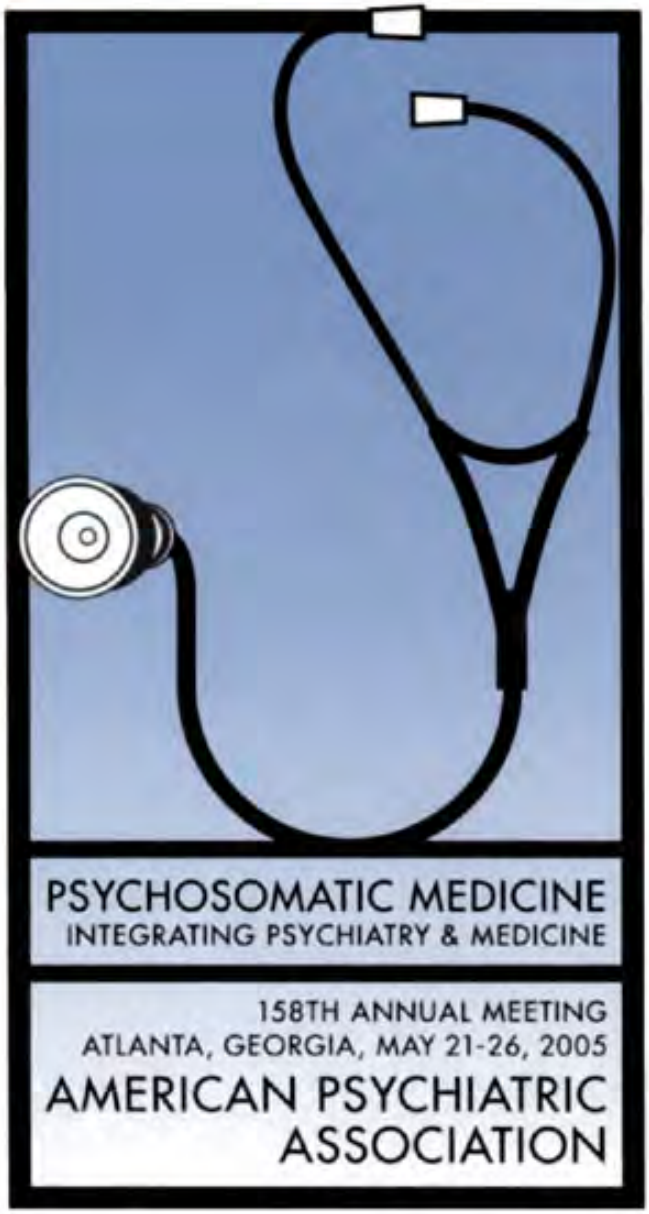
SYLLABUS &

SYLLABUS & PROCEEDINGS SUMMARY

AMERICAN PSYCHIATRIC ASSOCIATION

2005 ANNUAL MEETING



ATLANTA, GA ✦ MAY 21–26, 2005

PROCEEDINGS SUMMARY

A CERTIFICATE OF ATTENDANCE AND DAILY ACTIVITY LOG FOR YOUR RECORDS

The American Psychiatric Association certifies that

_____

attended the
158th Annual Meeting of the APA
Psychosomatic Medicine: Integrating Psychiatry and Medicine
held in Atlanta, GA, May 21-26, 2005

and earned _____ AMA PRA credits.

Michelle Riba, M.D

Michelle B. Riba, M.D.
APA President

James H Scully Jr MD

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

Deborah J. Hales MD.

Deborah J. Hales, M.D.
Director, Division of Education

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

The APA has designated this activity for a maximum of 66 category 1 credits toward the Physician's Recognition Award of the American Medical Association and for the CME requirement of the APA. Each physician should claim only those credit hours that he/she actually spent in the activity.

The American Medical Association has determined that physicians not licensed in the United States who participate in this CME activity are eligible for AMA PRA credit.

For nonphysician participants, the APA certifies that this activity is designated for a maximum of 66 AMA PRA credits.

[See reverse side for Daily Log]

DAILY LOG FOR ATTENDANCE AT CME FUNCTIONS AT THE ANNUAL MEETING OF THE AMERICAN PSYCHIATRIC ASSOCIATION, May 21-26, 2005, Atlanta, GA

Members are responsible for keeping their own CME records and certifying compliance with the APA CME requirement to the APA Department of Continuing Medical 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	

American Psychiatric Association
Continuing Medical Education Requirement

APA Continuing Medical Education Requirement

By referendum in 1974, the membership of the American Psychiatric Association (APA) voted to have participation in Continuing Medical Education 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.

In May 1976, the Board of Trustees endorsed the following standards of participation in CME activities: All APA members in the active practice of psychiatry must participate in at least 150 hours of continuing medical education activities during a three-year reporting period, of which a minimum of 60 hours must be in category 1 CME activities. Category 1 activities are those programs sponsored by organizations accredited for CME and that meet specific standards of needs assessments, planning, professional participation and leadership, and evaluation and other activities which meet the AMA definition of category 1. The 90 hours remaining after the category 1 requirement has been met may be reported in either category 1 or category 2, which includes meetings not designated as category 1, reading, research, self-study projects, consultation, etc. APA members residing outside of the United States are required to participate in 150 hours of CME activities during the three-year reporting period, but are exempt from the categorical requirements.

Life members and Life Fellows who were elevated to life status during or prior to May 1976 are exempt from the CME requirement. Members achieving those member classes after May, 1976 are subject to the CME requirement. Members who are retired are exempt from the requirement when the APA receives notification of their retirement.

Obtaining an APA CME Certificate

The APA CME certificates are issued to members upon receipt of a report of CME activities. You may report your activities to the APA in print or electronically using the official APA report form. This form may be obtained from the APA Department of Continuing Medical Education, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209, (703) 907-8661, or on the APA web site at www.psych.org.

Members may also receive the CME certificate by reporting CME activities using one of the following alternate reporting methods: members may submit: *a copy of your current Physician's Recognition Award (PRA)* from the American Medical Association, or *a copy of your current re-registration of medical licensure* from Hawaii, Kansas, Maine, Maryland, Michigan, Nevada, New Hampshire, New Mexico, or Rhode Island, or *a copy of your current CME certificate from the state medical society* of Kansas, New Jersey, Pennsylvania, or Vermont.

Reciprocity With AMA

By completing the APA's CME membership requirement and qualifying for the APA CME certificate, members may also qualify for the standard Physician's Recognition Award (PRA) of the American Medical Association (AMA).

Reciprocity With Canadian Psychiatric Association/Royal College of Physicians and Surgeons

APA sponsored CME activities qualify as accredited group learning activities as defined by the Maintenance of Certification Program of the Royal College of Physicians and Surgeons of Canada. By completing the APA's CME membership requirement and qualifying for the APA CME certificate, Canadian members may also receive credit towards completion of the requirements of the Royal College of Physicians and Surgeons as administered by the Canadian Psychiatric Association.

APA Report Form

CME credit is reported to the APA Department of Continuing Medical Education by category 1 and category 2 on the APA CME Report form.

In addition to category 1 CME activities designated by accredited sponsors, the APA recognizes these additions to category 1 credit as part of the APA requirement and in agreement with the AMA Physician's Recognition Award: articles published in peer-reviewed journals (journals included in the Index Medicus)–10 category 1 credits for each article, 1 article per year; poster preparation for an exhibit at a medical meeting designated for AMA PRA category 1 credit, including published abstract–5 category 1 credits per poster, 1 presentation per year; teaching, e.g., presentations for activities designated for AMA PRA category 1 credits–2 credit hours for preparation and presentation of new and original lecture or teaching material designated for category 1 credit by an accredited sponsor, to a maximum of 10 credits per year; medically-related degrees, such as the Master's in Public Health–25 AMA PRA category 1 credits following award of the advanced degree.

APA members may also claim 25 hours of category 1 CME credit for the successful completion of Part I and 25 hours for the successful completion of Part II of the examinations of the American Board of Psychiatry and Neurology, and the Royal College of Physicians and Surgeons (of Canada). Members may claim 25 hours for successful completion of the certifying examination in Addiction Psychiatry, Administrative Psychiatry, Child Psychiatry, Forensic Psychiatry, Geriatric Psychiatry, and Psychosomatic Psychiatry.

Members may claim 50 hours of category 1 CME credit for each full year of training in a program that has been approved by the Accreditation Council for Graduate Medical Education (ACGME). Following completion of an ACGME approved residency, APA members are considered to be in compliance with the APA CME requirement. Reporting should begin with three years.

By signing a CME Compliance Postcard, which the APA will send you on request at the end of each three-year reporting cycle, members may demonstrate that they have fulfilled the APA requirement; compliance will be recorded, but a certificate will not be issued.

Members who are licensed in California, Delaware, Florida, Georgia, Hawaii, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Nevada, New Hampshire, New Mexico, Minnesota, Missouri, Ohio, Rhode Island, or Utah, do not need to submit a report or compliance postcard. These states have CME requirements for licensure or for risk insurance that are comparable to those of the APA, and the APA considers members in these states to have met the APA CME requirement; compliance will be recorded, but a certificate will not be issued.

The APA maintains a record of member CME compliance and reporting; however, the APA does not keep detailed or cumulative records for members; members are responsible for maintaining their own records. Members may maintain and track their CME activities on the APA web site, www.psych.org/cme, through the CME recorder.

SYLLABUS
AND
SCIENTIFIC PROCEEDINGS

IN SUMMARY FORM

THE ONE HUNDRED AND FIFTY-EIGTH
ANNUAL MEETING OF THE
AMERICAN PSYCHIATRIC ASSOCIATION

Atlanta, GA

May 21-26, 2005

© American Psychiatric Association, 2005
Published by

$29.95

AMERICAN PSYCHIATRIC ASSOCIATION

1000 Wilson Boulevard, Suite 1825

Arlington, VA 22209

May 2005

This page intentionally left blank

TABLE OF CONTENTS

OTHER FORMATS ALPHABETICALLY

SCIENTIFIC PROGRAM COMMITTEE

MARIAN I. BUTTERFIELD, M.D., *Chairperson,* Durham, NC
DAVID M. MCDOWELL, M.D., *Vice-Chairperson,* New York, NY
TANYA ANDERSON, M.D., Chicago, IL
ROBERT W. BAKER, M.D., Indianapolis, IN
DAVID A. BARON, D.O., Philadelphia, PA
DAVID A. CASEY, M.D., Louisville, KY
JOSEPHA A. CHEONG, M.D., Gainesville, FL
CATHERINE C. CRONE, M.D., Falls Church, VA
RICHARD E. D'ALLI, M.D., Durham, NC
CARRIE ERNST, M.D., Cambridge, MA
DONALD M. HILTY, M.D., Sacramento, CA
LESLIE A. HORTON, M.D., Los Angeles, CA
SHEILA JUDGE, M.D, Philadelphia, PA
STEPHANIE LEMELLE, M.D., New York, NY
PHILIP R. MUSKIN, M.D., New York, NY
ANAND PANDYA, M.D., New York, NY
ANTHONY J. ROTHSCHILD, M.D., Worcester, MA
KENNETH R. SILK, M.D., Ann Arbor, MI
ASHER SIMON, M.D., New York, NY
HARVEY STABINSKY, M.D., J.D., Harrison, NY
DAVID H. TAYLOR, M.D., Oakland, CA
LINDA L.M. WORLEY, M.D., Little Rock, AR

Consultants
ROBERT J. BOLAND, M.D., Providence, RI
LEAH J. DICKSTEIN, M.D., Louisville, KY
DAVID F. GITLIN, M.D., Boston, MA
MARION Z. GOLDSTEIN, M.D., Buffalo, NY
GEETHA JAYARAM, M.D., Baltimore, MD
JULIO LICINIO, M.D., Los Angeles, CA
SUSAN J. LIEFF, M.D., Toronto, ON

COUNCIL ON MEDICAL EDUCATION AND LIFELONG LEARNING

RICHARD BALON, M.D., *Chairperson,* Rochester Hills, MI

COMMITTEE ON CME/LIFELONG LEARNING

DAVID B. MALLOTT, M.D., *Chairperson,* Baltimore, MD
CARLYLE H. CHAN, M. D., Milwaukee, WI
THOMAS A.M. KRAMER, M.D., Chicago, IL
PHILIP R. MUSKIN, M.D., New York, NY
MARK H. RAPAPORT, M.D., La Jolla, CA
EUGENE J. SCHNEIDER, M.D., Rochester, NY
DANIEL K.WINSTEAD, M.D., *Corresponding Member,* New Orleans, LA

COMMITTEE ON COMMERCIAL SUPPORT

DAVID M. MCDOWELL, M.D., *Chairperson,* New York, NY
RICHARD BALON, M.D., Rochester Hills, MI
STEPHEN M. GOLDFINGER, M.D., Brooklyn, NY
CHARLES R. GOLDMAN, M.D., Bloomfield Hills, MI
TREVOR R.P. PRICE, M.D., Philadelphia, PA
DAVID B. MALLOTT, M.D., Baltimore, MD
ANAND PANDYA, M.D., New York, NY

MEDICAL DIRECTOR'S OFFICE

JAMES H. SCULLY, JR., M.D., *Medical Director*
ROSALIND KEITT, *Chief-of-Staff*

ANNUAL MEETINGS DEPARTMENT

CATHY L. NASH, C.M.P., *Director, Division of Education*
VERNETTA V. COPELAND, *Associate Director*
YASHICA L. JOYNER, *Program Assistant*
AKOSUA B. KANKAM, *Scientific Program Coordinator*
BYRON PHILLIPS, *Scientific Program Coordinator*
ELIZABETH RUMSEY, *Administrator, CME Courses*
DESTA WALLACE, *Scientific Program Coordinator*

DIVISION OF EDUCATION

DEBORAH J. HALES, M.D., *Director*
KATHLEEN DEBENHAM, M.A., *Director, Department of Continuing Medical Education*
LINDA BUENO, R.N., *Manager for Commercially-Supported CME*
DAVIN CHITRA, *Program Assistant*

FOREWORD

This book incorporates all abstracts of the *Scientific Proceedings* in *Summary Form* as have been published in previous years as well as information for Continuing Medical Education (CME) purposes.

Readers should note that most abstracts in this syllabus include educational objectives, a list of references, and a summary of each individual paper or session.

We wish to express our appreciation to all of the authors and other session contributors for their cooperation in preparing their materials so far in advance of the meeting. Our special thanks are also extended to Akosua Kankam, Desta Wallace, and Byron Phillips in the APA Annual Meetings Department.

Marian I. Butterfield, M.D. *Chairperson*
David M. McDowell, M.D. *Vice-Chairperson*
Scientific Program Committee

Full Texts

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

EMBARGO: News reports or summaries of APA 2005 Annual Meeting presentations contained in these program materials may not be published or broadcast before the local time and date of presentation.

The information provided and views expressed by the presenters in this *Syllabus* are not necessarily those of the American Psychiatric Association, nor does the American Psychiatric Association warrant the accuracy of any information reported.

This page intentionally left blank

Michelle B. Riba, M.D.

PAPER NO. 1: PRESIDENTIAL ADDRESS

PSYCHOSOMATIC MEDICINE: INTEGRATING PSYCHIATRY AND MEDICINE

"Every affection of the mind that is attended by either pain or pleasure, hope or fear, is the cause of agitation whose influence extends to the heart."

Wm. Harvey, 1628

Psychosomatic medicine has a long and rich history, developed by great physician leaders, and in 2003 received official recognition by the American Board of Psychiatry and Neurology through the American Board of Medical Specialties.

Psychosomatic medicine is focused on the interface between psychiatry and other medical disciplines. It broadly addresses the relationship and interactions between mind and body in patients who are ill and who often have complex medical problems. Our research, clinical care, and teaching is of particular importance for patients who have comorbid psychiatric and medical/surgical illnesses; psychiatric symptoms or disorders that are the direct result of a primary medical/surgical condition or its treatment; and those with somatoform and functional disorders. Clinical care can be provided in a variety of inpatient and outpatient settings.

Research in psychosomatic medicine has been robust, leading to important contributions. There are now a number of randomized, clinical trials of pharmacological and psychological interventions that have demonstrated a reduction of distress and improved quality of life when applied to patients with comorbid medical and psychiatric problems. Yet, there is a tremendous gap in psychiatric and psychosocial services for patients. Stigma, reimbursement issues, lack of mental health benefits, time pressures, shortage of knowledgeable mental health professionals in medical/surgical clinics, etc., all contribute to this gap in services.

Training the next generation of physicians who are proficient in psychosomatic medicine is extremely exciting. We find medical students and residents are energized by the ability to take advanced training and skill development in accredited psychosomatic medicine training programs. This will surely help improve the care of medically/surgically ill patients and their families and will promote the highest quality of integrated psychiatric services.

This page intentionally left blank

SATURDAY, MAY 21, 2005

INDUSTRY-SUPPORTED SYMPOSIUM 1—ANXIETY: DIVERSE POPULATIONS AND PRESENTATIONS, UNIQUE INDIVIDUALS AND TREATMENTS
Supported by UCB Pharma, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the attendee will recognize the diverse manifestations of anxiety in a variety of patient populations and their implications for tailoring care to the unique individual.

No. 1A
UNTANGLING THE ROLE OF GENDER: THE COURSE AND TREATMENT OF ANXIETY DISORDERS IN WOMEN

Naomi Simon, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WANG ACC 815, Boston, MA 02114*

SUMMARY:

While the higher rates of anxiety disorders, such as panic disorder, in women compared with men have been well documented, there is a paucity of data available to explain the etiology of this gender difference. Possible contributions may include factors such as differences in genetic susceptibility and differential exposure and response to negative life events. Recent work has also suggested that the course of anxiety disorders may be more severe in women. Further, the impact of menstrual cycle, pregnancy and the postpartum period, and the perimenopause on anxiety disorders has begun to be studied, and suggest there may be periods of elevated risk for worsening or recurrence of anxiety disorders in women. Studies examining gender differences in anxiety disorders, as well as treatment issues for women, will be discussed.

No. 1B
EVALUATION AND TREATMENT OF ANXIETY IN PATIENTS WITH COMORBID MENTAL ILLNESS

Peter P. Roy-Byrne, M.D., *Department of Psychiatry, University of WA/Harborview Medical Center, 325 Ninth Avenue, Box 359911, Seattle, WA 98104*

SUMMARY:

A large proportion of patients with anxiety disorders have comorbid medical illness. With the aging of the population, and an increased appreciation of the importance of anxiety in the elderly population, this comorbidity will be increasing. While much has been written about how anxiety and depression can impact the presentation, course, and outcome of comorbid medical illness, less has been written about how comorbid medical illness can impact both the diagnosis and treatment of anxiety disorders. In addition to the well-known fact that many anxiety disorders have prominent physical symptoms that can mimic medical illness, the presence of specific medical illness and/or its prescribed treatments can both provoke or set off an anxiety disorder, as well as affect a patient's physical symptom perception and alter the symptomatic presentation of anxiety disorders. In addition, medical illness and its prescribed treatments can alter the effects of anxiolytic treatments by increasing side-effect sensitivity, complicating treatment regimes and impacting adherence, creating drug-drug interactions, and altering patient motivation to seek out, accept, and adhere to specific kinds of treatment modalities. Because chronic disease management approaches to improving treatment for mood and anxiety disorders are also frequently used to manage a variety of chronic medical illnesses, a combined approach using elements related to both anxiety and medical illness management could be fruitfully employed to optimize anxiety treatment in these patients.

