infection, the potential for significant drug interactions that may exist between mood-altering and psychiatric agents, and anti-retroviral therapy.

SUMMARY:

Current treatment of HIV infection has evolved from the treatment of opportunistic infections, in which the physician was limited to an acute intervention to treatment of the underlying viral infection such that progression to an immunoincompetent state can be avoided by early intervention. This has resulted in a more complex role for the physician managing patients with HIV infection. Ongoing care, in many cases for years, means that many patients will establish a very long-standing doctor-patient relationship with their HIV physicians.

The management of HIV infection involves the judicious use of a variety of anti-retroviral agents that inhibit the proliferation of this virus. Successful inhibition requires careful monitoring of viral activity and the use of combinations of agents that minimize the development of viral resistance. Many of these agents are associated with a wide variety of adverse effects; both directly or when combined with other pharmaceuticals. This drug interaction may be a major problem for physicians who are caring for HIV patients and requires that close communication be maintained between the physician who manages HIV infection and consultants.

This brief presentation will focus on the management of HIV infection through the use of anti-retroviral agents. The effects of these agents, especially on the central nervous system, and their interaction with other drugs will be emphasized.

REFERENCES:

1. Flexner C: HIV Protease Inhibitors. New England Journal of Medicine 338:1281-1292, 1998.
2. Tseng AL, Foisy MM: Management of Drug Interactions in Patients with HIV. Annals of Pharmacotherapy 31:1040-1058, 1997.

3. MANAGEMENT OF LOWER BACK PAIN

Richard E. Grant, M.D., *Orthopaedic Chief Resident, Howard University Hospital, 2041 Georgia Avenue, NW, Washington, DC 2006020037*

4. PROGRESS IN THE TREATMENT OF BREAST CANCER

Marc E. Lippman, M.D., *New Research Building, 3970 Reservoir Road, NW, Suite E-501, Washington, DC 20007*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be able to define prognostic variables for relapse, survival, and response to therapy of patients with metastatic breast cancer; outline current strategies for chemotherapy and endocrine therapy of metastatic breast cancer; define the activity of effectiveness of adjuvant chemotherapy; and describe more experimental approaches either entering or soon to enter clinical trial.

SUMMARY:

Breast cancer remains overwhelmingly the most common malignancy of women with approximately 200,000 cases of invasive breast cancer to be reported in the U.S. this year. There has been extraordinary progress in the use of systemic agents to palliate metastatic disease, to significantly improve the survival and probably cure of many patients at risk for relapse, and finally to prevent the disease. Many of these developments have been based on large-scale empiric trials; however, there is now significant promise in new biological approaches based upon targeting molecules involved in the pathogenic disease process. This presentation will briefly review all of these advances and place them in a context of reasonable expectations for clinicians and their patients.

REFERENCES:

1. Lippman ME: Breast Cancer. In: *Harrison's Principles of Internal Medicine, 14th Edition.* Rauci AS, Braunwald E, Isselbacher KJ, Wilson JD, Martin JB, Kasper DJ, Hauser SJ, Longo DL (eds). McGraw-Hill, Inc., pp. 562–567, New York, NY, 1996.

2. Lippman ME: Biological Therapy of Breast Cancer. In: *Diseases of the Breast.* Harris JR, Lippman ME, Morrow M, Hellman S (Eds.). Lippincott-Raven Publishers, pp. 743–751, Philadelphia, PA, 1996.

NIH WORKSHOP

Collaborative Session with the National Institute on Health

NIAAA/NIDA/NIMH GRANTS AND CAREER DEVELOPMENT

Chairperson: Walter Goldschmidts, Ph.D.
Co-Chairperson: Andrea Baruchin, Ph.D.
Participant: Ernestine Vanderveen, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will have a greater understanding of the NIH grant review and funding process and how to write a successful grant application.