No. 1C
IMPROVING THE TREATMENT OF ANXIETY, ONE INDIVIDUAL AT A TIME

Jerrold F. Rosenbaum, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WAC 812, Boston, MA 02114*

SUMMARY:

In practice, treatment of anxiety often involves the flexible adoption of a variety of treatment strategies to address the unique challenges faced by each affected individual. Treatment-related, patient-related, as well as systemic factors may all contribute to unsatisfactory response to initial treatment and require the application of novel therapeutic approaches to improve outcome. In this presentation, we will examine a number of the common and important factors that may contribute to inadequate treatment response in the anxious patient, review the relevant systematic attempts to address this issue, and discuss how consideration of these factors may influence development of an effective treatment plan. We will then discuss a variety of innovative therapeutic strategies including use of novel pharmacological agents and their combinations, and the practical integration of effective cognitive-behavioral therapy techniques that may optimize the care of anxious individuals.

No. 1D
BRIDGING CULTURES AND LANGUAGES: MODIFYING THERAPY FOR REFUGEES WITH PTSD

Michael W. Otto, Ph.D., *Center of Anxiety, Boston University, 648 Beacon Street, Sixth Floor. Kenmore Square, Boston, MA 02215*

SUMMARY:

A number of refugee groups represent severely traumatized populations living in the United States. This presentation discusses a variety of culturally-specific manifestations of traumatic stress reactions and focuses, for illustrative purposes, on the modification of exposure-based treatment for the treatment of non-English speaking Cambodian refugees, victims of the Pol Pot regime, with posttraumatic stress disorder. To address some of the challenges brought by differences in language and culture between providers and patients, critical treatment modifications include: (1) the use of metaphors and culturally-relevant examples to aid the communication of core concepts by translators, (2) an emphasis on teaching the "process" of exposure therapy rather than relying on specific exposure practice in the group setting, (3) a focus on interoceptive (internal sensation) exposure to allow more effective group practice and to address culturally-specific symptom interpretations, (4) attention to the way in which treatment procedures interacted with culturally-specific beliefs, and (5) efforts to integrate treatment services within the community.

No. 1E
ANXIETY AND SUBSTANCE ABUSE: COMPLEXITIES AND SOLUTIONS

Kathleen T. Brady, M.D., *Institute of Psychiatry, Medical University of South Carolina, 67 President Street, Charleston, SC 29425*

SUMMARY:

The relationship between anxiety disorders and substance-use disorders is complex. It is clear from epidemiologic data as well as data from treatment-seeking populations that anxiety and substance use disorders co-occur more commonly than would be expected by chance. Anxiety disorders are heterogeneous and it is likely that the etiologic connection between substance use and anxiety is determined by features of the specific anxiety disorder and individual factors, such as genetics and early childhood experiences. Investigations of the neurobiology of substance use and anxiety disorders have revealed many commonalities in the neural circuitry. In particular, corticotropin releasing factor (CRF), GABA, glutamate, and other excitatory amino acid neurotransmitters have been implicated in both anxiety and substance use. It is likely that this overlap in neural circuitry is one of the explanations underlying the high comorbidity between anxiety and substance use. There have been a number of recent advances in the treatment of both anxiety disorders and substance-use disorders. In particular, agents targeting the GABA and glutamate systems have shown promise in both substance abuse and anxiety, and, are a logical choice in individuals with co-occurring disorders. In this presentation, new developments in the neurobiology of anxiety disorders and substance use disorders will be discussed. A number of pharmacotherapy and psychotherapy treatment studies for co-occurring anxiety disorders and substance use will be reviewed.

REFERENCES:

1. Yonkers KA, et al: Chronicity, relapse, and illness—course of panic disorder, social phobia, and generalized anxiety disorder: findings in men and women from 8 years of follow-up. Depress Anxiety 2003; 17(3):173-179.
2. Shemesh E, Rudnick A, Kaluski E, et al: A prospective study of posttraumatic stress symptoms and nonadherence in survivors of a myocardial infarction (MI). Gen Hosp Psychiatry 2001; 23(4):215-22.
3. Pollack MH, Otto MW, Rosenbaum JF (Eds): Challenges in Clinical Practice: Pharmacologic and Psychosocial Strategies. Guilford Press, New York, 1996.
4. Otto MW, Hinton D, Korbly NB, Chea A, Phalnarith B, Gershuny BS, Pollack MH: Treatment of pharmacotherapy-refractory posttraumatic stress disorder among Cambodian refugees: a pilot study of combination treatment with cognitive-behavior therapy vs. sertraline alone. Behav Res Ther 2003; 41:1270-1276.
5. Kessler RC, Nelson CB, McGonagle KA, Edlund MJ, Frank RG, Leaf PJ: The epidemiology of co-occurring addictive and mental disorders: implications for prevention and service utilization. Am J Orthopsychiatry 1966; 66:17-31.

INDUSTRY-SUPPORTED SYMPOSIUM 2—THE IMPACT OF DEPRESSION AND ANXIETY ON WELL-BEING ACROSS THE LIFE CYCLE
Supported by Pfizer Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) review the relationship between anxiety, depression, and medical comorbidity, (2) discuss how the effective management of depression and anxiety improves patient well being

No. 2A
COMORBID DEPRESSION AND ANXIETY: WHEN TO START AND CONTINUE WITH PSYCHOTHERAPY AND PHARMACOTHERAPY

Martin B. Keller, M.D., *Department of Psychiatry, Brown University, 345 Blackstone Boulevard, Providence, RI 02906*

SUMMARY:

Epidemiologic surveys show that, in the community, about half the patients who meet the criteria for major depression also suffer from a concurrent anxiety disorder. Once a patient has been diagnosed with major depression, it is highly likely that a concurrent anxiety disorder also is present. Conversely, a high percentage of patients diagnosed with an anxiety disorder are likely to develop major depression within one year. Failure to detect and treat comorbid anxiety and depression places patients at an increased risk of psychiatric hospitalization and attempted suicide (beyond the risk contributed by major depression alone). From a clinical perspective, one needs to consider when to approach depression and anxiety as a single disorder, based on the assumption that the diagnosis of the one suggests the presence or imminent emergence of the other, and when to think of them as separate conditions. How this influences the choice and staging of different classes of medications needs to be considered. Selective serotonin reuptake inhibitors (SSRIs) and serotonin/norepinephrine reuptake inhibitors (SNRIs) have been demonstrated to be efficacious in the treatment of major depression, a wide range of anxiety disorders; and concurrent depression and anxiety. Agents from other classes may be necessary, especially at the beginning of treatment alone or in combination to address the anxiety component. Discussion will include which classes of agents to use in continuation and maintenance treatment.

No. 2B
COMORBID DEPRESSION AND ANXIETY IN YOUTH WITH ASTHMA

Marcia J. Slattery, M.D., *Department of Psychiatry, University of Wisconsin Medical School, 6001 Research Park Boulevard, Madison, WI 53719*

SUMMARY:

Depression and anxiety disorders are commonly associated with asthma in children and adolescents. Each of these disorders is highly prevalent in children, and when comorbid, often contribute to more severe psychiatric and medical disease. Several bidirectional risk factors appear to contribute to the development and clinical exacerbation of anxiety/depression and asthma. Asthma-related physiological and child/family psychosocial components may increase the likelihood of developing anxiety and depression in youth, while also impacting the treatment course of these disorders. Conversely, depression and anxiety in asthmatic children and their parents are commonly associated with more severe asthma morbidity. Stress may contribute to the onset and morbidity associated with both groups of disorders. A psychiatric consultation requires a thorough examination of the interplay between asthma and symptoms of depression and anxiety, while also integrating developmental constructs unique to children and adolescents. This presentation will discuss factors related to the comorbidity of asthma, depression, and anxiety in youth, including assessment and treatment approaches.

No. 2C
DEPRESSION AND ANXIETY IN ELDERLY PATIENTS WITH DEMENTIA

Davangere P. Devanand, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive Unit 126, New York, NY 10032;* Gregory H. Pelton, M.D.

SUMMARY:

Dementia and depression occur frequently in the elderly population. Patients with dementia, including the subtypes of Alzheimer's disease, vascular dementia, and Lewy body dementia, can develop depression. Depression occurring during the course of dementia often fluctuates spontaneously over time, and placebo response in clinical trials is fairly high. Overall, controlled trials show a small advantage for antidepressant medications, particularly selective serotonin reuptake inhibitors, over placebo to treat depression in patients with dementia. However, no specific class of antidepressant medication has been shown to be superior to any other in treating depression in patients with dementia. Adverse effects of antidepressant medications in demented patients appear to be similar to the adverse effects observed in elderly depressed, non-demented patients. Monitoring of efficacy, somatic side effects, cognition, and functional ability is advisable when using antidepressant medications in patients with dementia. Anxiety can occur in patients with dementia, and the use of anxiolytics may become necessary. Benzodiazepines may lead to worsening cognition and falls, and should be reserved for short-term and emergency use. In contrast to depression, few research studies have examined anxiety symptoms and disorders in patients with dementia.

No. 2D
DEPRESSION AND ANXIETY AS THEY RELATE TO CARDIOVASCULAR ILLNESS

K. Ranga R. Krishnan, M.D., *Department of Psychiatry, Duke University Medical Center, Box 3950 DUMC, Durham, NC 27710*

SUMMARY:

One in five patients has major depression at the time of cardiac catheterization or following myocardial infarction (MI). Anxiety symptoms and anxiety disorders are also common. Many patients who are free of depression initially following an acute MI go on to develop an episode of depression within a year. Lesperance found that approximately 33% of patients develop major depression at some time during the year following a myocardial infarction. Follow-up studies of depression in the post MI-population document that depression tends to follow a chronic course during the first year after the MI. In patients with congestive heart failure, estimates of the prevalence of major depression have ranged from 17% to 37%. Anxiety has also been shown to affect cardiac morbidity in some, but not all, studies. Three studies have been conducted with regard to treatment of depression in post MI patients. One study using CBT showed that depression improves although there was no discernible cardiac benefit. Sertraline was shown to be effective in treating post MI depression and showed a trend toward reduction in morbidity and mortality. A small fluoxetine study also showed a benefit in treating post MI depression.

No. 2E
IMPACT OF DEPRESSION AND ANXIETY IN WOMEN OF REPRODUCTIVE AGE

Ruta M. Nonacs, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 812, Boston, MA 02114*

SUMMARY:

Women are approximately twice as likely as men to suffer from depression and anxiety; most commonly, mood and anxiety disorders emerge during the child-bearing years. Although reasons for this gender difference are not fully understood, shifts in the reproductive hormonal environment are thought to increase vulnerability to depression. Depression in this population is prevalent, yet many women with depression fail to receive adequate treatment, particularly when depression emerges in the context of pregnancy or childbirth.

Untreated depression and anxiety in child-bearing women may have significant negative repercussions. Depression and anxiety are associated with neuroendocrine abnormalities that may affect reproductive functioning, and there are data suggesting that depression and anxiety may have a negative impact on fertility and pregnancy outcomes. In addition, depression in a mother places her child at risk. We will discuss the negative effects of maternal depression on the child's cognitive development, behavior, and vulnerability to psychiatric illness.

REFERENCES:

1. Zimmerman M, Chelminski I: Clinician recognition of anxiety disorders in depressed outpatients. J Psychiatr Res 2003; 37:325-333.
2. Mrazek DA: Psychiatric symptoms in patients with asthma causality, comorbidity, or shared genetic etiology. Child Adoles Psychiatric Clin N Am 2003; 12:459-471.
3. Devanand DP, Pelton GH, Marston K, Camacho Y, Roose SP, Stern Y, Sackeim HA: Sertraline treatment of elderly patients with depression and cognitive impairment. Int J Geriatr Psychiatry 2003; 18:123-130.
4. Jiang W, Krishnan RR: Should selective serotonin reuptake inhibitors be prescribed to all patients with ischemic heart disease? Curr Psychiatry Rep 2004; 6(3):202-209.
5. Young EA, Midgley AR, Carlson NE, Brown MB: Alteration in the hypothalamic-pituitary-ovarian axis in depressed women. Arch Gen Psychiatry 2000; 57(12):1157-62.

INDUSTRY-SUPPORTED SYMPOSIUM 3—MANAGEMENT OF DISRUPTIVE BEHAVIORAL AND PERVASIVE DEVELOPMENTAL DISORDERS
Supported by Janssen Pharmaceutica and Research Foundation

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to demonstrate an understanding that aggression is a common symptom in children and adolescents with disruptive behavioral disorders (DBDs) and pervasive developmental disorders (PDDs); recognize the consequences of untreated aggression to caregivers and society; demonstrate an understanding of appropriate pharmacological and non-pharmacological approaches to the management of aggression in DBDs and PDDs.

No. 3A
THE UNMET TREATMENT NEEDS OF YOUTH WITH SEVERE BEHAVIORAL PROBLEMS

David J. Posey, M.D., *Department of Psychiatry, Indiana University-Riley Hospital, 702 Barnhill Drive, Room 3701, Indianapolis, IN 46202-5200;* Kimberly A. Stigler, M.D.; Christopher J. McDougle, M.D.

SUMMARY:

This presentation will review the phenomenology, assessment, and treatment of aggression in youths, using published practice guidelines as well as selected articles. Aggression and related severe behavioral problems (self-injury, property destruction, and agitation) are the presenting symptoms of a variety of neuropsychiatric disorders, including disruptive behavior disorders and pervasive developmental disorders. This symptom cluster frequently leads to inpatient psychiatric hospitalization and residential treatment. It is also associated with extreme personal and financial costs to families, caregivers, and society. A comprehensive psychiatric evaluation is recommended for all aggressive children due to the large differential diagnosis and numerous factors contributing to violence. Current guidelines suggest a multimodal approach to treatment that focuses on treatment of the primary disorder associated with the aggression. In addition, an approach based on targeted symptoms is crucial. Treatment should include psychosocial interventions in addition to pharmacological treatments. Research to date has suggested a dichotomy between a "controlled-predatory" and an "impulsive-affective" subtype of aggression. It is the latter subtype that is thought to be most amenable to pharmacological treatment. Youths presenting with aggression and severe behavioral problems are an important population in need of treatment, and additional research aimed at their most effective treatment is needed.

No. 3B
PHARMACOLOGICAL MANAGEMENT OF AGGRESSION IN DISRUPTIVE BEHAVIORAL DISORDERS

Robert L. Findling, M.D., *Department of Psychiatry, Case Western University, 11100 Euclid Avenue, Suite 200, Cleveland, OH 44106-5080*

SUMMARY:

Conduct disorder (CD) is a heterogeneous condition associated with dysfunction in several domains. As CD is oftentimes associated with substantial dysfunction and poor outcome, effective treatments for CD are needed. Because young people with CD may not adequately respond to psychosocial interventions, psychopharmacological treatments are sometimes prescribed to these patients. This presentation will discuss symptoms and characteristics of patients with CD that might be most appropriate for medication therapy. The results of recent clinical trials that examined the use of medication in the treatment of youths with a primary diagnosis of conduct disorder and its related conditions will be reviewed. Recent methodologically sound studies have reported that methylphenidate, risperidone, lithium, and divalproex sodium are superior to placebo in ameliorating aggressive behavior in CD. The available evidence suggests that persistent impulsive aggressive behavior, rather than premeditated aggressive behavior, is the most appropriate target symptom for medication treatment for patients who suffer from CD. In short, pharmacotherapy might be a rational form of intervention for some pediatric patients with CD. Future research is needed to determine whether behaviors other than impulsive aggression are rational target symptoms for medication treatment in young people suffering from CD.

No. 3C
PHARMACOTHERAPY OF BEHAVIORAL SYMPTOMS IN PERVASIVE DEVELOPMENTAL DISORDERS

Christopher J. McDougle, M.D., *Department of Psychiatry, Indiana University, 1111 W. 10th Street, PBA 305, Indianapolis, IN 46202-4800;* David J. Posey, M.D., Kimberly A. Stigler, M.D.

SUMMARY:

Significant advances have been made in the pharmacotherapy of pervasive developmental disorders (PDDs), including autism. Pharmacological management of PDDs remains largely based on identifying target symptoms that may be drug responsive. Many younger-aged patients present with motor hyperactivity and inattention. Results from studies of psychostimulants have shown modest benefit, at best, for theses symptoms. Preliminary studies of alpha-2 agonists and the norepinephrine reuptake inhibitor atomoxetine, have shown some promise for these symptoms. A limited number of controlled studies of serotonin reuptake inhibitors have suggested that this class of drugs may be helpful for ritualistic behavior, particularly in post-pubertal patients. Significant aggression and self-injury can also accompany the PDDs. The use of atypical antipsychotics have proven particularly helpful for these serious behaviors, as demonstrated in the NIMH-sponsored Research Units on Pediatric Psychopharmacology (RUPP) Network study of risperidone in 101 children and adolescents with autism. Results from early trials of drugs with prominent effects on the glutamate system, such as D-cycloserine, are encouraging for the social impairment of autism. In light of significant advances that have been made in the pharmacotherapy of PDDs, additional controlled studies are necessary.

No. 3D
NONPHARMACOLOGIC APPROACHES TO THE MANAGEMENT OF BEHAVIORAL SYMPTOMS

Elizabeth Pappadopulos, Ph.D., *Department of Child Psychiatry, Columbia University, 1051 Riverside Drive Annex, Room 235, New York, NY 10032*

SUMMARY:

An extraordinary proportion of mental health resources are used to treat severely aggressive, disruptive, and defiant children and adolescents. Chronic externalizing behavioral difficulties cut across psychiatric diagnoses affecting youth (e.g., ADHD, psychosis, mood disorders, PDD, etc.) and are associated with poorer outcomes and prolonged intensive treatments. Diagnosing and treating comorbid aggression is challenging for even the most experienced clinician, and there is limited guidance from the literature on the best ways to treat children and adolescents with complex behavioral difficulties. Interventions that integrate psychosocial and pharmacological approaches and involve caregivers in treatment are associated with improved outcomes. This presentation will review methods for evaluating abnormal aggression and highlight the use of a systematic and comprehensive approach to treatment. Models for combining evidence-based environmental, psychosocial, and pharmacological treatments across treatment settings will be examined, with particular attention paid to the Treatment Recommendations for the Use of Antipsychotics for Aggressive Youth (TRAAY). Strategies for forming collaborative partnerships with caregivers that are based on parent reports will also be emphasized.

REFERENCES:

1. McDougle CJ, Stigler KS, Posey DJ: Treatment of aggression in children and adolescents with autism and conduct disorder. J Clin Psychiatry 2003; 64[suppl 4]:16-25.
2. Aman MG, De Smedt G, Derivan A, Lyons B, Findling RL, Risperidone Disruptive Behavior Study Group: Double-blind, placebo-controlled study of risperidone for the treatment of disruptive behaviors in children with subaverage intelligence. American Journal of Psychiatry 2002; 159:1337-1346.
3. McDougle CJ, Posey DJ: Autistic and other pervasive developmental disorders, in Pediatric Psychopharmacology: Principles and Practice. Edited by Martin A, Scahill L, Charney DS, Leckman JF. New York, Oxford University Press, 2003, pp 563-579.

4. Pappadopulos EA, Jensen PS: Research update: a review of the growing evidence base for pediatric psychopharmacology. Child Adolesc Psychiatr Clin N Am, in press.

INDUSTRY-SUPPORTED SYMPOSIUM 4—PSYCHOSOMATIC ILLNESS: A 21ST-CENTURY PERSPECTIVE
Supported by GlaxoSmithKline

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the complex relationships between physical illnesses and anxiety and mood disorders; recognize the role of the psychiatrist in treating chronic pain and health problems unique to women; identify ways to improve outcomes in medically ill patients with anxiety problems.