SUMMARY:

If you are looking for federal support to further your research training and career development and are thinking about submitting your first research grant application to the NIH or would like to know more about the new Patient-Oriented Research support opportunities available from NIH, this workshop will be good for you. Representatives from the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the National Institute on Drug Abuse (NIDA), and the National Institute of Mental Health (NIMH) will provide information and guidance to the audience on how to prepare a successful application for NIH research support. Important elements regarding grant writing, review and funding processes will be discussed. Opportunities for new investigators to further their research training and career development will be highlighted throughout the session. Workshop attendees will have an opportunity to meet one-on-one with representatives from all of the participating institutes as part of the program.

REFERENCE:

1. National Institutes on Health: Preparing a Research Grant Application to the NIH. U.S. Government Printing Office, 1995.

PRESIDENTIAL SYMPOSIUM

STATE MEDICAID PROGRAMS: ACCESS AND QUALITY FOR MENTAL HEALTH CARE

Chairperson: Rodrigo A. Muñoz, M.D.
Co-Chairperson: Donna M. Norris, M.D.
Participants: Mary Jane England, M.D., Commissioner Bruce Bullen, Roy Wilson, M.D., Danna Mauch, Ph.D., Robert Bernstein, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will understand the Medicaid and SCHIP programs for adults and children with mental illness.

SUMMARY:

Medicaid has become a major funding source for children and adults with mental and addictive disorders. This presidential symposium will convene leaders from the states to present their initiatives. Federal and state Medicaid officials, a state mental health commissioner, a managed care executive and an advocate for the rights of the mentally ill will present their positions. APA initiatives to provide timely, on-line information to the district branches will be presented and website information and access will be available.

REFERENCES:

1. Koyenagi C: Managing Managed Care for Publicly Financed Mental Health Services. *Bazelon Center for Mental Health Law,* 1995.
2. Bullen B: Managed Behavioral Health in the Public Sector. *Psychiatric Services,* January, 1999.

RESEARCH ADVANCES IN HERBAL AND ALTERNATIVE MEDICINE: BIOLOGICAL AND CLINICAL EFFECTS

Chairperson: Philip R. Muskin, M.D.
Participants: Jonathan R.T. Davidson, M.D., Richard P. Brown, M.D., and Catherine Crone, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will have an increased knowledge about a variety of herbals and nutrients. They will know about which substances may hold potential benefit for patients and which may cause potentially harmful drug interactions.

SUMMARY:

In 1997 over $12 billion was spent in the U.S. on vitamins, minerals, herbals, botanicals, sports supplements and specialty supplements. While there is some data to support the use of some of these substances, for many there is no reliable evidence of benefit. In addition, what harm could result from the use of these substances, how they interact with standard medications and how they might be used in place of efficacious medications, are areas about which we have little information. This session will focus upon what is known about some of the many products which our patients use, looking at the data which supports the use, as well as the potential for harm to the individual. The session will also include a presentation concerning the use of herbals in a population of medically ill patients, focusing on potential problems that can result.

REFERENCES:

1. Crone CC, Wise TN: Use of Herbal Medicines Among Consultation-Liaison Populations. A Review of Current Information Regarding Risks, Interactions and Efficacy. *Psychosomatics* 3(1):3-13, Jan-Feb, 1998.
2. NIH Office of Dietary Supplements Website: www.nal.usda.gov/fnic/IBIDS
3. Bresssa GM: SAME as Antidepressant: A Meta-Analysis of Clinical Studies. *Acta Neurol Scand* 154(Suppl):7-14, 1994.

RESEARCH ADVANCES IN PSYCHIATRY

RESEARCH ADVANCES IN PSYCHIATRY: AN UPDATE FOR THE CLINICIAN

Chairperson: Herbert Pardes, M.D.
Co-Chairperson: Pedro Ruiz, M.D.
Participants: Jack M. Gorman, M.D., Igor Grant, M.D., Katherine A. Halmi, M.D., Alan F. Schatzberg, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will become familiar with new advances in research, especially those covered at the 1999 Annual Meeting. In addition, participants will learn about new research in depression, neuropsychiatric disorders, eating disorders and schizophrenia.

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 1999 Annual Meeting, but will attempt to give participants some notion of the national priorities in research.

REFERENCE:

1. Riba MB, Oldham JM (eds): *Review of Psychiatry Volume 17,* Washington, DC, American Psychiatric Press, Inc., 1998.

REVIEW OF PSYCHIATRY

SECTION I OF THE REVIEW OF PSYCHIATRY

GENDER DIFFERENCES INI MOOD AND ANXIETY DISORDERS: FROM BENCH TO BEDSIDE

Chairperson: Ellen Leibenluft, M.D.

1. **Gender Differences in Neuroimaging**
   Peg C. Nopoulos, M.D.
2. **Women, Stress and Depression: Sex Differences in HPA Axis Regulation**
   Elizabeth Young, M.D.
3. **Modulation of Anxiety by Reproductive Hormones**
   Margaret Altemus, M.D.
4. **Hormone Replacement and Oral Contraceptive Therapy: Do They Induce or Treat Mood Symptoms?**
   Kimberly Yonkers, M.D.
5. **The Modulation of Monoamine Neurotransmitters by Estrogen: Clinical Implications**
   Charles DeBattista, D.M.H., M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will be able to identify the major gender differences in the prevalence, course and treatment of mood and anxiety disorders; understand the biological mechanisms that might mediate these gender differences, such as gender differences in brain function, and the psychotropic effects of reproductive hormones; and understand the current literature regarding the mood-altering effects of exogenous gonadal steroids.

SUMMARY:

Gender differences in the prevalence of anxiety and mood disorders have been well-documented; beginning at puberty, major depression, dysthymia and anxiety disorders are 2 to 3 times more common in women than men. Gender differences also exist in the course and treatment response of these illnesses, and female reproductive milestones can influence the course of some of these disorders. The purpose of this Section of the Annual Review is to review current research that might u ultimately explain these observed gender differences, and that might elucidate how female reproductive events impact on mood and anxiety disorders.

After a review by Dr. Leibenluft of the gender differences in disease prevalence, treatment response and course that have been identified, Dr. Nopoulos will review the neuroimaging literature on gender differences in human brain structure and function. Dr. Young will discuss sex differences in hypothalamic-pituitary-adrenal axis regulation that have been described in both animals and humans. These sex differences in HPA axis regulation might cause sex differences in the stress response, which in turn might explain the increased prevalence of mood and anxiety disorders in women. Dr. Altemus will review the effects of a number of reproductive hormones on anxiety symptoms; her review of this neglected area will include not only gonadal steroids, but also neurosteroids, oxytocin, and prolactin. Dr. Yonkers will present the literature on the effects of exogenous gonadal steroids (i.e., hormone replacement therapy or oral contraceptives) on mood, and will give treatment recommendations. Finally, Dr. DeBattista will discuss the effects of estrogen on serotonin, dopamine and other monoamine neurotransmitters, and will discuss the clinical implications of these data for treatment.

REFERENCES:

1. Altshuler L, Hendrick V, Cohen L: Course of Mood and Anxiety Disorders During Pregnancy and the Postpartum Period. *J Clin Psychiatry* 59:29–3, 1998.
2. Kessler R, McGonagle K, Swartz M, et al: Sex and Depression in the National Comorbidity Survey I: Lifetime Prevalence, Chronicity and Recurrence. *J Affective Disorders* 29:85–96, 1993.
3. McEwen BS, Alves SE, Bulloch K, et al: Ovarian Steroids and the Brain. *Neurology* 48(Supplement 7):S8–S15, 1997.
4. Zweifel JE, O'Brien WH: A Meta-Analysis of the Effect of Hormone Replacement Therapy Upon Depressed Mood. *Psychoneuroendocrinology* 22:189–212, 1997.

SECTION II OF THE REVIEW OF PSYCHIATRY

MALE PSYCHOSEXUALITY

Chairperson: Richard C. Friedman, M.D. and Jennifer I. Downey, M.D.