No. 4A
IMPACT OF ANXIETY AND MOOD DISORDERS ON PHYSICAL DISEASE: THE WORRIED NOT-SO-WELL

Murray B. Stein, M.D., *Department of Psychiatry, University of California at San Diego, 9500 Gilman Drive Mail Code 0985, La Jolla, CA 92093-0985*

SUMMARY:

Mental and physical disorders are frequently comorbid, and there is evidence that the presence of anxiety and mood disorders may adversely impact on the functioning of medically ill individuals. From a population-based perspective, it is evident that the combination of major depression and physical illness is associated with substantially more disability (and health care utilization) than either disorder alone. These associations are particularly profound for certain classes of medical illness, such as diabetes, cardiac disease (eg, post-myocardial infarction), and pulmonary disease (eg. asthma). These associations are explained, at least in part, by the effects of major depression and anxiety on health habits such as smoking, overeating, and sedentary lifestyle; the latter may be caused by anergia in major depression or fear of exercise-related sensations in panic disorder. Adherence to medical treatment regimens may also suffer because of factors such as apathy in major depression or fear of side effects in panic disorder. Physicians should be aware that certain medical illnesses in combination with major depression are associated with increased risk of suicidal ideation. It has also been shown that traumatic events and posttraumatic stress disorder can influence symptom severity (eg. asthma symptoms) and health care-seeking. This presentation will provide a state-of-the-art overview of research in this area, emphasizing the importance of detecting and treating anxiety and mood disorders in medically ill patients.

No. 4B
FACILITATING TREATMENT FOR ANXIOUS PATIENTS WITH COMORBID MEDICAL ILLNESS

Peter P. Roy-Byrne, M.D., *Department of Psychiatry, University of WA/Harborview Medical Center, 325 Ninth Avenue, Box 359911, Seattle, WA 98104*

SUMMARY:

Although treatment resistance is responsible for some cases of failed treatment in the anxiety disorders, failures in effectively delivering treatment are responsible for many more cases. Although clinician error makes some contribution to treatment-delivery failure (eg, medication selection and dosing errors, unfamiliarity with evidence-based psychological treatments), patient failures to engage fully in treatment and adhere to guideline-concordant care make the greatest contribution. This presentation will discuss the factors affecting patient engagement in treatment, which include beliefs and knowledge that shape treatment attitudes, preferences for specific treatment modalities or types of treatment, motivation or readiness to change, social stigma about mental disorders, and attitudes about treatment in family and close friends. Studies of these factors in anxious patients and the scant literature that has included comorbid medical illness will be used to speculate about the possible effects of comorbid medical illness on treatment engagement and the role that standard approaches to improving treatment adherence might play in this situation.

No. 4C
CHRONIC PAIN SYNDROMES: A PSYCHIATRIC PERSPECTIVE

Prakash S. Masand, M.D., *Department of Psychiatry, Duke University Medical Center, 110 Swift Avenue Suite I, Durham, NC 27705*

SUMMARY:

A bidirectional relationship exists between anxiety and other mood disorders and chronic pain syndromes, such as fibromyalgia, irritable bowel syndrome, diabetic neuropathy, and rheumatoid arthritis. Studies have demonstrated that improvement of physical illnesses may depend on the severity of the comorbid anxiety disorder. Currently, benzodiazepines, selective serotonin reuptake inhibitors, and serotonin-norepinephrine reuptake inhibitors are the only pharmacologic treatments approved for anxiety disorders. These medications also may be effective in treating the somatic manifestations of anxiety and physical illnesses. Serotonin appears to mediate both physical illness and anxiety, providing a possible explanation for the improvement of both disorders with agents that increase circulating serotonin levels. To improve overall management of patients with mood, anxiety, and somatic disorders, this program will review available data, particularly double-blind, randomized, placebo-controlled trials, on the pharmacological (psychotropic medications) and nonpharmacological treatment of chronic pain syndromes, with or without associated psychiatric comorbidity.

No. 4D
INTERFACE OF WOMEN'S MENTAL AND REPRODUCTIVE HEALTH

Hadine Joffe, M.D., *Psychiatry Department, Massachusetts General Hospital, 15 Parkman Street, WACC 815, Boston, MA 02114*

SUMMARY:

Women are twice as likely to experience depression during their lifetime, and their risk for depression is particularly high between menarche and menopause. The strong association between depression and the reproductive years raises specific concerns regarding the management of women with mood disorders. Clinicians should consider the potential role of hormonal factors and reproductive life events when evaluating and treating their female patients.

Hormonal changes occurring during the menstrual cycle, postpartum phase, and menopause transition may contribute to risk for depression. The normal fluctuations of estrogen and progesterone have central nervous system effects on serotonergic neurotransmitter systems and brain regions involved in mood regulation. The specific reproductive-endocrine mood disorders that have hormonal etiologies include premenstrual dysphoric disorder (PMDD), postpartum mood disturbance, and perimenopausal depression. Assessment of

women for these disorders can inform clinical decisions about optimal treatment approaches in women.

The interactions between reproductive hormones and serotonin have important therapeutic implications. Antidepressants, particularly those with serotonergic activity, are effective treatments of specific reproductive-endocrine mood disorders. In addition, the mood effects of birth-control pills and menopausal hormone therapy used for non-psychiatric indications should be considered. Hormonal therapies also have therapeutic benefits for specific reproductive-endocrine mood disorders.

REFERENCES:

1. Stein MB: Attending to anxiety disorders in primary care. J Clin Psychiatry 2003; 64(suppl 15):35-39.
2. Garakani A, Win T, Virk S, Gupta S, Kaplan D, Masand PS: Comorbidity of irritable bowel syndrome in psychiatric patients: a review. Am J Ther 2003; 10:61-67.
3. Schmidt PJ, Nleman LK, Dannceau MA, Adams LF, Rubinow DR: Differential behavioral effects of gonadal steroids in women with and in those without premenstrual syndrome. N Engl J Med 1998; 338:208-216.
4. Hazlett-Stevens H, Craske M, Roy-Byrne PP, Sherbourne CD, Stein MB, Bystrisky A: Predictors of willingness to consider medication and psychosocial treatment for panic disorder in a primary care sample. Gen Hosp Psychiatry 2002; 24:316-321.

INDUSTRY-SUPPORTED SYMPOSIUM 5—THE DEVELOPMENTAL TRAJECTORY OF IMPULSIVITY
Supported by Ortho-McNeil Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium the participant will understand the commonality of impulse dyscontrol in several psychiatric disorders across the lifespan to improve its recognition and encourage further investigation of appropriate treatments. These concepts are critical to the appropriate management of a wide spectrum of psychiatric disorders.

No. 5A
COMORBIDITIES OF IMPULSE CONTROL DISORDERS ACROSS THE LIFESPAN

Eric Hollander, M.D., *Department of Psychiatry, Mount Sinai School of Medicine, One Gustave L. Levy Place, Box 1230, New York, NY 10029*

SUMMARY:

It is thought that the manifestation of the trait of impulsivity changes throughout development, and therefore may be expressed as different impulse control disorders in adults than in children or adolescents. Furthermore, the vast majority of psychiatric disorders do not occur in isolation. Rather, they are often accompanied by comorbid disorders or associated symptom domains that shape the expression of the course of illness as well as treatment response. For example, the presence of affective instability in patients with impulsivity may suggest that a trial of anticonvulsant medication is appropriate. Although the exact mechanism by which this comorbidity occurs has not been identified, the presence of more than one psychiatric disorder or symptom domain may be the rule rather than the exception. Regardless of the underlying causes, the presence of comorbid conditions or associated symptoms complicates both the diagnosis and treatment of impulse control disorders. This presentation will compare the common comorbidities and associated symptom domains of impulse control disorders across development. Implications for the diagnosis and treatment of disorders with impulsivity throughout development will also be addressed.

No. 5B
THE RELATIONSHIP OF TRAUMA AND IMPULSIVITY IN PTSD

Lori L. Davis, M.D., *Research Department, Tuscaloosa VA Medical Center, 3701 Loop Road East (151C), Tuscaloosa, AL 35404*

SUMMARY:

The importance of recognizing impulsivity in patients with PTSD is often overlooked, and the relationship of trauma and impulsivity in PTSD is poorly understood. However, recent advances in neuroscience have improved our ability to understand the neuroregulation of fear-mediated behaviors that include impulsivity, hyperarousal, anxiety, and reexperiencing symptoms. These behaviors are likely regulated by an intricate balance between gamma-aminobutyric acid (GABA) and glutamate at the level of the amygdala. A relationship between trauma and impulsivity will be discussed in terms of each serving as a potential predisposing vulnerability factor for the other. Finally, the impulse nature underlying the core PTSD symptoms, which include reexperiencing, hyperarousal, and avoidant clusters will be discussed, as will the development of PTSD across the lifespan from childhood to late life. Greater appreciation of the relationship between trauma and impulsivity and the underlying neuropathology will aid the clinician in diagnosing and treating PTSD, thereby reducing impulsive behaviors that may include suicide attempts and self-destructiveness. Psychotherapy and pharmacotherapy aimed at reducing these symptoms will be discussed.

No. 5C
ADOLESCENT SUBSTANCE ABUSE AND IMPULSE DYSCONTROL

Deborah Deas, M.D., *Department of Psychiatry, Medical University of South Carolina, 67 President Street, P.O. Box 250861, Charleston, SC 29425*

SUMMARY:

Adolescent substance abuse and its related consequences are far reaching. Some of the consequences include impaired family relations, increased aggressive behaviors, motor vehicle accidents, and risky sexual behaviors. This presentation will focus on the epidemiology, assessment, comorbidities, and treatment of adolescent substance abuse, focusing on elements of impulse dyscontrol. A substantial proportion of adolescents have symptoms of substance dependence but do not meet DSM-IV criteria for a substance-use disorder. Adolescents with substance-use disorders are more likely to engage in risky behaviors such as unprotected sex, and are more likely to have mood and disruptive disorders, including conduct disorder. Findings also suggest that adolescent bipolar disorder is a risk factor for early-onset substance-use disorders. In addition, untreated comorbid ADHD and substance-use disorders predict earlier onset and more severe substance abuse. Both psychosocial and pharmacologic treatments need to be evaluated and employed in the treatment of adolescents with substance-use disorders. Care must be taken in the treatment of adolescents with substance-use disorders, since assessments and treatments that work in adults are not transferable to adolescents without modifications. The similarities and differences between adult and adolescent substance-use disorders will also be discussed.

No. 5D
BIPOLAR DISORDER FROM ADOLESCENCE TO ADULTHOOD

Melissa P. DelBello, M.D., *Department of Psychiatry and Pediatrics, University of Cincinnati, College of Medicine, 231 Albert Sabin Way, PO Box 670559, Cincinnati, OH 45267-0559*

SUMMARY:

Bipolar disorder commonly presents in childhood and adolescence. Important phenomenologic differences between adolescent and adult patients with bipolar disorder exist. Although the underlying reasons for these dissimilarities are unknown, pediatric bipolar disorder often presents with higher rates of mixed episodes, rapid cycling, and co-occurring attention deficit/hyperactivity disorder. The differences may result in a significant number of adolescent patients with bipolar disorder having their condition unrecognized or misdiagnosed. Furthermore, these differences may affect the success of pharmacological treatments for bipolar disorder. Impulsivity is both a state and trait characteristic of patients with bipolar disorder and, in part, may contribute to some of the differences in presentation between age groups. Higher rates of impulsive behaviors may be present in pediatric bipolar disorder compared with adults with bipolar disorder. Despite these differences, characterization of impulsive behaviors in patients with bipolar disorder may lead to improved treatment interventions.

No. 5E
POTENTIAL TREATMENTS FOR IMPULSIVITY: DRIVE VERSUS BRAKE

Larry J. Siever, M.D., *Department of Psychiatry, Mt. Sinai School of Medicine, 24 Manor Pond Lane, Irvington, NY 10533*

SUMMARY:

The neurobiology of impulsivity can be understood in the context of a balance between prefrontal cortical inhibitory influences (the brakes) and urges or drives emanating from the limbic system in response to environmental provocations (drive). Impulse dyscontrol is the product of enhanced limbic drive and decreased frontal brakes (while excessive inhibition would represent the opposite configuration). Laboratory measures such as the continuous performance task and blink/startle protocols may help to identify these two components and imaging studies may help to characterize the brain circuitry involved in their regulation. Reduced prefrontal cortical activation in response to pharmacologic and psychologic perturbations suggest reduced frontal activation in impulsive patients, while responses of limbic system structures such as the amygdala suggest hyperreactivity in response to emotional provocation in both fMRI and PET studies. Abnormal serotonergic modulation of cingulate and orbital frontal cortex may contribute to reduced prefrontal inhibition; serotonergic and cingulate activation abnormalities associated with impulsivity can be identified throughout the life span, but may change their character over development. This model also has implications for both psychosocial and pharmacologic treatment as serotonergic enhancing agents may enhance prefrontal inhibition, as may stimulants in individuals with attention deficits, while anticonvulsants may stabilize excessive limbic irritability.

REFERENCES:

1. Hollander E, Evers M: New developments in impulsivity. Lancet 2001; 22: 358(9286):949-50.
2. Kotler M, lancu I, Efroni R, Amir M: Anger, impulsivity, social support, and suicide risk in patients with posttraumatic stress disorder. J Nerv Ment Dis 2001; 189(3):162-7.
3. New AS, Hazlett EA, Buchsbaum MS, Goodman M, Reynolds D, Mitropoulou V, Sprung L, Shaw RB Jr, Koenigsberg H, Platholi J, Silverman J, Siever LJ: Blunted prefrontal cortical 18fluorodeoxyglucose positron emission tomography response to meta-chlorophenylpiperazine in impulsive aggression. Arch Gen Psychiatry 2002; 59(7):621-9.
4. Hirschfield-Becker DR, Biederman J, et al: Behavioral inhibition and disinhibition as hypothesized precursors to psychopathology: implications for pediatric bipolar disorder. Biol Psychiatry 2003; 53:985-999.
5. Deas-Nesmith D, Brady KT, White R, Campbell S: HIV risk behaviors in adolescent substance abusers. Journal of Substance Abuse Treatment 1999; 16(2):169-172.

INDUSTRY-SUPPORTED SYMPOSIUM 6—INTEGRATING NEUROBIOLOGY AND PSYCHOPATHOLOGY INTO EVIDENCE-BASED TREATMENT OF SOCIAL ANXIETY DISORDER
Supported by Forest Laboratories, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the demographic and clinical characteristics of SAD, and the importance of improving detection; understand the neurobiology involved in fear conditioning and anxiety, and its role in SAD; gain and improve knowledge about emerging new evidence-based theories for the effective pharmacological treatment for SAD, including suggested first-line treatment, duration, and management of treatment-resistant patients.

No. 6A
SOCIAL ANXIETY DISORDER: EPIDEMIOLOGY, DIAGNOSIS, AND COMORBIDITIES

Michael R. Liebowitz, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 120, New York, NY 10032-2603*

SUMMARY:

Social anxiety disorder (SAD) is a common, chronic psychiatric disorder that often is complicated by comorbid conditions. SAD is characterized by a persistent fear of social or performance situations in which embarrassment can occur. SAD can be classified into two subtypes, non-generalized and generalized. This disorder typically begins at an early age, with a mean age of onset between 14 and 16 years, and must be differentiated from normal shyness. It is estimated that the majority of patients with (SAD) have comorbid mental disorders, including mood, anxiety, and substance abuse. Following onset in adolescence, patients with generalized SAD often experience a lifelong and unremitting mental disorder characterized by severe anxiety and functional disability. To facilitate accurate diagnosis, the clinical features and differential diagnosis of SAD will be described, together with useful clinical assessment instruments. The prevalence, rates of recognition and treatment, and natural history of SAD also will be explored. The frequency and patterns of comorbidity, as well as quality-of-life issues, including the impact of SAD on educational attainment, social and occupational functioning, marital status, and health care utilization will be discussed.

No. 6B
RECENT ADVANCES IN THE COGNITIVE NEUROSCIENCE OF SOCIAL BAHAVIOR

Philip T. Ninan, M.D., *Department of Psychiatry, Emory University, 1841 Clifton Road, 4th Floor, Atlanta, GA 30329*

SUMMARY:

Social anxiety disorder (SAD) typically appears early in life during the mid-adolescent years and is unremitting throughout life unless properly treated. No single developmental theory has been proposed to account for the origins of SAD, although current understanding of the etiology of SAD posits an interaction between psychological and biological factors. Several risk factors associated with this disorder include environmental and parenting influences, such as rejection and over-protection, and dysfunctional cognitive and conditioning events in early childhood, including negative behavior modeling and socialization experiences. Recent research indicates that individuals with SAD selectively process or have better memory retrieval of threatening or negative information. This dysfunctional processing of information may help explain the development and maintenance of this disorder. This presentation will provide an overview of the origins of SAD and its implications for therapies in the clinical setting.

No. 6C
NEUROBIOLOGICAL MECHANISMS OF SOCIAL ANXIETY DISORDER

Franklin R. Schneier, M.D., *Department of Psychaitry, Columbia University, 1051 Riverside Drive, Unit 69, New York, NY 10032*

SUMMARY:

Social anxiety disorder (SAD) is associated with persistent symptoms of anxiety, fearful cognitions, avoidance behavior, and demoralization. Etiological models of SAD suggest a relationship to submissive and attachment behaviors that have evolved in group-living species. Both twin and developmental studies demonstrate that environmental and genetic factors are both important in the emergence of SAD. The delineation of the basic neurobiology underlying normal and pathological anxiety is a major focus of anxiety research. Neurochemical dysfunction appears to be a feature of the neurobiology of SAD, as evidenced by studies of neuroreceptor imaging, neuroendocrine function, and profiles of response to specific medications. SAD symptoms have been associated with various neurotransmitter systems, including norepinephrine, dopamine, serotonin, and GABA, and the hypothalamic-pituitary-adrenal axis. Pathological anxiety in SAD has been associated with abnormal conditioning of fear responses through neural circuits. Neuroimaging techniques offer an unprecedented opportunity to map the neuronal correlates of cognitive, affective, and behavioral abnormalities associated with SAD. A review of chemical and neuroendocrine challenges, autonomic nervous symptom functioning, neuroreceptor mapping, and other neuroimaging studies in SAD, as well as implications of these findings for future treatment and research will be discussed.

No. 6D
EVIDENCE-BASED PHARMACOTHERAPY OF SOCIAL ANXIETY DISORDER

Carlos Blanco-Jerez, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, New York, NY 10032*

SUMMARY:

In recent years, a number of clinical trials have demonstrated that benzodiazepines and antidepressants, including monoamine inhibitors, serotonin-norepinephrine reuptake inhibitors (SNRIs), and selective serotonin reuptake inhibitors (SSRIs) are effective in the treatment of social anxiety disorder (SAD). The SSRIs are emerging as the first-line treatment for SAD, based on their proven safety, tolerability, and efficacy. SAD presents as two subtypes: the more common and debilitating generalized form, and the non-generalized form, which is usually present in more predictable social or performance situations. Recent meta-analyses suggest that SSRIs and benzodiazepines work well in the generalized form, though SSRIs have an advantage of also being effective for frequently comorbid psychiatric disorders, such as depression. Whether one particular class of medication is preferable to another for treatment of the non-generalized form of SAD remains to be fully explored. Other goals for ongoing and future research include development of therapeutic approaches to achieve remission (as opposed to response), prevent relapse, and maintain wellness during long-term treatment, and identify and treat partial and non-responders successfully.

REFERENCES:

1. Blanco C, Nissenson K, Liebowitz MR: Social anxiety disorder: recent findings in the areas of epidemiology, etiology, and treatment. Curr Psychiatry Rep 2001; 3:273-280.
2. Argyropoulos SV, Bell CJ, Nutt: Brain function in social anxiety disorder. Psychiatr Clin North Am 2001; 24(4):707-22.
3. Ollendick TH, Hirschfeld-Becker DR: The developmental psychopathology of social anxiety disorder. Biol Psychiatry 2002; 51:44-58.
4. Blanco C, Raza MS, Schneier FR, Liebowitz MR: The evidence-based pharmacological treatment of social anxiety disorder. Intl J Neuropsychopharm 2003; 6:427-442.