6. **Male Sexual Fantasy and Behavior: Selected Clinical Issues**
   Richard C. Friedman, M.D. and Jennifer I. Downey, M.D.
7. **Male Heterosexuality**
   Stephen B. Levin, M.D.
8. **The Evaluation and Treatment of Erectile Dysfunction**
   Stanley E. Althof, Ph.D. and Allen D. Seftel, M.D.
9. **Casualties of Recovered Memory Therapy: The Impact of False Allegations of Incest on Accused Fathers**
   Harold I. Lief, M.D. and Janet M. Fetkewicz, B.A.
10. **Fatherhood As a Transformation of the Self: Toward a New Psychology of Boys and Men**
    William S. Pollack, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will understand the determinants and consequences of sexual fantasy and sexual activity in men; the causes and treatments of erectile dysfunction; the impact of false allegations of incest on accused fathers; and an overview of the biopsychosocial aspects of fathering.

SUMMARY:

Since male sexual activity is motivated by erotic fantasy, a history of fantasy as well as activity should be included in the patient evaluation. The important influence of unconscious guilt on self-destructive sexual activity is illustrated with clinical vignettes. Countertransferential problems which may cause therapists to avoid sexual material are discussed.

Heterosexuality, a line of psychological development consists, by adulthood, of three interacting mental domains: a partially conscious dynamic infrastructure, a conscious default structure and a partially conscious moral superstructure. In addition to discussing these from a developmental perspective, additional manifestations of heterosexual developmental failure are considered.

The nosology, prevalence and risk factors for erectile dysfunction are reviewed with emphasis on the interplay between psychological and biological variables. Current medical treatment options for erectile dysfunction are discussed including the role of mental health clinicians.

An underemphasized area in the clinical literature is the impact of false accusations of sexual abuse on fathers who have not engaged in such behavior. This area is reviewed and clinical examples illustrate the deleterious consequences of such false allegations.

An overview is presented of the biopsychosocial aspects of fathering. The health inducing aspects of fatherhood are discussed as well as psychotherapeutic remediation of difficulties that lead to impaired fathering.

REFERENCES:

1. Friedman RC, Downey J: Psychoanalysis, Psychobiology and Homosexuality. *J Amer Psychoanalytic Assoc* 41(5):1159–1198, 1993.

2. Levine SB: Sexual Life: *A Clinicians Guide.* Plenum Publications, New York, 1992.
3. Althof S, Seftel A: The Evaluation and Management of Erectile Dysfunction. In: *Psychiatric Clinics of North America.* Levine SB, Saunders WB (Eds). Philadelphia, pp. 171–192, 1995.
4. Lief HI: Psychiatry's Challenge: Defining an Appropriate Therapeutic Role when Child Abuse is Suspected. *Psychiatric News* 27(16):14, August, 1992.

SECTION III OF THE REVIEW OF PSYCHIATRY

COUNTERTRANSFERENCE IN PSYCHIATRIC TREATMENT

Chairperson: Glen O. Gabbard, M.D.

11. An Overview of Countertransference: Theory and Technique
Glen O. Gabbard, M.D.

12. Countertransference in General Psychiatry
Marcia K. Goin, M.D., Ph.D.

13. Countertransference in the Treatment of the Suicidal Borderline Patient
John T. Maltsberger, M.D.

14. Countertransference Issues with Antisocial Personality Disorders
John L. Lion, M.D.

15. Countertransference and Assisted Suicide
Frank T. Varghese M.B.B.S. and Brian Kelly, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will have knowledge about the current theory and technique of countertransference; will be able to describe situations in general psychiatry when knowledge of countertransference is useful; inform psychiatrists about the prominent countertransference difficulties encountered with antisocial personality disordered patients; educate psychiatrists about the countertransference difficulties encountered with suicidal borderline patients and improve the management of those patients; and illustrate how countertransference issues may be extremely significant in assessing the need for physician-assisted suicide.

SUMMARY:

This session provides an overview of applying the concept of countertransference to a variety of situations within the field of psychiatry. The session begins with an overview of recent theoretical developments in countertransference, specifically the literature on projective identification, enactments and role responsiveness. Controversies around self-disclosure in the psychotherapeutic setting are also discussed. The second presentation illustrates the problematic countertransference problems when treating suicidal borderline patients and suggests management strategies to deal with those. The third presentation describes how countertransference may operate in a variety of different treatment settings within psychiatry, including hospital treatment, pharmacotherapy, and forensic settings. In the fourth presentation, the specific countertransference problems associated with patients who have antisocial personality disorder are addressed. In addition, the intrinsic differences between prison settings and hospital settings are also illustrated. Finally, with the increasing attention in the popular press and in the scientific literature devoted to the area of physician-assisted suicide, countertransference issues are often left out. In the fifth presentation, the presenters will provide an in-depth analysis of potential countertransference pitfalls in the assessment of whether or not a patient is suited for physician-assisted suicide. Much of their discussion is based on the experience in the Northern Territory of Australia where the practice had temporarily been legal.

REFERENCES:

1. Gabbard GO: Countertransference: The Emerging Common Ground. *International J Psychoanalysis* 76(3):475–485, 1995.
2. Maltsberger JT, Buie DH: Countertransference Hate in the Treatment of Suicidal Patients. *Archives of General Psychiatry* 30:625–633, 1973.
3. Kelly B, Varghese FT. Assisted Suicide and Euthanasia: What About the Clinical Issues? *Australia and New Zealand J of Psychiatry* 30:3–8, 1996.
4. Lion JR: Outpatient Treatment of Psychopaths. In: *The Psychopath: A Comprehensive Study of Antisocial Disorders and Behaviors.* Reid WH (ed). Brunner/Mazel, New York, 1978.

SECTION IV OF THE REVIEW OF PSYCHIATRY

DISRUPTIVE BEHAVIOR DISORDERS IN CHILDREN AND ADOLESCENTS

Chairperson: Robert L. Hendren, M.D.

16. ADHD
Timothy E. Wilens, M.D.

17. Conduct Disorder
Hans Steiner, M.D.

18. Oppositional Defiant Disorder
Joseph M. Rey, M.D.

19. Substance Abuse and Disruptive Behavior Disorders
Paula De Graffenreid Riggs, M.D.

20. Violence and Mental Disorders in Youth
Jerry M. Wiener, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be familiar with the biopsychosocial etiology of the disruptive behavior disorders (ADHD, Conduct Disorder, Oppositional Defiant Disorder, substance abuse and violence) seen in children and adolescents; have knowledge of the etiology of disruptive behavior disorders into an effective, state-of-the-art biopsychosocial treatment plan for these disorders; and be able to identify research directions and needs to further understanding of disruptive behavior disorders in youth.

SUMMARY:

The first presentation of this session will be on the presentation and treatment of ADHD and will be given by Dr. Timothy Wilens. It provides a comprehensive review of the diagnostic, epidemiologic and biologic aspects of this popular disorder and describes the state-of-the-art for this pharmacologic treatment. Dr. Hans Steiner will thoughtfully review the complex etiology of Conduct Disorder. This understanding is then integrated into a brief and concise review of treatment. Dr. Joseph Rey will review the evolution of the Oppositional Defiant Disorder classification. All aspects of treatment will be discussed ranging from practical advice to parents about better communication, to guidelines for when to consider inpatient hospitalization. Dr. Paula De Graffenreid Riggs will give a comprehensive review of substance use disorders and disruptive behavior disorders and where understanding of substance use disorders in youth is today and where research in the field is going and should be going. Finally, Dr. Jerry Wiener will review the history and the evidence for the frequent association of violence and mental illness in youth.