INDUSTRY-SUPPORTED SYMPOSIUM 7—BIPOLAR DISORDER: PSYCHIATRIC AND MEDICAL IMPLICATIONS FOR OPTIMAL PATIENT MANAGEMENT
Supported by Pfizer Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize and manage the implications of medical and psychiatric comorbidities in the bipolar patient.

No. 7A
PSYCHIATRIC COMORBIDITY IN BIPOLAR DISORDER

Susan L. McElroy, M.D., *Department of Psychiatry, University of Cincinnati College of Medicine, MSB559-231 Albert Sabin Way, Cincinnati, OH 45267-0559*

SUMMARY:

Patients with bipolar disorder frequently have one or more psychiatric comorbidities which result in sicker patients and more complicated clinical management. Bipolar disorder has well-documented associations with several psychiatric conditions, including anxiety disorders, psychosis, eating disorders, and substance abuse. Because of the frequent co-occurrence of bipolar disorder and other psychiatric conditions, psychiatrists must demonstrate due diligence in identifying psychiatric comorbidities during the initial work-up and evaluation of the bipolar patients and in subsequent follow up. Bipolar disorder complicated by psychiatric comorbidity presents substantial implications for clinical management. The psychiatrist must monitor the status of the bipolar illness and the psychiatric comorbidity on an ongoing basis, as the co-occurring conditions have a bidirectional clinical relationship. Psychiatric comorbidity influences management decisions relative to bipolar disorder, and the bipolar illness influences management of the comorbid psychiatric condition. During this presentation, some of the common psychiatric comorbidities seen in patients with bipolar disorder will be reviewed, along with current practices for diagnosing, evaluating, and managing these complicated patients. The discussion will emphasize the need for

comprehensive care that addresses the needs and challenges posed separately and individually by bipolar disorder and the comorbid conditions that complicate the bipolar illness.

No. 7B
TREATMENT AND MONITORING GUIDELINES FOR THE PATIENT WITH BIPOLAR DISORDER

Trisha Suppes, M.D., *Department of Psychiatry, University of Texas Southwestern, 5323 Harry Hines Boulevard, Dallas, TX 75390-9121*

SUMMARY:

Dramatic expansion of treatment options for bipolar disorder has created a need for clinical direction and guidance, which has led to the development of multiple clinical guidelines and recommendations. Examples of existing guidelines and recent guideline development include the APA Practice Guidelines for Bipolar Disorder; the Expert Consensus Guidelines, which will be updated during 2004; the Texas Medication Algorithm Project (TMAP) and the Texas Implementation of Medication Algorithms, both due to be updated and published in 2004; and the American Diabetes Association guidelines regarding metabolic effects of antipsychotic medications. Appropriate application of guidelines requires an understanding of the current recommendations, including their similarities and differences; recognition that guidelines represent a combination of evidence-based psychiatric practice and expert opinion; use of guidelines for both treating and monitoring patients; and appreciation of the value and limitations of the guidelines with respect to managing complicated bipolar patients with comorbid medical or psychiatric conditions. TMAP clinical experience supports clinical guidelines can positively influence clinical practice, including both better outcomes and economic advantages. In applying guidelines to clinical practice, psychiatrists must remain flexible, recognizing the need to adapt recommendations to individual patient circumstances and needs and the evolving knowledge base related to management of bipolar disorder.

No. 7C
BIPOLAR DISORDER COMPLICATED BY MEDICAL COMORBIDITY

Roy H. Perlis, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street WACC 812, Boston, MA 02114*

SUMMARY:

Relative to the general population, patients with bipolar disorder are at increased risk of death, not just from suicide, but also from medical conditions. Indeed, the presence of so-called complicated bipolar disorder — that is, concurrent bipolar disorder and other medical illness — has important implications for the treatment and course of both illnesses. The medical illness may be unrelated to bipolar disorder, but exacerbated by the consequences of bipolar disorder itself (for example, poor health maintenance habits) or the treatments used to control it (for example, medications that cause obesity). Patients with complicated bipolar disorder tend to have increased utilization rates for health care resources, both medical and psychiatric. Unfortunately, contemporary clinical guidelines and algorithms offer little direction about the management of such patients. For example, many standard bipolar pharmacotherapies contribute to obesity, and the obese patient may present a particular treatment challenge. A comprehensive psychiatric and medical evaluation is essential. Patients with complicated bipolar disorder require ongoing monitoring of their medical and psychiatric conditions.

No. 7D
MANAGEMENT OF THE COMPLICATED BIPOLAR PATIENT

Paul E. Keck, Jr., M.D., *Biological Psychiatry Department, University of Cincinnati, Medicine, 231 Albert Sabin Way, ML559, Cincinnati, OH 45267-0559*

SUMMARY:

The frequent occurrence of bipolar disorder with comorbid medical and psychiatric conditions complicates treatment of both the bipolar illness and the comorbid condition. The recent dramatic expansion of treatment options for bipolar disorder, particularly options with demonstrated efficacy, has further complicated treatment decisions for psychiatrists. Clinical guidelines for treatment and monitoring bipolar patients provide little direction regarding management of complicated patients. In caring for patients with bipolar disorder complicated by comorbid conditions, psychiatrists must consider both acute and long-term effects of bipolar therapy on the comorbidities, as well as the effects of the comorbid conditions and their therapies on the clinical course of bipolar disorder. Follow up should include careful review of patients' prescription and nonprescription medications. Effective management of complicated patients requires a long-range clinical perspective. Ongoing monitoring of complicated bipolar patients should reflect the types and frequency of monitoring (laboratory and clinical) indicated by the status of the bipolar illness and comorbid conditions. Clinical management should be modified as necessary on the basis of monitoring results and their interpretation. Psychiatrists must recognize the potential for adverse events and adjust the patient management strategy appropriately. The clinical strategy should emphasize integration of psychiatry and medicine to achieve optimal results.

REFERENCES:

1. Freeman MP, Freeman SA, McElroy SL: The comorbidity of bipolar and anxiety disorders: prevalence, psychobiology, and treatment issues. J Affect Disord 2002; 68:1-23.
2. Post RM, Baldassano CF, Perlis RH, Ginsberg DL: Treatment of bipolar depression. SNC Spectr 2003; 8:1-10; quiz 11.
3. Suppes T, Rush AJ, Dennehy EB, et al: Texas Medication Algorithm Project, phase 3 (TMAP-3): clinical results for patients with history of mania. J Clin Psychiatry 2003; 64:370-382.
4. Keck PE Jr, Nelson EB, McElroy SL: Advances in the pharmacologic treatment of bipolar depression. Biol Psychiatry 2003; 53:671-679.

INDUSTRY-SUPPORTED SYMPOSIUM 8— EXPANDING USES OF ATYPICAL ANTIPSYCHOTICS: ADDRESSING REAL-WORLD CHALLENGES
Supported by Bristol-Myers Squibb and Otsuka America Pharmaceutical, Inc.

EDUCATIONAL OBJECTIVES:

After attending this symposium, participants should be better able to:

- Discuss the different pharmacologic profiles of atypical antipsychotics and their clinical implications.
- Review the evidence for the use of atypical antipsychotics in childhood psychiatric disorders and recognize their potential side effects.
- Describe the state-of-the-art management of psychosis in the acute care setting and the impact emerging therapies may have on patient care.

- Recognize the role of atypical antipsychotics in improving neurocognition in patients with schizophrenia and their implication on patients' long-term outcomes.

No. 8A
DIFFERENTIAL PHARMACOLOGY OF ANTIPSYCHOTIC AGENTS: CLINICAL IMPLICATIONS

Jeffrey A. Lieberman, M.D., *Department of Psychiatry, Columbia University Medical Center, 1051 Riverside Drive, Unit 4, New York, NY 10032*

SUMMARY:

The discovery of antipsychotic drugs was one of the great breakthrouths in medical therapeutics of the 21st century. First-generation antipsychotic drugs, called neuroleptics, alleviated psychotic symptoms of schizophrenia-related disorders and prevented recurrence. However, they do not greatly improve other sympto dimensions and have high rates of neurologic side effects. Second-generation antipsychotic drugs, or atypicals, were a significant therapeutic advancement. These drugs have little or no neurologic side effects and superior efficacy. However, they may have other porentially serious side effects.

While significant progress has been made in pharmacotherapy and drug development, much remains to be done. Many patients do not respond to even the best current treatments and most are left with significant residual symptoms. Side effects affect tolerability and patient compliance with treatment. Thus, there is a need for new drug development using novel strategies.

New strategies for treatment development have focused on two approaches. The first is the development of agents as adjunctive treatments targeting specific symptom domains of the illness (e.g. cognition, psychosis, negative symptoms). In this context the NIMH MATRICS and TURNS programs illustrate such programmatic efforts to develop treatments for cognitive deficits in schizophrenia. The second is through the establishment of molecular libraries of neurobiologic targets through the identification of new genes associated with schizophrenia and related psychoses, and the identification of candidate molecules through studies of animal models.

Finally, drug development requires the characterization of bio or surrogate markers of the disease and treatment effects to enable more eficient and reliable proof of efficacy and determination of efficacy of novel compounds.

In summary, new drug development in the 21st century for major mental disorders such as schizophrenia must adhere to a reational process of drug discovery and development. This presentation will describe the current state of antipsychotic pharmacotherapy and innovative drug development.

No. 8B
USE OF ANTIPSYCHOTIC MEDICATIONS IN CHILDREN

Karen D. Wagner, M.D., *Division of Child and Adolescent Psychiatry, University of Texas Medical Branch, 1.302 Rebecca Sealy, 301 University Boulevard, Galveston, TX 77555-0188*

SUMMARY:

Given the favorable safety profile of atypical antipsychotics compared with conventional agents, they are increasingly being used for a variety of psychiatric disorders in children and adolescents. There are limited controlled clinical data evaluating the use of antipsychotics in pediatric patients, and most information is based upon open-label studies, case reports, and chart reviews. This presentation reviews the evidence base for the use of atypical antipsychotics in the treatment of children with bipolar disorder, schizophrenia, autistic disorder, and disruptive behavior disorders. The differential safety profiles of atypical antipsychotics in pediatric patients will be presented.

No. 8C
COMPARATIVE EFFECTIVENESS OF ANTIPSYCHOTIC MEDICATION FOR OPTIMIZING THE MANAGEMENT OF PSYCHOSIS IN GERIATRIC PATIENTS

David L. Sultzer, M.D., *Department of Psychiatry, VA Greater Los Angelos Health Care System,*11301 Wishire Boulevard 3 South Room 3424, Los Angelos, CA 90073

No. 8D
MANAGING PSYCHOSIS IN THE ACUTE CARE SETTING

John E. Kraus, Jr., M.D., *Department of Psychiatry, University of North Carolina at Chapel Hill, C8-7160, Chapel Hill, NC 27599*

SUMMARY:

Management of psychosis in the acute care setting presents a unique challenge to clinicians. Treatment goals include calming the agitated, aggressive, violent, or disruptive patient: Identifying comorbid conditions, and preventing relapses. The mainstay of acute psychosis treatment for many years has been the intramuscular administration of conventional antipsychotics like haloperidol with or without benzodiazepines or benzodiazepines alone. However, conventional antipsychotics have attendant risks and adverse effects. Comparatively, atypical antipsychotics have a superior tolerability and safety profile offering clinical benefits to patients. The advent of intramuscular preparations of atypical antipsychotics provides important options to clinicians practicing in the acute-care setting and offers patients the opportunity for continuity of pharmacotherapy.

No. 8E
IMPROVING NEUROCOGNITION WITH ATYPICAL ANTIPSYCHOTICS

Richard S.E. Keefe, Ph.D., *Department of Psychiatry, Duke University Medical Center, DUMC 3270, Durham, NC 27710*

SUMMARY:

Neurocognitive dysfunction is a core feature of schizophrenia and is correlated with poor long-term outcomes and adaptive dysfunction. Such dysfunction involves several domains, including executive function, intellectual function, and memory. Improvements of these impairments may have a significant impact on a patient's functioning. There is increasing evidence suggesting that neurocognitive function can be significantly improved with atypical antipsychotics, especially if combined with focused psychologic interventions. This presentation will review the evidence to date, including an update of the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) project, which offers the unique opportunity for the comparison of the available antipsychotic agents.

REFERENCES:

1. Finding RL, McNamara NK: Atypical antipsychotics in the treatment of children and adolescents; clinical applications. J Clin Psychiatry 2004; 65(suppl 6):30-44.
2. Sultzer DL: Psychosis and antipsychotic medications in Alzheimer's disease: clinical management and research perspectives. Dement Geriatr Cogn Disord 2004; 17(1-2):78-90.

3. Citrome L: Atypical antipsychotics for acute agitation. New intramuscular options offer advantages. Postgrad Med 2002; 112(5):85-8, 94-5.
4. Harvey PD, Green MF, Keefe RS, Velligan DI: Cognitive functioning in schizophrenia: a consensus statement on its role in the definition and evaluation of effective treatments for the illness. J Clin Psychiatry 2004; 65:361-372.

INDUSTRY-SUPPORTED SYMPOSIUM 9—ACHIEVING REMISSION IN DEPRESSION: IS THE BAR SET TOO HIGH OR TOO LOW?
Supported by Cephalon, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants will be familiar with the definition and assessment of response and remission in the treatment of depressive disorders and have a greater appreciation for the therapeutic potential and limitations of advances in the pharmacological, psychotherapeutic, and neurotherapeutic treatment of unremitted depression.

No. 9A
REMISSION IN DEPRESSION: DEFINITION AND TREATMENT APPROACHES

Joshua A. Israel, M.D., *Department of Psychiatry, University of California, San Francisco, 4150 Medical Center #116N, San Francisco, CA 94121*

SUMMARY:

This talk will review remission as it is currently understood in the field of psychiatry to pertain to major depression. Particular differences will be emphasized in comparison to rates of remission versus rates of response. Practitioners should gain a realistic understanding of possible outcomes in treating patients with major depression. There will be an overview of currently available modalities to improve rates of remission, including a discussion of comorbid conditions that can impede full remission, such as personality disorders, substance abuse, and medical illness.

No. 9B
AUGMENTATION AND COMBINATION STRATEGIES IN PARTIAL AND NONRESPONDERS TO ANTIDEPRESSANTS

Charles DeBattista, M.D., *Psychiatry & Behavioral Sciences, Stanford University School of Medicine, 401 Quarry Road, #2137, Stanford, CA 94305-5723*

SUMMARY:

Most patients fail to achieve full response to monotherapy with an antidepressant in acute trials. As a result, combination or augmentation strategies are frequently employed to enhance antidepressant response. Most augmentation strategies are poorly studied in combination with newer antidepressants. For example, two of the more widely studied augmentation strategies, lithium and thyroid supplements, have primarily been studied in combination with TCAs. This symposium evaluates the role of common and novel augmentors to antidepressant therapy including bupropion, dopamine agonists, sex steroids, atypical antipsychotics, and glucocorticoid receptor antagonists.

No. 9C
THE ROLE OF PSYCHOTHERAPY TO ENHANCE THE EFFICACY OF ANTIDEPRESSANTS

Timothy J. Petersen, Ph.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 812, Boston, MA 02114*

SUMMARY:

Residual symptoms are common even after antidepressant treatment of adequate dosage and duration. Patients with residual symptoms experience higher rates of relapse and recurrence when compared with those treated to a completely symptom free state. Pharmacologic approaches that may prove useful to treatment of residual symptoms include increasing dose, augmentation, combination treatments, and switching. Recent research suggests that evidenced-based psychotherapies may play an important role in improving the long-term outcome of antidepressant treatment. Such approaches include delivery of psychotherapy during the continuation and maintenance phases of treatment, modification of the content of psychotherapy to address residual symptoms and enhance well-being, and integration of evidence-based psychotherapies into medical specialty care settings.

The role of psychotherapy as an adjunct to acute-phase antidepressant treatment is less clear, with mixed findings on the advantages of combining evidenced-based psychotherapies with antidepressants. It appears that specific patient illness and sociodemographic characteristics may predict who benefits from combined acute-phase treatments.

Unanswered research questions include what patient factors indicate the use of sequenced pharmacotherapy / psychotherapy treatments, in what specific ways CBT and IPT must be adapted for phases of depression treatment, and whether there is significant benefit to combining antidepressant and psychotherapeutic treatments during the acute phase of treatment.

No. 9D
PHARMACOLOGICAL APPROACHES TO THE TREATMENT OF RESIDUAL SYMPTOMS

Maurizio Fava, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC-812, Boston, MA 02114*

SUMMARY:

Most patients who are treated for major depressive disorder (MDD) do not achieve full remission despite receiving adequate (both in terms of dose and duration) antidepressant treatment. When it comes to antidepressant treatment, residual psychological, behavioral, and/or physical symptoms are more the rule than the exception. Even among responders, residual symptoms are not uncommon. In some cases, residual symptoms may be complicated by the emergence of treatment-related adverse events, and the distinction between side effects and residual symptoms may become blurred. In any case, the persistence of depressive symptoms despite a significant improvement with antidepressant treatment represents a significant challenge to clinicians. There are several pharmacological approaches to the management of residual symptoms, including dose changes, augmentation, and combination. These pharmacological approaches have been primarily based on anecdotal reports on the results of studies utilizing these strategies in depressed patients who have not achieved adequate response to antidepressant treatment. This presentation will review the empirical evidence for the efficacy of these pharmacological approaches, their relative advantages and disadvantages, and will discuss the need for further studies to investigate the effects of such pharmacological treatments specifically in MDDD patients with residual symptoms. Clinicians must marshal these different treatment options to increase their patients' chances of achieving sustained remission from depression and resolution of residual symptoms.

No. 9E
NEUROTHERAPEUTICS IN RESISTANT DEPRESSION

Linda L. Carpenter, M.D., *Department of Psychiatry, Brown Medical School, Butler Hospital, 345 Blackstone Boulevard, Providence, RI 02906*

SUMMARY:

Central neuromodulatory techniques, such as electroconvulsive therapy (ECT) have been in use since the late 1930s to treat severe major depression. Meta-analyses of controlled studies support the conclusion that short-term efficacy is greater for ECT than for pharmacotherapy, but more data are needed to address technical variables, patient selection, memory impairment, and high posttreatment relapse rates. More recently, alternative methods of brain stimulation have been investigated. Repetitive transcranial maganetic stimulation (rTMS) is a noninvasive method of focusing subseizure-threshold stimulation on specific brain regions by passing strong magnetic fields through the scalp in the awake patient. Meta-analyses suggest rTMS has a statistically significant effect on depressive symptoms. Preliminary reports of magnetic seizure therapy (MST), which employs intense levels of rTMS to induce a generalized tonic-clonic seizure under anesthesia, suggest antidepressant benefits similar to ECT but with markedly reduced cognitive side effects. Vagus nerve stimulation (VNS) involves implantation of a pacemaker-like device in the chest wall attached to an electrode delivering pulsed electrical stimulation to the brain via afferent fibers of the 10th cranial nerve. Recent studies have suggested efficacy of adjunct VNS for treatment-resistant depression. Deep brain stimulation (DBS), an established therapy for movement disorders, involves direct electrical stimulation of deep neuroanatomical targets via surgically implanted electrodes and pulse generators. Pilot studies of DBS for intractable neuropsychiatric disorders are under way. Available efficacy and safety data for these neuromodulatory treatments will be reviewed.