REFERENCES:

1. Hendren RL, Butler K: Impulse Control Disorders in Adolescents. *Annals of Adolescent Psychiatry* 22:85–112, 1998.
2. Wilens TE, Biederman J, Spencer TJ: Attention-Deficit Hyperactivity Disorder and the Psychoactive Substance Use Disorders. *Child and Adolescent Psychiatric Clinics of North America* 5(1):73–91, 1996.

3. Steiner H. Practice Parameters for the Assessment and Treatment of Children and Adolescents with Conduct Disorder. *J American Acad Child & Adolescent Psychiatry* 36:1–18S, 1997.
4. Riggs PD: Clinical Approach to Treatment of ADHD in Adolescents with Substance Use Disorders and Conduct Disorder. *J American Acad Child & Adolescent Psychiatry* 37(3):331–332, 1998.
5. Rey JM: Oppositional Defiant Disorder. *Am J Psychiatry* 150:1769–1778, 1993.

SECTION V OF THE REVIEW OF PSYCHIATRY

SCHIZOPHRENIA IN A MOLECULAR AGE

Chairperson: Carol A. Tamminga, M.D.

21. The Multidimentional Phenotype of Schizophrenia
Peter F. Liddle, M.D.

22. The Implications of Early Sensory Processing and Subcortical Involvement for Cognitive Dysfunction in Schizophrenia
John Gruzelier, Ph.D.

23. Disruption of Information Flow Within Cortical-Limbic-Circuits and the Pathophysiology of Schizophrenia
Anthony A. Grace, Ph.D.

24. Functional Neuroimaging Applied to the Syndrome of Schizophrenia: Symptom, Treatment, and Etiologic Observations
Henry H. Holcomb, M.D.

25. Molecular Biology and Antipsychotic Medications
S. Charles Schulz, M.D.

SUMMARY:

Schizophrenia is a disease with unknown pathophysiology and etiology. Until recently, what was best known about schizophrenia derived from clinical observation. Clinicians have described disease presentation, clinical course, and therapeutic response to medication with great insight. In contrast, replicated biological data which inform pathophysiology are weak at best. While the clinical are still the best known schizophrenia facts, the situation will be rapidly changing. Preclinical neuroscience is burgeoning with discoveries and advances in all areas of brain function, particularly the cellular and the molecular. Ultimately, the mechanisms of all human diseases must be understood in terms of changes in gene expression within pertinent cell groups of the body. Genes which regulate CNS processes are being rapidly identified. The entire human genome is being cloned, a project promised before the year 2003. The genes which encode proteins and the processes which control this genetic expression are the pivotal regulators of cellular, system, and organism function. This regulation is complex, however, and can be environmentally influenced. In order for psychiatrists to fully utilize this new molecular information and orientation, we will need to reformulate (possibly re-meter) the units of psychological function to fit with the anticipated units of genetic expression and protein translation.

In the first talk, Dr. Peter Liddle reviews attempts of his own and others to delineate the phenotypes of schizophrenia. Dr. John Gruzelier will present evidence for the neurobiologic basis of the cognitive impairments in schizophrenia. Dr. Henry Holcomb will discuss the new and still evolving techniques of function brain imaging and what they can tell us about normal brain function and its pathology. Dr. Anthony Grace uses preclinical electrophysiological representations of brain function to model potential pathophysiologic phenomena of schizophrenia in animals. Finally, Dr. S. Charles Schulz will discuss the molecular mechanisms of antipsychotic drug action and the group of new antipsychotics

REFERENCES:

1. Tamminga CA: Neuropsychiatric Aspects of Schizophrenia. In: *The Textbook of Neuropsychiatry,* Yudofsky SC, Hales RE (eds.). American Psychiatric Press, pp. 855-882, 1997.
2. Liddle PF, Friston KJ, Frith CD, Jones T, Hirsch SR, Frackowiak RSJ: Patterns of Cerebral Blood Flow in Schizophrenia. *British J Psych* 160:179-186, 1992.
3. Grace AA: Cortical Regulation of Subcortical Dopamine Systems and its Possible Relevance to Schizophrenia. *J Neural Transmission* 37:111–134, 1993.
4. Seeman P, Van Tol HH: Dopamine Receptor pharmacology. *Trends in Neuroscience* 15:264–270, 1994.
5. Lahti AC, Lahti RA, Tamminga CA: Neuroleptics and Experimental Antipsychotics. In: *Antipsychotic Drugs,* Breier A (ed). American Psychiatric Press, pp 63–100, 1995.