REFERENCES:

1. Casacalenda N, Perry JC, Looper K: Remission in major depressive disorder: a comparison of pharmacotherapy, psychotherapy, and control conditions. American Journal of Psychiatry 2002; 159(8):1354-60.
2. Hirschfeld RM, Montgomery SA, Aguglia E, Amore M, Delgado PL, Gastpar M, Hawley C, Kasper S, Linden M, Massana J, Mendlewicz J, Moller HJ, Nemeroff CB, Saiz J, Such P, Torta R, Versiani M: Partial response and nonresponse to antidepressant therapy: current approaches and treatment options. J Clin Psychiatry 2002; 63(9):826-37. Review.
3. Nierenberg AA, Petersen TJ, Alpert JE: Prevention of relapse and recurrence in depression: the role of long-term pharmacotherapy and psychotherapy. J Clin Psychiatry 2003; 64 Suppl 15:13-7.
4. Fava M: Psychopharmacological management of residual symptoms and treatment resistance in major depressive disorder, in Handbook of Chronic Depression. Edited by Alpert E, Fava M. Marcel Dekker, New York, in press.
5. Carpenter LL, Friehs GM Price LH: Cervical vagus nerve stimulation for treatment-resistant depression. Neurosurg Clin N Am 2003; 14(2):275-82.

INDUSTRY-SUPPORTED SYMPOSIUM 10—DEALING WITH DEPRESSION: THE ADDED BURDEN FOR MEDICAL PATIENTS
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, attendees will be able to identify key aspects related to the long-term repercussions of depression, the appropriate treatment methods using pharmacotherapy and psychotherapy, along with effective strategies for maintaining remission.

No. 10A
GENERAL MEDICAL COMORBIDITIES ASSOCIATED WITH DEPRESSION

Wayne J. Katon, M.D., *Department of Psychiatry, University of Washington Medical Center, 1959 N.E. Pacific, Box 356560, Seattle, WA 98195-6560*

SUMMARY:

Patients with a chronic medical illness have a high prevalence of major depressive illness. Major depression may decrease their ability to habituate to the aversive symptoms of chronic medical illness, such as pain. The progressive decrements in function associated with many chronic medical illnesses may cause depression, which is associated with additional functional impairment. Comorbid depression is associated with approximately 50% higher medical costs for the chronic medical illness, even after controlling for severity of physical illness. Increasing evidence suggests that both depressive symptoms and major depression may be associated with increased morbidity and mortality from such illnesses as diabetes and heart disease. The adverse effect of major depression on health habits (such as smoking, diet, overeating, and sedentary lifestyle), its maladaptive effect on adherence to medical regimens, as well as its direct adverse physiological effects (ie, decreased heart rate variability and increased adhesiveness of platelets) may explain this association with increased morbidy and mortality.

No. 10B
THE IMPACT OF PSYCHOSOMATIC SYMPTOMS ON DEPRESSION AND ITS TREATMENT

David A. Fishbain, M.D., *Department of Psychiatry, University of Miami Pain Center, 1400 NW 10th Avenue, (D-79), Miami, FL 33136*

SUMMARY:

Fibromyalgia (FMS) is the quintescential psychosomatic disease. It is characterized by widespread pain, psychiatric comorbidity (depression), and fatigue. This presentation will explore the following, utilizing FMS as a model: (1) the impact on the relationship between chronic pain and depression and the alleged psychosomatic etiology of FMS; (2) the effect of chronic pain on fatigue, an alleged somatic equivalent of depression; (3) whether alleviating depression affects the perception of pain; (4) whether treating pain aggressively makes treating depression easier; (5) whether antidepressants have analgesic properties; and (6) whether some antidepressants are more effective analgesics than others.

No. 10C
STRATEGIES AND TACTICS OF TREATMENT FOR COMPLICATED DEPRESSION: AN ALGORITHMIC APPROACH

Madhukar H. Trivedi, M.D., *Mood Disorders Research Program and Clinic, University of Texas Southwestern Medical Center, 6363 Forest Park Road, Suite 1300, Dallas, TX 75390*

SUMMARY:

As the treatment for depression gets more complicated with increased numbers of treatment options in both psychotherapy and pharmacotherapy, the need for a clear, structured method for providing optimal treatment is apparent. This need has necessitated the development and implementation of treatment algorithms that utilize

current research data to provide clinicians a framework from which changes in treatment strategy can be determined. When the more complicated patients with depression are considered, their psychiatric and medical comorbidities make the need for support tools even greater. Treatment algorithms could be adapted to different practices based on the priority for treating each comorbid state, as well as the importance for avoiding treatment interactions. These guidelines would greatly ease the decision-making process of clinical practice, and with effective support tools could allow for a wide degree of flexibility in treating your patients. Treatment algorithms, including the Texas Medication Algorithm Project (TMAP) and the NIMH-funded Sequenced Treatment Alternatives to Relieve Depression (STAR*D), have developed critical decision points that assist physicians with the implementation of evidence-based treatments.

No. 10D
THE ROLE OF PSYCHOTHERAPY IN THE TREATMENT OF COMPLICATED DEPRESSION

Ellen Frank, Ph.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh, PA 15213*

SUMMARY:

Psychotherapy was once the predominant treatment for all so-called neurotic disorders. As we enter the 21st century, the place of psychotherapy in the outpatient treatment of depression is quite different, as are the kinds of psychotherapies being used for this purpose. The empirical basis for the use of psychotherapy in the treatment of depression will be described. Particular emphasis will be given to Klerman and Weissman's interpersonal psychotherapy (IPT) and to Beck et al's cognitive therapy (CT). The presentation will then focus on what role psychotherapy can play in the treatment of depression complicated by medical illness. For example, in which conditions would one want to use psychotherapy as a stand-alone treatment? When is combination therapy more appropriate? What might the role of telephone-based therapy be for those patients who are too ill to attend regular outpatient visits? Specific adaptations of IPT and CT for patients with depression and co-occurring medical conditions such as cancer and HIV/AIDS will be described. Results from trials of these treatments will be presented. Finally, the question of how psychotherapy is best delivered to medically ill patients and by whom will be addressed.

No. 10E
MAINTAINING REMISSION IN DEPRESSION

James M. Martinez, M.D., *Department of Psychiatry, Baylor College of Medicine, 6655 Travis Road Suites 560, Houston, TX 77030*

SUMMARY:

The optimal outcome of the treatment of patients with major depressive disorder is complete and sustained symptomatic and functional recovery, or full remission. Available data suggest that inadequate treatment of depression to response or only partial remission is associated with continued symptomatic and functional impairment, increased risk of depressive episode relapse or recurrence, and significant psychiatric, medical, and economic costs. Importantly, untreated or undertreated depression in the context of comorbid major medical problems can adversely affect overall psychiatric and medical outcomes. Thus, it is imperative that clinicians not only target remission as the goal of treatment, but also aggressively attempt to maintain remission during the continuation and maintenance phases of treatment. Strategies for achieving and maintaining remission include (1) making accurate diagnoses, (2) aggressively treating both syndromal and subsyndromal depressive symptoms to complete resolution, (3) vigilantly monitoring the patient for signs and symptoms heralding depressive episode relapse or recurrence, and (4) educating the patient regarding expected treatment outcomes and the need for strict adherence to the treatment plan. This presentation will provide participants with an overview of current definitions of remission, implications of not achieving complete remission, and treatment principles and strategies to achieve and maintain remission.

REFERENCES:

1. Katon WJ: Clinical and health services relationships between major depression, depressive symptoms, and general medical illness. Biological Psychiatry 2003; 54:216-226.
2. Fishbain DA, Cutler R, Rosonoff HL, Steele-Rosonoff R: Chronic pain associated with depression: Antecedent or consequence of chronic pain? A review. Clin J Pain 1997:13:116-137.
3. Trivedi MH, Rush AJ, Crismon ML, et al: The Texas Medication Algorithm Project (TMAP): clinical results for patients with major depressive disorder. Archives of General Psychiatry, in press.
4. Markowitz JG: Psychotherapy for depressed HIV-positive patients. Ital J Psychiatry Behav Sci 1998; 8:17-20.
5. Lam RW, Kennedy SH: Evidence-based strategies for achieving and sustaining full remission in depression: focus on meta-analyses. Can J Psychiatry 2004; 49(3 suppl 1):17S-26S.

SUNDAY MAY 22, 2005

INDUSTRY-SUPPORTED SYMPOSIUM 11—SYSTEMATIC TREATMENT OF BIPOLAR DISORDER: BRINGING EVIDENCE INTO PRACTICE
Supported by GlaxoSmithKline

EDUCATIONAL OBJECTIVES:

Upon completion of this session, the participant should be able to discuss the STEP-BD disease management model, including treatment study data for depression, mania, and rapid cycling that has become available over the course of the project.

No. 11A
APPROACH TO TREATMENT: INTEGRATION OF MEASUREMENT AND MANAGEMENT

Andrew A. Nierenberg, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street WACC 815, Boston, MA 02114-3117*

SUMMARY:

To tailor a suit that fits, the tailor uses a standard measure to cut the cloth. Likewise, to tailor treatment for someone who has bipolar disorder, the clinician can use standardized assessments to plan treatment, such as the affective disorders evaluation and the clinical monitoring form used in STEP. By using these standardized assessments, the clinician can measure changes with treatment (and communicate these changes to patients) to make further appropriate changes, i.e. an iterative approach. Once the treatment tactics become clear, the clinician can collaborate with the patient to negotiate acceptable options by using a menu of reasonable choices. Using evidence and individual factors, the clinician and patient can share decision making, balancing the risk of side effects with the probability that particular treatments may work, and finding the right mix of patient autonomy and clinician authority. Finally, the option of psychosocial treatments developed for patients with bipolar disorder (cognitive-behavioral therapy, family-focused therapy, collaborative

care plus) can also be offered so that patients can have optimal outcomes.

No. 11B
VIEW OF THE ILLNESS: COURSE AND COMORBIDITY FINDINGS

Claudia F. Baldassano, M.D., *Department of Outpatient Psychiatry, University of Pennsylvania, 3535 Market Street, 2nd Floor, Philadelphia, PA 19104-3309*

SUMMARY:

Bipolar disorder is underdiagnosed and often mistaken for unipolar depression. Patients with bipolar disorder spend 33% of their time in a state of depression compared with 11% of time spent in a manic state. Duration of time depressed and severity of depression are associated with increased risk for suicide, which occurs in 10% to 20% of bipolar patients. Current study areas of focus include the development of treatment guidelines based on current expert recommendations and systematic assessment techniques that will immediately improve the care of numerous bipolar patients.

No. 11C
WHAT IS THE BEST TREATMENT FOR MANIC AND MIXED EPISODES?

Gary S. Sachs, M.D., *Department of Psychiatry, Harvard-Massachusetts General Hospital, 50 Staniford Street, Suite 580, Boston, MA 02114*

SUMMARY:

The Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) uses a collaborative care approach in which critical decision points are arranged in treatment pathways. This presentation will review the nine critical decision points in the STEP-BD treatment pathway for mixed and manic episodes. Important early decisions include ensuring safety, choosing the appropriate venue for treatment, and choosing either the sequential care strategy (tolerability takes priority) or an urgent care strategy (efficacy takes priority). In addition, this presentation reviews evidence from randomized, controlled trials reporting outcomes for patients with mixed and manic episodes and discusses applying these data in selecting a menu of reasonable choices at each decision point.

No. 11D
WHAT IS THE BEST TREATMENT FOR BIPOLAR DEPRESSION?

Michael J. Ostacher, M.D., *Department of Psychiatry, Harvard Medical School, 50 Staniford Street, Suite 580, Boston, MA 02114*

SUMMARY:

Guidelines for the treatment of bipolar disorder are rapidly changing. As data improve, it becomes essential that patients be given treatment choices in a context that allows for objective monitoring of treatment response. The goal of increasing the concordance between clinician and patient can be facilitated by the flexible integration of somatic and psychosocial treatments.

No. 11E
WHAT IS THE BEST TREATMENT FOR RAPID CYCLING?

Christopher D. Schneck, M.D., *Department of Psychiatry, University of Colorado, Health Sciences Center, 4455 E 12th Avenue, Denver, CO 80220-2415*

SUMMARY:

Rapid cycling bipolar patients have more severe symptoms than non-rapid cycling bipolar patients. Based on a cross-sectional sample of 500 rapid cycling and non-rapid cycling bipolar patients with either bipolar I or bipolar II disorder, rapid cycling patients were more likely to be female, a fact more evident in bipolar I than bipolar II patients. Rapid cycling patients also showed a younger age of onset and a higher occurrence of depression at study entry. In the year prior to the study, the rapid cycling group showed poorer global functioning and a significantly greater rate of depressive and hypomanic/manic episodes. History of psychosis showed no correlation with rapid cycling, but bipolar I patients were more likely to have symptoms of psychosis than bipolar II patients.

No. 11F
MANAGING COMORBIDITY

Michael J. Ostacher, M.D., *Department of Psychiatry, Harvard Medical School, 50 Staniford Street, Suite 580, Boston, MA 02114*

SUMMARY:

Comorbidity complicates the course of bipolar disorder. Anxiety disorders, substance use disorders, and ADHD are comorbid with bipolar disorder at rates many times that found in the general population, leading to increased rates of chronicity, suicide, and disability in these patients. Strategies to address these problems will be discussed.

No. 11G
PSYCHOSOCIAL INTERVENTIONS

David J. Miklowitz, Ph.D., *Department of Psychology and Psychiatry, University of Colorado, Muenzinger Building, Boulder, CO 80309-0345*

SUMMARY:

The STEP-BD program includes psychosocial interventions as part of its disease management model for bipolar depression. This talk will review the randomized, control trial evidence for three intensive psychosocial interventions for bipolar disorder intended as adjuncts to pharmacotherapy—family-focused treatment, cognitive-behavior therapy, and interpersonal and social rhythm therapy—in preventing mood disorder relapses. These three treatments are contrasted with a psychosocial control group in the STEP-BD acute depression pathway. Data will be presented from STEP-BD on the role of psychosocial stress variables in the course of bipolar disorder. Although randomized results from STEP-BD are not yet available, we have examined the effects of psychosocial interventions in the STEP standard-care pathway, in which patients are followed naturalistically and treated with best-practice pharmacotherapy. In this pathway, the intensity of psychosocial treatments (received in or outside of STEP) predicted reductions in depression for those patients who were more severely depressed in the prior interval of follow up. Implications of these findings for the maintenance psychosocial treatment of bipolar disorder will be discussed.

No. 11H
MULTIPHASE SUICIDE PREVENTION STRATEGIES IN BIPOLAR DISORDER

Ellen B. Dennehy, Ph.D., *Department of Psychological Sciences, Purdue University Room 1120, 703 Third Street, West Lafayette, IN 47907-2081*

SUMMARY:

Forty-eight percent of patients with bipolar disorder make at least one suicide attempt. Ongoing assessment and management of suicide

risk is paramount to the continued safety and maintenance of the bipolar patient. With the STEP disease management model, the prevention of suicide involves a multiphase approach, through the acute, continuation, and maintenance stages of the illness. Under the STEP model, the suicide prevention pathway incorporates collaborative, concordant care that involves patient and support systems.

Assessment of suicidal risk by ongoing measurement of current factors using the Affective Disorders Evaluation (ADE) and the Clinical Monitoring Form (CMF) will be demonstrated. Managing suicidal risk during the acute phase of illness by maintaining safety and stabilization through collaborative care involving the patient and his or her support system will be explored. This involves strategic measurement of the means for suicide and inclination of the patient. To minimize relapses and recurrence of symptoms—continuation phase objectives—patient's use of STEP tools such as the daily mood chart will be considered. Achieving concordance to maintain wellness and quality of life during the maintenance phase will be explored.

REFERENCES:

1. Sachs GS, Thase ME, Otto MW, Bauer M, Miklowitz D, Wisniewski SR, Lavori P, Lebowitz B, Rudorfer M, Frank E, Nierenberg AA, Fava M, Bowden C, Ketter T, Marangell L, Calabrese J, Kupfer D, Rosenbaum JF: Rationale, design, and methods of the systematic treatment enhancement program for bipolar disorder (STEP-BD). Biological Psychiatry 2003; 53(11):1028–42.
2. Post RM, Baldassano CF, Perlis RH, Ginsberg DL: Treatment of bipolar depression. CNS Spectr 2003; 8(12):1–20.
3. Sachs GS: Managing Bipolar Affective Disorder. Science Press Ltd, Porters South, 4 Crinan Street, London N1 9 KW, UK. 2004.
4. Sachs GS, Thase ME, Otto MW, Bauer M, Miklowitz D, Wisniewski SR, Lavori P, Lebowitz B, Rudorfer M, Frank E, Nierenberg AA, Fava M, Bowden C, Ketter T, Marangell L, Calabrese J, Kupfer D, Rosenbaum JF: Rationale, design, and methods of the systematic treatment enhancement program for bipolar disorder (STEP-BD). Biol Psychiatry 2003; 53(11):1028–42.
5. Schneck CD, Miklowitz DJ, Calabrese JR, Allen MH, Thomas M, Wisniewski SR, Miyahara S, Shelton M, Ketter TA, Goldberg JF, Bowden CL, Sachs GS: Phenomenology of rapid cycling bipolar disorder: Data from the first 500 participants in the Systematic Treatment Enhancement Program for Bipolar Disorder. American Journal of Psychiatry, in press.
6. Perlis RH, Miyahara S, Marangell LB, Wisniewski SR, Ostacher M, DelBello MP, Bowden CL, Sachs GS, Nierenberg AA, STEP-BD Investigators: Long-term implications of early onset in bipolar disorder: data from the first 1000 participants in the systematic treatment enhancement program for bipolar disorder (STEP-BD). Biol Psychiatry 2004; 55(9):875–81.
7. Frank E, Swartz HA, Kupfer DJ: Interpersonal and social rhythm therapy: managing the chaos of bipolar disorder. Biol Psychiatry. 2000; 48:593–604.
8. Sachs GS, Yan LJ, Swann AC, Allen MH: Integration of suicide prevention into outpatient management of bipolar disorder. J Clin Psychiatry 2001; 62 Suppl 25:3–11.

INDUSTRY-SUPPORTED SYMPOSIUM 12—TOO LITTLE, TOO MUCH: WHAT IS DISORDERED EATING? Supported by Ortho-McNeil Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant will have knowledge of the medical and psychiatric complications of eating disorders as well as new treatments.

No. 12A
MEDICAL MORBIDITY OF EATING DISORDERS

Laurel Mayer, M.D., *Department of Psychiatry, NY State Psychiatric Institute-Columbia University, 1051 Riverside Drive, Unit 98, New York, NY 10032*

SUMMARY:

The consequences of eating disorders extend beyond psychiatric considerations. Eating disorders are also associated with significant medical morbidity, though the types of medical issues that arise from each eating disorder differ. The most dangerous, yet most rare eating disorder, is anorexia nervosa (AN). AN has the highest death rate of any psychiatric-disorder. Its medical complications affect multiple systems including (but not limited to) cardiac (including arrhythmias, orthostatic hypotension, mitral valve prolapse, and heart failure), reproductive (amenorrhea) and musculoskeletal (e.g. osteoporosis). The medical morbidity associated with bulimia nervosa (BN) is often related to the method of purging. Vomiting and the use of laxatives and diuretics are associated with electrolyte disturbances (e.g. low sodium and potassium levels), which can also lead to cardiac arrhythmias. Repeated self-induced vomiting can erode tooth enamel, causing dental problems, and can irritate or tear the lining of the throat, esophagus, and stomach. Although a rare consequence, rupture of the stomach following binge eating has been reported. With repeated use, patients may also become physically dependent on laxatives. The most common eating disorder, binge eating disorder (BED), is associated with obesity. Obesity carries significant medical risk for diabetes, high blood pressure, elevated cholesterol levels, elevated triglyceride levels, and has become a national health concern.

No. 12B
GENETIC EPIDEMIOLOGY OF EATING DISORDERS

James I. Hudson, M.D., *Department of Psychiatry, Harvard/McLean Hospital, 115 Mill Street, Belmont, MA 02478*

SUMMARY:

Family studies have shown that the eating disorders anorexia nervosa, bulimia nervosa, and binge eating disorder aggregate in families. They have also suggested that eating disorders coaggregate with mood disorders in families. Twin studies have confirmed a strong genetic component to anorexia nervosa, bulimia nervosa, and binge eating behavior. Genetic linkage and association studies have identified a number of potential regions of interest and candidate genes for eating disorders. This presentation will review the genetic epidemiology of disordered eating and will conclude with a survey of current genetic epidemiologic research on disordered eating, as well as a discussion of future directions.

No. 12C
PSYCHIATRIC COMORBIDITY OF EATING DISORDERS: UNDERSTANDING THE CONTRIBUTION OF IMPULSIVITY

Susan McElroy, M.D., *Department of Psychiatry, University of Cincinnati College of Medicine, MSB559 - 231 Albert Sabin Way, Cincinnati, OH 45267-0559*

SUMMARY:

Although historically considered related to obsessive-compulsive disorder, eating disorders (EDs) share important similarities with impulse control disorders (ICDs). EDs and ICDs have similarities with respect to phenomenology, comorbidity, and treatment response. In terms of phenomenology, impulsivity and impulsive behaviors have been shown to be elevated in patients with eating disorders, and binge eating itself resembles an ICD. Regarding com-

orbidity, ICDs (e.g., kleptomania) commonly occur in patients with EDs, whereas EDS (especially those characterized by binge eating) commonly occur in patients with ICDs. Also, EDs and ICDs may be more likely than OCD to co-occur with other conditions characterized by pathological impulsivity, including substance use disorders, cluster B personality disorders, and bipolar spectrum disorders. Regarding treatment, whereas OCD is consistently responsive to SSRIs, but not to other agents, the response of EDs, like ICDs, is mixed to SSRIs, but has been positive to other classes of agents, including mood stabilizers and anticonvulsants. This presentation, however, will focus on the role of impulsivity in the consideration of common psychiatric comorbidities of eating disorders. In addition, the presence of comorbid ICDs may negatively affect outcome in patients with EDs. The importance of impulsivity in the expression and treatment of EDs will be highlighted.

No. 12D
PSYCHOTHERAPY FOR EATING DISORDERS: WHEN YES, WHEN NO

Cynthia M. Bulik, Ph.D., *Department of Psychiatry, University of North Carolina, 101 Manning Drive, First Floor, NSH CB7160, Chapel Hill, NC 27514-4220*

SUMMARY:

Psychotherapies investigated for use in the treatment of eating disorders include cognitive-behavioral therapy (CBT), interpersonal psychotherapy (IPT), family-based therapy, and behavioral weight-loss treatment (BWL). Delivery options range from paper and pencil self-help, web-based self-help, guided self-help, and traditional one-on-one or group psychotherapy. The degree of involvement of the treatment provider varies across these interventions, as do the potential benefits for individual patients. Rather than a one-size-fits-all approach, the eating disorders field is moving toward having at its disposal an appropriately broad palette of treatment options that can be tailored to individual needs.

Parameters to consider when recommending treatment options include age of patient, distance from treatment settings, comorbid psychopathology, and medical morbidity, including obesity. This presentation will review the evidence for the efficacy of each of these therapeutic modalities and therapeutic approaches in the treatment of anorexia nervosa, bulimia nervosa, and binge-eating disorder. Clinical evidence regarding these treatments will be translated into recommendations for clinical practice with regard to choosing psychotherapeutic treatments for specific types of patients, and also with regard to determining which patients are appropriate candidates for psychotherapeutic treatments.

No. 12E
PHARMACOTHERAPY TRENDS IN THE EATING DISORDER SPECTRUM

Scott J. Crow, M.D., *Department of Psychiatry, University of Minnesota, F2 82/2A West 2450 Riverside Avenue, Minneapolis, MN 55454*

SUMMARY:

A number of medications have shown efficacy in the treatment of eating disorders in randomized, controlled trials. For bulimia nervosa, medications that have been shown to reduce both binge eating and purging include fluoxetine, phenelzine, fenfluramine, and topiramate. For binge-eating disorder, tricyclic antidepressants and dexfenfluramine have been shown to reduce binge eating, while serotonin reuptake inhibitors, sibutramine, and topiramate have been shown to reduce both binge eating and weight. Medications shown to be effective in the treatment of anorexia nervosa in certain randomized, controlled trials include lithium, pimozide, and fluoxetine. The existing evidence for these agents will be presented, as will guidelines and caveats for their use.

REFERENCES:

1. Agras WS: The consequences and costs of the eating disorders. Psychiatr Clin North Am 2001; 24(2):371–9.
2. Bulik CM, Sullivan PF, Wade TD, Kendler KS: Twin studies of eating disorders: a review. Int J Eat Disord 2000; 27(1):1–20.
3. Fischer S, Smith GT, Anderson KG: Clarifying the role of impulsivity in bulimia nervosa. Int J Eat Disord 2003; 33(4):406–11.
4. Wilfley DE, Welch RR, Stein RI, et al: A randomized comparison of group cognitive-behavioral therapy and group interpersonal psychotherapy for the treatment of overweight individuals with binge-eating disorder. Arch Gen Psychiatry 2002; 59(8):713–21.
5. Appolinario JC, McElroy SL: Pharmacological approaches in the treatment of binge eating disorder. Curr Drug Targets 2004; 5(3):301–7.

INDUSTRY-SUPPORTED SYMPOSIUM 13—SPOTLIGHT ON THE UNIQUENESS OF DEPRESSION AND ANXIETY IN THE ELDERLY
Supported by Forest Laboratories, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to differentiate late-onset depression from other depressive disorders, understand treatment strategies for handling comorbid depression and systemic illness, recognize symptoms of major depression and anxiety disorders in the context of bereavement and diagnose and execute appropriate pharmacotherapeutic treatment for comorbid depression and anxiety in the elderly.

No. 13A
LATE-ONSET DEPRESSION: A DISTINCTIVE DISEASE ASSOCIATED WITH THE ELDERLY

Steven P. Roose, M.D., *Department of Psychiatry, New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032*

SUMMARY:

Depression diagnosed with its first onset later than age 60 is termed late-onset depression. Late-onset depression refers to a subset of patients with depression whose later age imparts different clinical characteristics, suggesting the possibility of distinct etiology. Risk factors for late-onset depression include widowhood, physical illness, and impaired functional status. Little is currently known about differences in rate of remission, relapse, recovery, and recurrence of late-onset depression. Biological data suggests that it is associated with an increased severity of carebrovascular disease, increased subcortical lesions, reduced number of cortical serotonin receptors, and pre-existing genetic vulnerability. The existence of a systemic illness may be linked to the development of depression in late life, even constituting a negative prognostic factor for the outcome of depression. Multiple barriers exist in the diagnosis of late-onset depression, some of which can be attributed to age-associated afflictions, lack of health-care provider education, and inaccurate self-reporting. Geriatric depression also has a poorer prognosis than depression in younger patients. Therapeutic intervention includes pharmacotherapy, mainly with antidepressants, and psychotherapy. Even more important is the use of medications that have no effect on comorbid disease processes and no drug interactions. The risk of recurrence of depression and treatment resistance are relatively high among patients with late-onset of depression. The most serious consequence of depression in later life is increased mortality from either suicide

or somatic illness. The focus of this talk will delineate late-onset depression from other forms of depression, with an emphasis on appropriate diagnostic recognition and treatment.

No. 13B
RECOGNIZING DEPRESSIVE DISORDERS COMORBID WITH MEDICAL ILLNESSES IN THE ELDERLY

Eric Lenze, M.D., *Department of Panic and Anxiety, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh, PA 15213-4504*

SUMMARY:

Late-life depression is often detected in association with medical illness, creating both diagnostic and management challenges for mental health clinicians. Clinically significant depression in late life often arises in the context of chronic, disabling illnesses such as heart disease, stroke, cancer, arthritis, and Parkinson's disease. Conversely, depression in the context of these somatic illnesses increases disability and mortality and reduces the efficacy of medical rehabilitation. Screening and treatment for depression in the elderly who present with other pre-existing conditions is often complicated by etiology of symptoms, coexisting cognitive impairment, poor compliance with medical regimens, potential toxicity of some psychotropic medications, and inadequacy of follow-up. This talk will highlight the challenges in diagnosing and treating depression in older adults who present with comorbid medical illness.

No. 13C
BEREAVEMENT-RELATED DEPRESSION AND ANXIETY

Katherine Shear, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara St, Pittsburgh, PA 15213*

SUMMARY:

According to recent U.S. Census data, 78% of widowed persons were 65 years of age or older. Spousal bereavement has been described as the most disruptive and distressing event of ordinary life. By age 65 years, over 50% of women and 14% of men have been widowed at least once. Compared with married individuals, there is an increase in general medical consultation by widows in the first year post loss. In addition, there is an increased use of counseling, especially pastoral counseling, and significantly increased use of tranquilizers, hypnotics and alcohol. Bereavement is associated with increased mortality in the bereaved. The causes of the deaths have varied in different studies, but always include suicide and accidents. In one study there is an increase in deaths from cirrhosis of the liver among the bereaved. It is likely that unrecognized and untreated depression accounts for a substantial portion of this increased mortality. Widow(er)s with MDE, compared with those without depression, have poorer self perceived medical health, are more likely to engage in unhealthy behavior, such as smoking and drugs, and are more likely to have impaired immunological function. In addition, studies have documented that bereavement is a risk factor for the onset of anxiety disorder. Sudden death of a loved one can trigger PTSD. Panic Disorder, GAD and OCD are also seen in the aftermath of loss. Traumatic Grief, a recently identified condition, is a particularly debilitating condition. This presentation will review data concerning the clinical presentation, risk factors and treatment for bereavement-related mood and anxiety disorders, including traumatic grief.

No. 13D
ANTIDEPRESSANTS AND ANXIOLYTICS IN THE ELDERLY: A FOCUS ON SAFETY

George S. Alexopoulos, M.D., *Department of Psychiatry, Cornell University, 10 Bloomingdale Road, White Plains, NY 10605*

SUMMARY:

Pharmacological treatment of depression and anxiety in older adults is similar to that in other adults, but the selection of medications is more complex due to side-effects and interactions with medications used for concomitant medical disorders. Several medication families are effective in geriatric depression but their risk varies. Tricyclic antidepressants are efficacious in the elderly, however, their effects on cardiac conduction and their anticholinergic and urological side effects restrict their use in older patients. Selective serotonin reuptake inhibitors (SSRIs) produce fewer anticholinergic and cardiovascular side effects, but drug-drug interactions, especially with regard to cytochrome P450 should be considered. For elders refractory to other antidepressants, monoamine oxidase inhibitors present an efficacious but potentially dangerous treatment option. Electroconvulsive therapy remains an important part of the acute treatment armamentarium for severe geriatric depression. Benzodiazepines may be used in the early phases of the acute treatment of anxiety disorders until more definitive treatment with SSRIs takes effect. However, benzodiazepines impair memory, increase the risk of falls, and often lead to dependence. For this reason, they should only be used for short periods of time. Other considerations in making treatment decisions for the elderly include: (1) review of all medications as some may lead to delirium or mania, (2) age-related factors that affect drug accumulation and elimination, and (3) pharmacodynamic changes that may affect treatment response. The aim of this discussion is to highlight drug treatment decisions in the geriatric population with regard to safety and tolerability.

REFERENCES:

1. Roose SP, Katz IR, Pollock BG, Valuck RJ: Contemporary issues in the diagnosis and treatment of late-life depression. J Am Med Dir Assoc 2002; 3(4 Suppl):H26–9.
2. Lenze EJ: Comorbidity of depression and anxiety in the elderly, Curr Psychiatry Rep. 2003; 5(1):62–7.
3. Reynolds, C.F. et al: Treatment of bereavement-related major depressive episodes in later life: a randomized, double-blind, placebo-controlled study of acute and continuation treatment with nortriptyline and interpersonal psychotherapy. American Journal of Psychiatry 1999; 156:202–208.
4. Alexopoulos GS, Buckwalter K, Olin J, Martinez R, Wainscott C, Krishnan KR: Comorbidity of late life depression: an opportunity for research on mechanisms and treatment. Biol Psychiatry 2002; 52(6):543–56.

INDUSTRY-SUPPORTED SYMPOSIUM 14—BRAIN STIMULATION: NEW TREATMENTS FOR MOOD DISORDERS
Supported by Cyberonics, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the attendees will become familiar with the mechanisms of action and evidence for safety and efficacy of five major methods to stimulate the brain to treat depression: ECT, rTMS, MST, VNS, and DBS.

No. 14A
OPTIMIZING THE THERAPEUTIC ELEMENTS OF ECT

Harold A. Sackeim, Ph.D., *Department of Psychiatry, New York Psychiatric Institute, 1051 Riverside Drive, Unit 126, New York, NY 10032*

SUMMARY:

Electroconvulsive therapy (ECT) is the biological treatment with the longest history of continuous use in psychiatry. As a front of brain situation, it is unparalleled in its capacity to produce rapid and complete antidepressant effects. Our knowledge of how ECT acts in the brain is rapidly changing, and there have been important recent breakthroughs in optimization of treatment delivery. Depending of technical factors, including stimulus waveform, electrical dose, anatomic positioning of electrodes, ECT may be fully effective or fully ineffective. Similarly, the magnitude of cognitive side effects is moderated by these factors. This presentation summarizes these advances in the administration of ECT and highlights new treatments on the horizon, especially focal electrically-administered seizure therapy (FEAST).

No. 14B
CURRENT STATUS OF REPEATED TRANSCRANIAL MAGNETIC STIMULATION

Mark S. George, M.D., *Department of Psychiatry, Medical University of South Carolina, 67 President Street, Room 502 North, Charleston, SC 29425-0720*

SUMMARY:

Transcranial magnetic stimulation (TMS) is a new brain stimulation intervention that modulates activity in discrete cortical regions and associated neural circuitry through the non-invasive induction of intracerebral currents. TMS is also a research tool for mapping brain-behavior relations and determining functional connectivity. Recent human studies have demonstrated effects of TMS lasting beyond the time of direct stimulation. This talk focuses on the acute antidepressant therapeutic potential of TMS, an issue that has been the subject of a large number of single-site, small-sample studies. Virtually all reviews of this preliminary work conclude that daily repetitive TMS (rTMS) over the prefrontal cortex has antidepressant properties. All the meta-analyses indicate that there is a large effect size for symptom change when compared with sham treatment. Dose-response relationships have been found for several key variables such as the intensity and length of treatment. However, there is continued controversy about the quality of the extant research, including the validity of the sham conditions and small sample sizes. After reviewing the work to date, we will outline current efforts and future work needed to fill these gaps in knowledge and determine whether and how rTMS will fit into treatment algorithms for depression.

No. 14C
CURRENT STATUS OF MAGNETIC STIMULATION THERAPY (MST)

Sarah H. Lisanby, M.D., *Department of Biological Psychiatry, Columbia University, 1051 Riverside Drive, NYSPI #126, New York, NY 10032-2695*

SUMMARY:

ECT remains an important and highly effective treatment for severely depressed patients, but its use is limited by its cognitive side effects. It has long been known that these side effects vary depending on how the treatment is administered. Recent innovations in the technique for delivering the electrical stimulus have demonstrated that the cognitive side-effect profile of convulsive therapy can be substantially improved. Magnetic seizure therapy (MST) is one such innovation that uses magnetic fields to induce the seizure. Magnetic stimulation provides better control over the site of stimulation and seizure initiation because they pass through the scalp and skull unimpeded, unlike electricity that is inherently more difficult to focus. Recent research suggests that strategies to focus current and seizure initiation in prefrontal cortex may enhance efficacy. Likewise, limiting current and seizure spread in medial temporal lobes might be expected to reduce side effects. This presentation will review the development of MST, from device development, to pre-clinical testing, to clinical trials. Preliminary results indicate that seizures induced with MST have a better acute side-effect profile than those induced with ECT. Results of clinical trials on the antidepressant efficacy of MST will be presented.

No. 14D
CURRENT STATUS OF VAGUS NERVE STIMULATION (VNS)

Lauren B. Marangell, M.D., *Department of Psychiatry, Baylor College of Medicine, 6655 Travis, Suite 560, Houston, TX 77030*

SUMMARY:

Vagus nerve stimulation (VNS) delivered by an implantable, programmable pulse generator is an effective treatment for patients with medically intractable epilepsy. In addition, VNS has shown promising acute and long-term (one year) results in an open pilot study of adult outpatients with treatment-resistant depression (study D01, n=59). A subsequent randomized, controlled, double-blind trial for treatment-resistant depression did not demonstrate statistically significant improvement acutely when compared with the sham control group (study D02). However, data from naturalistic follow-up of D02 participants who received 12 months of VNS, in addition to other antidepressant treatments, found a significant improvement in average change $HRSD_{24}$ score across 12 months ($p < 0.001$). At 12 months, 30% (52/174) achieved a response ($HRSD_{24}$ reduction of greater than or equal to 50%) and within this group, over half (17%) achieved remission ($HRSD_{24}$ less than or equal to 10). The accrual of symptomatic benefit over time with VNS, now demonstrated in two cohorts, is unusual in a treatment-resistant population, and may be of mechanistic and clinical importance.

No. 14E
CURRENT STATUS OF DEEP BRAIN STIMULATION

Benjamin D. Greenberg, M.D., *Department of Psychiatry, Butler Hospital, 345 Blackstone Boulevard, Providence, RI 02906;* Gerhard Frieks, M.D., David Marlone, M.D., Ali Rezai, M.D., Scott L. Rauch, M.D., Lawrence H. Price, M.D., Steven A. Rasmussen, M.D.

SUMMARY:

In contrast to lesion procedures sometimes used for intractable OCD and depression, deep brain stimulation (DBS), FDA-approved for movement disorders, is nonablative, reversible, and adjustable. We began investigating safety and efficacy of DBS targeting the ventral anterior internal capsule and adjacent ventral striatum (VC/VS) in intractable OCD in a collaborative trial. Stimulation target and techniques were based on our prior experience with gamma knife capsulotomy and the initial experience with DBS for intractable OCD in Belgium. After multidisciplinary assessment and independent review of diagnosis, prior treatment adequacy, and consent capacity, they received bilateral implantation of custom DBS leads. Because we noted acute and longer-term mood elevation in the OCD patients undergoing DBS, we also began a study of VC/VS DBS

for intractable major depression. Although this study is in a much more preliminary stage, initial and longer-term clinical responses to stimulation have been encouraging in depressed patients as well. Persistent adverse effects have been infrequent in both patient groups. We will present safety and efficacy data in both patient groups.

REFERENCES:

1. Sackeim HA: Convulsant and anticonvulsant properties of ECT: relations to therapeutic effects. Clinical Neuroscience Research, in press.
2. George MS, Nahas Z, Lisanby SH, Schlaepfer T, Kozel FA, Greenberg BD: Transcranial magnetic stimulation, in Neurosurgery Clinics of North America Volume 14/Number 2. Edited by Rezai, Rasmussen, Greenberg. Harcourt, pp 283–301, 2003.
3. Lisanby SH, Luber B, Schlaepfer T, Sackeim HA: Safety and feasibility of magnetic seizure therapy (MST) in major depression: randomized within-subject comparison with electroconvulsive therapy. Neuropsychopharmacology 2003; 28:1852–1865.
4. Marangell LB, Rush AJ, George MS, Sacheim HA, Johnson CR, Husain MM, Nahas Z, Lisanby SH: Vagus nerve stimulation (VNS) for major depressive episodes: one year outcomes. Biol Psychiatry 2002; 51(4):280–7.
5. Greenberg BD, Rezai AR: Mechanisms and the current state of deep brain stimulation in neuropsychiatry. Spectr 2003; 8(7):522–6.