SOCIAL SECURITY WORKSHOP

JOINTLY SPONSORED BY THE SOCIAL SECURITY ADMINISTRATION, APA OFFICE OF PSYCHIATRIC SERVICES, AND THE APA CONSORTIUM ON ORGANIZED SERVICE SYSTEM

Disability Evaluation Under Social Security: A Presentation for Treating Psychiatrists

Chairperson: Jerome E. Shapiro, M.D.
Co-Chairperson: Dale M. Cox, B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to define the kinds and extent of medical evidence SSA needs to make disability determination; understand how SSA processes claims and determines that applicants meet the definition of disability using medical information provided by treating psychiatrists; and 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 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 segments: 1) the history of SSA's disability programs, including recent legislation effecting claimants disabled by drug abuse and/or alcoholism and welfare reform legislation affecting disabled children; 2) how psychiatrists can best serve patients who apply for SSA disability benefits; 3) a review of the clinical information required to expedite the disability determination process and the administrative steps in the adjudication of a claim; and 4) an interactive discussion using the clinical experience of participants in the application of the listing of mental impairments.

REFERENCES:

1. Social Security Administration: *Disability Evaluation Under Social Security,* 1995.
2. Meyerson AT, 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

The Future of Private Practice

Chairperson: Michael C. Hughes, M.D.
Participants: John S. McIntyre, M.D., Norman A. Clemens, M.D., Thomas K. Ciesla, M.D., Maria T. Lymberis, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant will recognize the current status, as well as future opportunities and problems, for the private practice of psychiatry; demonstrate possibilities, limitations and risks in working as a managed care provider; discuss solo office practice, group affiliations, and hospital work in relationship to economic change and the burgeoning growth of biopsychosocial knowledge.

SUMMARY:

The private practice of psychiatry, indeed all of medicine, is beset with economic constraints, increasing bureaucratic intrusions and an uncertain future. Nevertheless, fifty-one percent of American psychiatrists still define ourselves as private practitioners. Moreover, most of us are very busy and happy with our work and adapting to change. This workshop will discuss the state-of-the-art for psychiatric private practice. Michael Hughes, M.D., Chairperson of the Committee on Private Practice will introduce the program, describe the purpose and function of the COPP and moderate the interactive format. John McIntyre, M.D., Chairperson of the Steering Committee on Practice Guidelines, will discuss new information from the Practice Research Network about stability and change in psychiatric practice. Norman Clemens, M.D., Chairperson of the Commission on Psychotherapy by Psychiatrists, will review the practice of present day psychotherapies highlighting new developments and previewing future opportunities. Thomas Ciesla, M.D., COPP member and director of a multidisciplinary group, will share the experience of a private general psychiatrist, particularly group practice, hospital psychiatry, psychopharmacology and collaboration with other disciplines. Maria Lymberis, M.D., APA Treasurer and COPP member, will discuss solo office practice, emphasizing integration of burgeoning knowledge from the neurosciences within the biopsychosocial paradigm. Formal presentations will comprise half of the workshop followed by a colloquy among members of the Committee on Private Practice. Finally, the panel will share the remainder of the program with audience commentary and questions.

REFERENCES:

1. APA Office of Economic Affairs and Practice Management: *Economic Survival Kit,* in press.
2. Clemens N: The Future of Private Office Practice of Psychiatry in an Environment Dominated by Managed Care. In: *New Roles for Psychiatrists in Organized Systems of Care:* Lazarus J, Sharfstein S (eds). American Psychiatric Press, pp. 87–107, Washington, DC, 1997.

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