INDUSTRY-SUPPORTED SYMPOSIUM 15—PANIC DISORDER: CURRENT CONCEPTS AND FUTURE DIRECTIONS

Supported by Wyeth Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant will understand current conceptualizations of the underlying causes and manifestations of panic disorder and the role of acute and long-term treatment.

No. 15A
WINDOW INTO THE BRAIN: IMAGING PANIC DISORDER AND THE NEUROCIRCUITRY OF FEAR

Justine Kent, M.D., *Department of Psychiatry, Mirisstown Memorial Hospital, 100 Madison Avenue, Morisstown, NJ 07962*

SUMMARY:

Pathophysiologic models of panic disorder are as disparate as the methods used to provoke panic attacks in neurobiological challenge studies. Proposed models have emphasized a number of widely different factors including dysregulated ascending noradrenergic and serotonergic systems, abnormal responsivity to carbon dioxide at the level of brain stem (so called false suffocation alarm), global cerebral abnormalities in lactate metabolism, and abnormalities in the hippocampal amygdalar circuitry. In this presentation, neuroimaging findings contributing to current neuroanatomical models for panic disorder will be reviewed and related to the fear neurocircuitry established in preclinical models of anxiety. State-of-the-art imaging modalities and their application to the investigation of panic disorder will be discussed and results of structural, functional, and receptor-binding studies presented. The use of neuroimaging to inform models of panic disorder and to provide insights into the relevant manifestations of panic observed in the clinical setting will be explored.

No. 15B
GENETICS OF PANIC DISORDER: WHAT HAVE WE LEARNED?

Jordan W. Smoller, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WANG ACC 812, Boston, MA 02114*

SUMMARY:

Evidence from family and twin studies has demonstrated that panic disorder is familial and moderately heritable. In recent years, two lines of complementary research have advanced our understanding of the genetic basis of panic and related anxiety disorders. First, molecular genetic studies have begun to identify specific genomic regions and genes that may be associated with panic disorder. Recent studies have implicated several chromosomal locations and variants in brain expressed genes. At the same time, there has been active research aimed at developing better phenotype definitions for genetic studies. In particular, there is evidence that heritable forms of anxious temperament and anxiety proneness may provide key insights into the genetic basis of panic and phobic anxiety disorders. Clinical and genetic studies have also suggested that genetic determinants of panic disorder may overlap with those of other psychiatric (e.g. bipolar disorder) and medical conditions. The results of recent developments in understanding the genetic basis of panic disorder will be reviewed, and the implications of genetic research for clinical psychiatry will be discussed. An improved understanding of the role of genes in anxiety disorders may lead to novel treatment targets as well as provide insights into the nature and classification of anxiety disorders.

No. 15C
CROSS-CULTURAL ASPECTS OF PANIC AND OTHER ANXIETY DISORDERS

Michael R. Liebowitz, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 120, New York, NY 10032-2603;* Roberto Lewis-Fernandez, M.D., Randall D. Marshall, M.D., Carlos Blanco-Jerez, M.D.

SUMMARY:

The cross-cultural aspects of panic and other anxiety disorders are the subject of increasing investigation. To date, a number of factors have been identified that may account for noted differences in rates and expression of anxiety disorders across different cultural and ethnic groups. Specific symptom patterns that fit into a larger, culture-bound folk diagnosis may fail to be recognized as a particular disorder. This occurred for many years in Caribbean Hispanic culture where panic attacks and trauma-related symptoms were subsumed under the broader construct of *ataque de nervios.* Cultural characteristics also shape the expression of particular vulnerabilities, such as social anxiety disorder in Japan and South Korea being more frequently manifest by a fear of making others uncomfortable (''offensive'' subtype of social anxiety disorder or taijin kyofusho) than it is in western countries. Finally, a variety of factors, including but not limited to prior trauma exposure and different modes of responding to self-report questionnaires, may account for some of the findings of increased PTSD in Hispanic Americans in both civilian and military settings.

No. 15D
PANIC SYMPTOMS AND THE INTERFACE OF MIND AND BODY

Karleyton C. Evans, M.D., *Department of Psychiatry, Massachusetts General Hospital, WANG ACC 815, 15 Parkman Street, Boston, MA 02114*

SUMMARY:

Chest pain and dyspnea are two of the most common symptoms experienced by patients with panic disorder. As they are alarm signals for potentially life-threatening clinical events, chest pain and dyspnea are also the most frequently reported symptoms in general medical settings. The misinterpretation of these symptoms can lead to significant distress to the patient as well as burden to the medical system. Indeed, differentiating the etiology of cardiopulmonary symptoms poses a significant challenge to the clinician, as their origin may be primarily medical, psychiatric, or combined. This presentation will review the prevalence of panic symptoms reported in medical settings as well as examine the intersection of these symptoms in comorbid populations with both medical and anxiety disorders. Candidate neural substrates for dyspnea perception and cardiac symptoms will also be addressed as the brain networks underlying severe somatic experiences may serve as targets for future treatments.

No. 15E
TREATING PANIC DISORDER: ACUTE THERAPY AND BEYOND

Mark H. Pollack, M.D., Department of Psychiatry, Massachusetts General Hospital, Wang ACC-815, 15 Parkman Street, Boston, MA 02114

SUMMARY:

A variety of pharmacological and psychosocial therapies have demonstrable efficacy for the treatment of panic disorder. In this presentation, we will the examine the evidence supporting the use of the different classes of treatment for the acute reduction of panic disorder and associated symptoms, and discuss the utilization of these therapeutics over the long term to extend treatment gains and prevent relapse. Practical considerations for the administration of the various pharmacological and psychotherapeutic interventions will be discussed, as will strategies for the optimal integration of combined therapeutics when indicated. In addition, we will examine present strategies to improve outcome for patients remaining symptomatic despite initial treatment efforts.

REFERENCES:

1. Kent JM, Rauch SL: Neurocircuitry of anxiety disorders. Curr Psychiatry Rep 2003; 5(4):266–73.
2. Villafuerte S, Burmeister M: Untangling genetic networks of panic, phobia, fear, and anxiety. Genome Biol 2003; 4(8):224.
3. Schechter DS, Marshall RD, Salmán E, Goetz D, Davies S, Liebowitz MR: Ataque de nervios and history of childhood trauma. J Traumatic Stress 2000; 13:529–534.
4. Rosenbaum JF, Pollack MH: Panic disorder and its treatment. Marcel Dekker, New York, 1998.
5. Simon NM, Pollack MH: Treatment refractory panic disorder, in Psychiatric Clinics of North America: Annual of Drug Therapy. WB Saunders, Philadelphia, 1999.

INDUSTRY-SUPPORTED SYMPOSIUM 16—ANTIPSYCHOTIC DRUGS, MOOD STABILIZERS, AND THE METABOLIC SYNDROME
Supported by Janssen Pharmaceutica Products

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) assess the effect of antipsychotic drugs and mood stabilizers to induce the elements of the metabolic syndrome, (2) understand metabolic syndrome and its clinical significance for the risk of diabetes mellitus and cardiovascular disease, and (3) understand metabolic syndrome pathophysiology, and how to balance overall effectiveness of these drugs and their metabolic side effect profiles.

No. 16A
EFFECT OF ATYPICAL ANTIPSYCHOTICS ON WEIGHT, GLUCOSE METABOLISM, AND DIABETES MELLITUS

Daniel W. Haupt, M.D., *Psychiatry Department, Washington University School of Medicine, 660 South Euclid Avenue, Box 8134, St Louis, MO 63110*

SUMMARY:

Patients with schizophrenia, bipolar disorder, and major depression are at increased risk for diabetes mellitus (DM) due to an inherent vulnerability, lifestyle issues, stress, and treatment with antipsychotic drugs (although levels of risk vary among the atypicals). While the three latter factors represent modifiable targets of disease management, it is important to understand the magnitude of the effect of different drug treatments on weight, hyperglycemia, and DM. Weight gain and obesity have an important influence on adherence. Population-based studios suggest that antipsychotic drugs can be associated with exacerbations of existing type-1 and type-2 DM, new onset cases of type-2 DM, and infrequent cases of diabetic ketoacidosis. Multiple techniques of varying sensitivity have been used to assess treatment-related disturbances of glucose metabolism in vivo. Techniques will be reviewed and results critically presented. Long-term complications from obesity, hyperglycemia, DM, and other components of the metabolic syndrome, especially hyperlipidemia, include macrovascular disease events, such as myocardial infarction and stroko, increasing in frequency with increasing plasma glucose. The American Diabetes Association guidelines for monitoring the effects of antipsychotic drugs on metabolic measures will be discussed. Enhanced screening and management of weight gain and hyperglycemia may help to reduce adverse outcomes during antipsychotic treatment.

No. 16B
THE EFFECT OF ANTIPSYCHOTIC DRUGS ON LIPIDS AND OTHER ELEMENTS OF THE METABOLIC SYNDROME

Herbert Meltzer, M.D., *Department of Psychiatry, Vanderbilt University, 1601 23rd Avenue South, Suite 306, Nashville, TN 37212-8645;* John H. Gilliam, M.D.; Tianlai Tang, M.D.

SUMMARY:

Longitudinal studies that include the concomitant effects on glucose, weight gain, and blood pressure will be used to illustrate how the combined effects on these measures increase the proportion of patients who meet criteria for the metabolic syndrome. Using new and published data from direct comparisons among antipsychotic drugs, it will be shown that there are differences among drugs that are even more striking for lipids than for glucose and weight gain measures, and that the assessment period for risk should be at least six months before determining that the effects of a given drug in a specific patient are acceptable. New data showing a striking difference between the effect of divalproex sodium on lipids and other measures, in combination with specific antipsychotic drugs, will be presented. These data will enable the listener to understand the importance of this issue when Dr. Reaven, the next speaker and leading authority on the metabolic syndrome, presents the evidence for the long-term consequences of this syndrome, which we found

to be present in the *majority* of patients treated with some atypical antipsychotic drugs.

No. 16C
INSULIN RESISTANCE, DYSLIPIDEMIA, AND CARDIOVASCULAR DISEASE

Gerald Reaven, M.D., *Cardiovascular Medicine, Stanford University, 300 Pasteur Drive, Stanford, CA 94305*

SUMMARY:

Insulin-mediated glucose disposal varies six- to eight-fold in apparently healthy individuals, with the prevalence of insulin resistance increasing as individuals become heavier and more sedentary. When insulin-resistant individuals cannot secrete enough insulin to overcome this defect, Type 2 diabetes supervenes. Although most insulin-resistant individuals continue to secrete enough insulin to prevent fasting hyperglycemia, they are likely to develop an atherogenic lipoprotein profile characterized by a high plasma triglyceride (TG) and low high-density lipoprotein HDL cholesterol (HDL-C) concentration, the appearance of abnormal low-density lipoprotein (LDL)-particles, and enhanced postprandial accumulation of TG-rich remnant lipoproteins (RLPs). All four of these changes have been identified as increasing cardiovascular disease (CVD) risk.

The atherogenic lipoprotein profile associated with insulin resistance is secondary to muscle and adipose tissue insulin resistance, leading to daylong increases in plasma insulin and free fatty acid (FFA) concentrations. The combination of increased FFA and insulin concentrations acts upon a normally insulin sensitive liver stimulate hepatic TG synthesis and secretion, leading to hypertriglyceridemia. Once plasma TG concentrations increase, there will be a tendency for HDL-C concentrations to fall, LDL-particle diameter to decrease, and postprandial RLPs to accumulate. These dyslipidemic changes provide an important link between insulin resistance and CVD.

No. 16D
METABOLIC SEQUELAE OF ATYPICAL ANTIPSYCHOTICS: OBESITY AND TYPE II DIABETES

Marilyn Ader, Ph.D., *Department of Physiology, University of Southern California, 1333 San Pablo Street, MMR 624, Los Angeles, CA 90033*

SUMMARY:

Atypical antipsychotics are associated with weight gain, but effects on adiposity and known diabetes risk factors in absence of underlying disease are unknown. We examined affects of olanzapine, risperidone, or placebo on adiposity and glucose metabolism in normal dogs. Dogs were treated with olanzapine (n=10, 15 mg/d), risperidone (n=10, 5 mg/d), or placebo (n=8) for four wks. Before and after treatment, trunk adiposity (total, visceral, subcutaneous) was measured by abdominal MRI. Insulin sensitivity (SI) and secretion were quantified by hyperinsullnemic and hyperglycemic clamps, respectively. Total adiposity increased more with olanzapine (+18.5±1.8 cm^2) than either risperidone (9.9±2.7 cm^2; p=0.02) or placebo (7.5±2.8 cm^3; p=0.009), reflecting olanzapine-induced increase in subcutaneous (+106±24%) and visceral (+84±22%) stores (p<0.0001). Risperidone-induced changes were not different from placebo (p>0.33). Although both drugs induced modest decrement in overall SI, only risperidone-treated dogs exhibited appropriate increase in Insulin secretion (0.6±0.1 to 1.0±0.1 μU/ml per mg/dl: p=0.036), not apparent after olanzapine (1.2±0.2 to 1.1±0.3 μU/ml per mg/dl; p=0.6). Thus, olanzapine caused substantial adiposity that exceeded risperidone or placebo. Furthermore, unlike risperidone, olanzapine blocked pancreatic compensation for insulin resistance, providing a mechanistic basis for antipsychotic-associated diabetic ketoacidosis. These results may have important implications for Type 2 diabetes risk in psychiatric patients.

No. 16E
A CLINICIAN'S GUIDE TO MANAGING CARDIAC RISK FACTORS

Donald Goff, M.D., *Department of Psychiatry, Harvard Medical School, 25 Stanford Street, Boston, MA 02114*

SUMMARY:

The metabolic syndrome is emerging as an important contributor to elevated rates of medical morbidity and mortality in patients with schizophrenia. Clinicians need to assess cardiac risk factors, offer programs to modify unhealthy lifestyles, and monitor the adverse health effects of psychotropic medications. This approach will be described, including findings from recent controlled trials demonstrating substantial benefits from smoking cessation and weight reduction programs in patients with schizophrenia. Consensus panel conclusions regarding the relative effects of atypical antipsychotic agents on componcnts of the metabolic syndrome will also be reviewed, as well as recommendations for monitoring these effects. Selection and management of atypical agents reflect a balance between optimizing therapeutic effectiveness, modifying diet and exercise, and avoiding excessive weight gain, dyslipidemia, and insulin resistance.

REFERENCES:

1. Casey DE, Haupt DW, Newcomer JW, Henderson DC, Sernyak MJ, Davidson M, Lindenmayer JP, Manoukian SV, Banerji MA, Lebovitz HE, Hennekens CH: Antipsychotic-induced weight gain and metabolic abnormalities: implications for increased mortality in patients with schizophrenia. J Clin Psych 2004; 65(Supp 7):4–18.
2. Meyer JM: A retrospective comparison of weight, lipid, and glucose changes between risperidone and olanzapine-treated inpatients: metabolic outcomes after 1 year. J Clin Psych 2002 63:425–433.
3. Reaven GM: The insulin resistance syndrome. Curr Atheroscler Rep 2003; 5:364–371.
4. Bergman RN, Ader M, Huecking K, Van Cittars G: Accurate assessment of β-cell function: the hyperbolic correction. Diabetes 2001; 51 (suppl 1):S212–S220.
5. Consensus development conference on antipsychotic drugs and diabetes and obesity. Diabetes Care 2004; 27:596–601.

INDUSTRY-SUPPORTED SYMPOSIUM 17—BPD: PATHOPHYSIOLOGY, TREATMENT AND COURSE
Supported by Eli Lily and Company

EDUCATIONAL OBJECTIVES:

Spurred by support of foundations and the NIMH, investigators have redoubled their efforts to study borderline personality disorder (BPD) across a broad front. In recognition of the recent research efforts, we have designed this symposium to highlight enquiry into the pathophysiology of BPD using brain imaging and genetic strategies. These two state-of-the-art techniques are yielding important results. Imaging studies are revealing new information about how the brains of patients with BPD respond to emotional cues, while the genetic studies are yielding insights into vulnerabilities to temperaments associated with BPD.

Treatment research is moving along rapidly on both psychosocial and pharmacological lines. Advances in dialectical behavioral therapy (DBT) continue to demonstrate hope for patients with BPD. In

addition, DBT studies have now been combined with pharmacotherapy studies to explore potential synergistic effects. Just as psychosocial treatments have progressed, so has pharmacotherapy. From case series and letters describing single cases, the field has moved to randomized controlled trials of medications. In addition, studies of neurocognitive outcomes are being added to treatment trials.

Previously, there was pessimism in the field about the possibility of improved outcomes for patients with BPD but little controlled data. A 10-year outcome study from Harvard challenges these older assumptions and provides hope for patients with BPD.

No. 17A
TEN-YEAR COURSE OF BPD

Mary Zanarini, Ed.D., *McLean Hospital, 115 Mill Street, Belmont, MA 02478*

SUMMARY:

The purpose of this study was to assess the symptomatic and functional course of a sample of carefully diagnosed patients with borderline personality disorder (BPD) followed prospectively for 10 years.

Method: The symptomatic and functional status of 362 former inpatients participating in the McLean Study of Adult Development (MSAD) was assessed every two years using semistructured interviews of demonstrated reliability. A total of 290 met both DIB-R and DSM-III-R criteria for BPD and 72 others met DSM-III-R criteria for another axis II disorder (and neither criteria set for BPD). Over 93% of the surviving subjects were reinterviewed at all five follow-up waves.

Results: All told, 88% of the 275 patients with BPD reinterviewed at least once experienced a remission of their BPD and 75% attained good psychosocial functioning. Recurrences of BPD and suicide were relatively rare: 9% and 4%, respectively. It was also found that some symptoms (eg, self-mutilation, quasipsychotic thought) resolve relatively quickly and are acute in nature, while other symptoms (eg, intense anger, serious abandonment concerns) resolve relatively slowly and are temperamental in nature.

Conclusions: The results of this study suggest that both symptomatic remissions and the attainment of a good level of psychosocial functioning are common among even the most disturbed patients with BPD. These results also suggest a more hopeful prognosis for BPD than previously recognized.

No. 17B
NEUROBIOLOGY OF BPD: AN UPDATE

Christian Schmahl, M.D., *Central Institute of Mental Health, J 5, Mannheim 68159, Germany*

SUMMARY:

In recent years, there has been a rapid growth in biological research on borderline personality disorder. This presentation will review relevant findings of neurobiological research in BPD and will provide an integration of biological, psychological, and clinical findings in this disorder. BPD is best thought of in terms of dimensions rather than as a specific disorder. Each dimension has a biological profile and may be expressed differently in different patients. Four core elements, which can be differentiated clinically as well as by psychometric and physiological measurement, are suggested to play a major role in the development of BPD: traumatic stress, affective dysregulation, impulsivity, and dissociation and self-injurious behavior. We found structural as well as functional alterations in key regions of emotion processing in patients with BPD. Our group also measured variables of affective dysregulation using questionnaires as well as ambulatory monitoring methods. Impulsivity can best be thought of as a disturbance of prefrontal serotonergic pathways and appears to show a strong gender bias in BPD. Our group repeatedly demonstrated reduced pain perception in BPD. In addition, we could demonstrate a disturbance of prefrontal and limbic brain regions underlying disturbed pain processing in BPD. Overall, generic and environmental factors are suggested to lead to brain alterations that are the basis for specific presentations of the disorder such as self-injurious and impulsive-aggressive behavior.

No. 17C
BPD: PHARMACOTHERAPY STEPS UP

S. Charles Schulz, M.D., *Department of Psychiatry, University of Minnesota Medical School, 2450 Riverside Avenue, Minneapolis, MN 55454;* A. Adityanjee, M.D., Eric Brown, M.D.

SUMMARY:

During the last five years, there has been a renewed interest in medication treatment of borderline personality disorder (BPD). New medications have been assessed, APA guidelines have been published, and new technologies have been applied. At first, most studies were brief case reports and later, case series with objective ratings. Now there are more studies, including double-blind and placebo-controlled trials. Therefore, there are enough data to address questions that have challenged the field for many years, including: (1) What dimensions change with medication treatment? (2) Does clinical research support the APA guidelines? (3) Can new outcome measures improve our understanding of the treatment of BPD?

An analysis of new studies using rating scales designed to assess BPD symptoms show significant decreases in DSM-IV characteristics of BPD, not just decreases in general rating scales. These findings are an important step in clarifying the question of what we are treating. Further analysis of studies utilizing atypical antipsychotic medications indicates reduction in symptoms in multiple domains of BPD. This provides a challenge to the APA guidelines, which recommend treatment based on predominant symptoms.

Lastly, two recent studies have utilized neuropsychological test batteries to measure outcome. One preliminary report has indicated that quetiapine improves some cognitive measures over the time of the trial.

In conclusion, pharmacotherapy studies have made substantial progress in just the last five years. Because of the number of new studies and the quality of design, some fundamental issues in pharmacotherapy of BPD can be addressed.

No. 17D
NEURAL CIRCUITRY DYSFUNCTION IN BPD

Antonia S. New, M.D., *Department of Psychiatry, Mount. Sinai School of Medicine, 1 Gustave L. Levy Place, Box 1230, New York, NY 10029;* Marianne Goodman, M.D., Monte Buchsbaum, M.D., Erin Hazlett, Ph.D., Harold W. Koenigsberg, M.D., Janine Flory, Ph.D., Larry Siever, M.D.

SUMMARY:

Impulsive aggression presents a critical challenge in borderline personality disorder (BPD), accounting for a substantial portion of the morbidity associated with this disorder. Preclinical studies suggest that the orbital frontal cortex (OFC) and cingulate gyrus play an inhibitory role in regulating aggression. Using ^{18}FDG-positron emission tomography, we examined regional brain activity as shown by regional glucose metabolic rate (rGMR) in impulsive-aggressive patients with BPD and controls. Both at rest and after meta-chloropiperazine, rGMR in the OFC and anterior cingulate gyrus was lower in patients than controls. However, sex and aggression subtype influenced rGMR, with more severe and widespread deficits in patients

with a history of physical assault compared with those with verbal aggression only and controls (F=3.95,p=.005); this pattern was seen in men but not women, though aggression level was comparable between the sexes. Furthermore, correlations between rGMR in OFC regions and amygdala showed significant differences between patients and controls (p<.0001). Controls showed positive correlations between OFC and inferior amygdala, whereas patiets with BPD showed negative correlations between the OFC and both inferior and superior amygdala. This suggests a loss of functional specificity in the amygdala in BPD and supports a model of disinhibition through the failure to activate the OFC in response to amygdala activity in BPD. The implications of this neuroanatomical model of disinhibition in BPD will be discussed.

No. 17E
UPDATE ON DIALECTICAL BEHAVIORAL THERAPY FOR BPD

Marsha Linehan, Ph.D., *Department of Psychology, University of Washington, Department of Psychology, Seattle, WA 98195*

SUMMARY:

Dialectical behavioral therapy (DBT) is an empirically demonstrated, efficacious treatment for patients with parasuicidal behaviors that has been demonstrated to be effective for borderline personality disorder (BPD) and other illnesses. Recent research has demonstrated the impact of this psychosocial intervention in a variety of settings where patients width BPD receive care in different cultural environments. The initial portion of this presentation will provide an update of the empiric research with DBT.

Recently, there has been enthusiasm in the field to investigate the potential synergy of effective psychosocial interventions (eg, DBT) and medication treatments. Our group has completed a controlled trial in DBT in which subjects were blindly and randomly assigned to olanzapine vs placebo. The results of this trial will be presented.

REFERENCES:

1. Stone MH: The Fale of Borderline Patients. New York, Guilford Press, 1990.
2. Skodol AE, Siever LJ, Livesley WJ, Gunderson JG, Pfohl B, Widiger TA: The borderline diagnosis II: biology, genetics, and clinical course. Biological Psychiatry 2002; 51,951–963.
3. Schulz SC, Camlin KL, Berry SA, Jesberger JA: Olanzapine safety and efficacy in patients with borderline personality disorder and comorbid dysthymia. Biol Psychiatry 1999; 46:1429–1435.
4. New AS, Hazlett EA, Buchsbaum MS, Goodman M, Reynolds D, Mitropoulou V, Sprung L, Shaw RB Jr, Koenigsberg HW, Platholi J, Silverman J, Siever LJ: Blunted prefrontal cortical 18 fluorodeoxyglucose positron emission tomography response to meta-chlorophenylpiperazine in impulsive aggression. Arch Gen Psychiatry 2002; 59(7):621–629.
5. Bohus M, Haaf B, Simms T, Limberger MF, et al: Effectiveness of inpatient dialectical behavioral therapy for borderline personality disorder: A controlled trial. Behav Res Ther 2004:42; 487–499.

INDUSTRY-SUPPORTED SYMPOSIUM 18—JOINING NIGHT AND DAY: INSOMNIA AND THE SLEEP/WAKE CYCLE
Supported by Takeda Pharmaceuticals North America, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to compare the mechanistic differences between existing and emerging sleep agents, including effects of receptor-site activity; evaluate current thinking about regulatory processes involved in normal sleep-wake cycles.

No. 18A
INSOMNIA: PREVALENCE, IMPACT, AND CURRENT APPROACHES TO EVALUATION AND MANAGEMENT

Karl Doghramji, M.D., *Department of Psychiatry, Thomas Jefferson University, 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 suffers 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. Although these data are only associational in nature, emerging evidence with primary insomnia sufferers indicates that insomnia, regardless of cause, confers an independent risk for various cognitive, emotional, and occupational impairments.

The disorders that cause insomnia are diverse, spanning the gamut of psychiatric and medical conditions. This presentation will focus on differential diagnosis of insomnia including primary insomnia, psychophysiological insomnia, delayed sleep phase and advanced sleep phase, and restless-leg syndrome. Presenting characteristics, diagnostic approaches, models of pathophysiology, and methods of treatment will be summarized.

No. 18B
MEDICAL CAUSES OF INSOMNIA

Gerald Maguire, M.D., *Department of Psychiatry, University of CA at Irvine Medical Center, 101 The City Drive South, Irving, CA 92697-4089*

SUMMARY:

Although psychiatric disorders account for 40% of insomnia difficulties, medical disorders can cause considerable sleep disruption. A recognition of these disorders is also of relevance to psychiatrists. These disorders include asthma, gastroesophageal reflux, heart failure, pain, rheumatic conditions, medications, and others. This paper will discuss the various medical disorders that can be responsible for insomnia, and will propose a rational approach to their evaluation in psychiatric practice.

No. 18C
THE SLEEP/WAKE CYCLE AND CIRCADIAN PHASE IN PSYCHIATRIC DISORDERS

Alfred J. Lewy, M.D., *Department of Psychiatry, Oregon Health Science University, L469, 3181 S.W. Sam Jackson Park Road, Portland, OR 97239-3098*

SUMMARY:

Insomnia is a common complaint in psychiatric patients; 80% of patients with mood disorders, for example, have sleep-related complaints. The disorders most commonly associated with sleep-related complaints include major depressive disorder, dysthymic disorder, bipolar disorder, general anxiety disorder, posttraumatic stress disorder, and substance abuse. Early morning awakening is the most common sleep pattern, yet 10% to 15 percent present with morning

hypersomnia. Hypersomnia is also a common complaint in seasonal affective disorder, childhood depression, and bipolar depression. This presentation will include a discussion of these disorders and their potential circadian underpinnings. It will also discuss circadian treatment interventions.

No. 18D
CURRENT AND EMERGING TREATMENTS FOR INSOMNIA

Milton K. Erman, M.D., *Department of Psychiatry, Pacific Sleep Medicine Services, 10052 Mesa Ridge Court, #101, San Diego, CA 92121*

SUMMARY:

The management of insomnia is optimized when the treatment methods are tailored to address the underlying disorder. However, symptomatic management is often necessary, especially in the case of primary insomnia and when available treatments for the underlying conditions are not effective in addressing sleep-related complaints. Data with patients suffering from major depression indicate that, following effective management, more than 40% of remitted patients continue to complain of sleep disturbances for long periods of time.

Most currently available pharmacological agents for the management of insomnia enhance GABA neurotransmission by allosteric modulation of the postsynaptic receptor complex. They have proven to be highly effective in the management of insomnia. Their main shortfalls have included daytime sedation, effectively addressed by utilizing shorter half-life agents, and concerns regarding tolerance and misuse, especially by patients with histories of substance-use disorders. Concerns have also been expressed regarding the fact that they do not offer, in most cases, a conclusive end to the progression of insomnia. Therefore, agents with other applications are being utilized, and some are under development. They include antidepressants, antihistamines, anti-epileptics, and hormones. Their mechanisms of action are diverse, including serotonin 5HT2 postsynaptic blockade, histamine antagonism, inhibition of GABA reuptake, and enhancement of GABA release. Recent developments in the understanding of circadian physiology have also allowed the introduction of agents, which may be active at receptors involving the circadian system, especially melatonin. This paper will discuss current and emerging agents in the management of insomnia.

No. 18E
SPECIAL CONCERNS IN AGING

Sonia Ancoli-Israel, Ph.D., *Psychiatry Department, University of California, San Diego, 116A VasDHS 3350 La Jolla, San Diego, CA 92161*

SUMMARY:

Older adults experience insomnia at rates estimated between 20% and 40%. A recent study by the National Institute on Aging found that 42% of elderly had frequent difficulty initiating sleep, early morning awakenings, and/or difficulty maintaining sleep. Patients with depressed mood, respiratory symptoms, physical disability, or other health problems are at greater risk of experiencing insomnia. As a result of disturbed sleep, individuals my experience difficulty sustaining attention, problems with memory, and slowed response times. As these characteristics can be misinterpreted as dementia, it is of critical importance for clinicians treating older adults to be able to recognize the signs of sleep disturbances and be prepared to intervene with both pharmacologic and behavioral interventions. This presentation will address the challenges faced with recognizing sleep disturbances in aging populations and prepare clinicians with treatment and intervention options to reduce the risk of insomnia.

REFERENCES:

1. Doghramji K: Insomnia, in Conn's Current Therapy. Edited by Rake, Pope. Philadelphia, 2002, pp 30–35.
2. Martikainen K, et al: Sleep Med 2003; 4:201–206.
3. Lewy AJ: Dialogues in Clinical Neuroscience 2003; 5(4):399–413.
4. Erman MK: Insomnia, in Conn's Current Therapy, 52nd edition. Philadelphia, W.B. Saunders Company, 2000, 32–35.
5. Vitello MV: J Gerontol A Biol Sci Med Sci 1997; 52:m189–91.

INDUSTRY-SUPPORTED SYMPOSIUM 19—CLINICAL INTERVENTIONS FOR THE TREATMENT OF INSOMNIA ASSOCIATED WITH PSYCHIATRIC AND COMORBID MEDICAL ILLNESSES

Supported by Neurocine Biosciences, Inc. and Pfizer Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) identify the need for careful evaluation of insomnia that may present with psychiatric disorders and comorbid medical illnesses, (2) review the diagnostic strategies that are important for the assessment of insomnia in psychiatric and comorbid medical illnesses. Evaluate the medical-psychiatric aspects of insomnia, (3) recognize the interrelationship between insomnia, psychiatric disorder and comorbid medical illnesses and understand how treating the insomnia can impact clinical outcome, (4) evaluate the behavioral and pharmacologic approaches for the treatment of insomnia.

No. 19A
CLINICAL APPROACHES TO INSOMNIA

David J. Kupfer, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Room 210, Pittsburgh, PA 15213-2593*

SUMMARY:

Approximately 60 million adults experience occasional insomnia and about 10% to 20% experience it chronically. The estimates for primary care patients, women, older adults, and those with coexisting medical or psychiatric illness are even higher. Understanding and treating insomnia in patients with comorbid psychiatric or medical disorders is frequently a challenge to clinicians. The strongest comorbidity associations have been seen in affective disorders, cardiopulmonary disease, and painful musculoskeletal conditions. In evaluating insomnia, it is important to understand the details of an individual's sleep habits. Having the patient complete a log or diary detailing routines, medications, and the duration and quality of sleep each day helps to clarify the true nature of their sleep habits. Collateral information from a sleep partner or family member can provide clues to negative sleep habits. After a comprehensive medical, psychiatric, and sleep evaluation, treatments for insomnia are behavioral or pharmacological—often a combination of both provides the best and longest lasting response. Behavioral interventions used in the treatment include sleep hygiene, stimulus control, sleep restriction, cognitive restructuring, and relaxation therapy. Engaging the patient and having him or her participate in the treatment process can increase adherence and have a positive benefit on daytime performance and overall circadian functioning.

No. 19B
INTERRELATIONSHIP OF INSOMNIA TO MEDICAL ILLNESSES AND NEUROLOGICAL DISORDERS

Phyllis C. Zee, M.D., *Department of Neurology, Northwestern University, 710 North Lake Shore Drive, Chicago, IL 60611*

SUMMARY:

New insights from epidemiological data indicate that there is a high association between insomnia and chronic medical and mental illnesses. Important in the understanding of insomnia is the impact on physical health and its relationship to mental health. Insomnia is common among individuals with medical disorders, including cardiovascular disorders such as coronary artery disease, pulmonary disorders such as COPD and asthma, gastrointestinal conditions such as GERD, and neurological disorders such as Parkinson's and dementia. It can also occur in the context of medication use for the treatment of the medical and psychiatric conditions, as well as substance use such as alcohol, caffeine, and tobacco. Carefully reviewing physical symptoms and understanding that patients with medical problems and insomnia can show an exacerbation of symptoms as well as increased fatigue, irritability, decreased pain tolerance, as well as anxiety and depressive symptoms are essential. Insomnia affects individuals of all ages, but can be exacerbated in age-related chronic disorders. In the elderly, insomnia can often be overlooked or can intensify other symptomatology or illnesses. Education and raising public awareness of the beneficial effects of good sleep quality for both physical and mental health will have important implications for public health.

No. 19C
EFFECT OF CHRONIC PAIN SYNDROMES ON SLEEP

Raymond R. Gaeta, M.D., *Department of Anesthesia, Stanford University, 300 Pasteur Drive, S268 Grant Building, Stanford, CA 94305*

SUMMARY:

It is estimated that over 50 million Americans complain that nighttime pain interferes with their ability to fall asleep and/or causes frequent awakening during the night or early morning awakening. As many as 50% to 70% of patients in specialty clinics for chronic, nonmalignant pain report their sleep is impaired.

Evidence shows that there is a reciprocal relationship between sleep quality and pain and that painful disorders interfere with sleep. It is also important to understand that sleep disturbances contribute to the pain experience. Research based on sleep diaries or questionnaires found that sleep disturbance is correlated with a higher pain intensity, greater levels of depression and anxiety, and generally reduced activity levels.

Sleep disorders have been described as having a circular interrelationship with chronic pain in that pain leads to sleep disorders and sleep disorders increase the perception of pain. Research shows that sleep disorders in individuals with chronic pain remain underreported, under-diagnosed, and under-treated. Management of insomnia in patients experiencing chronic pain requires a multifaceted approach. Following a careful evaluation and diagnosis, the implementation of cognitive-behavioral interventions and appropriate pharmacological treatments can dramatically impact the quality of life in these patients.

No. 19D
GENDER-SPECIFIC SLEEP CONSIDERATIONS IN WOMEN

Hadine Joffe, M.D., *Psychiatry Department, Massachusetts General Hospital, 15 Parkman Street, WACC 815, Boston, MA 02114*

SUMMARY:

Sleep disturbance is a core symptom of depression in men and women. In women, hormonal factors also play an important role in sleep, which may contribute to the increased risk of depression in women. The assessment and treatment of insomnia is a critical component of depression management. Relieving insomnia increases daytime performance and overall well-being as well as adherence to treatment in depressed patients. In women with depression, the evaluation of sleep disturbance should include consideration of reproductive function. The normal fluctuations of reproductive hormones during the menopausal transition, postpartum period, and menstrual cycle may contribute to sleep and mood disturbance in women who have depression associated with these reproductive life events.

In perimenopausal and recently postmenopausal women, hot flashes may mediate the relationship between sleep and mood. Hot flashes interrupt sleep repeatedly throughout the night, and have been associated with fatigue and depression.

Menopausal hormone therapy is an effective treatment for sleep disturbance and depression in perimenopausal and postmenopausal women. However, other strategies to treat insomnia in depressed women with hot flashes must be considered, given increasing concern about using hormonal therapy for prolonged periods of time.

Hypnotic agents can improve sleep and quality of life significantly in such women.

No. 19E
NEW PHARMACOLOGIC APPROACHES FOR THE TREATMENT OF INSOMNIA

John W. Winkelman, M.D., *Psychiatry Sleep Center, Brigham & Women's Hospital, 1400 Centre Street, Suite 109, Newton Center, MA 02459*

SUMMARY:

Insomnia is the most common sleep problem, yet it is not always well managed in the context of a busy clinician's office. Recognition of the potential consequences of sleeplessness is frequently lacking, particularly in its ability to worsen the course of comorbid medical or psychiatric disorders. After appropriate diagnostic evaluation, approaches to the treatment of insomnia are twofold—behavioral interventions geared toward understanding and changing negative sleep habits and cognitive misperceptions, and pharmacological management. The goal of pharmacological management is to help the patient return to normal sleep patterns with a minimum of adverse effects or residual sedation. Benzodiazepine receptor agonists and sedating antidepressants are commonly prescribed for the treatment of insomnia; however, their use may be associated with tolerance or adverse effects. Newer hypnotic agents are on the horizon, which hold significant promise for insomnia treatment without some of the limitations of the currently available treatments. A description of these agents as well as their appropriate use within the context of overall psychiatric treatments will be described.

REFERENCES:

1. Quan SF, Zee P: Evaluating the effects of medical disorders on sleep in the older patient. Geriatrics 2004; 59(3):37–42; quiz 45.
2. Joffe H, Soares CN, Cohen LS: Assessment and treatment of hot flushes and menopausal mood disturbance. Psychiatr Clin North Am 2003; 26(3):563–80.
3. Kupfer DJ, Reynolds CF: Management of Insomnia. N Engl J Med 1997; 336(5):341–6. Review.
4. Zeisler CA, Winkelman JW, Richardson GS: Disorders of Sleep and Circadian Rhythms, in Harrison's Textbook of Internal Medicine. Edited by Braunwald E, Fauci A, Kasper DL, Hauser SL, Longo DL, Jameson JL. 15th edition, 2001; pp 155–163.
5. Schnider TW, Gaeta R, Brose W, Minto CF, Gregg KM, Shafer SL: Derivation and cross-validation of pharmacokinetic parame-

ters for computer-controlled infusion of lidocaine in pain therapy. Anesthesiology 1996; 84(5):1043–50.

INDUSTRY-SUPPORTED SYMPOSIUM 20—ALZHEIMER'S DISEASE PATHWAYS TO PRACTICE: ASSESSING DIAGNOSIS AND OUTCOME MEASURES

Supported by Forest Laboratories, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) review the role of neurotransmitters in Alzheimer's disease, (2) understand the basis of differential diagnosis in dementia, (3) comprehend the value of advanced imaging techniques and surrogate markers in Alzheimer's disease, (4) discuss the therapeutic rationale for Alzheimer's disease, (5) recognize the cognitive and behavioral implications in Alzheimer's disease.

No. 20A
THE INTERPLAY OF NEUROTRANSMITTERS IN ALZHEIMER'S DISEASE

Paul T. Francis, Ph.D., *Biomedical Science, Kings College, Guy's Campus, St. Thomas Street, London SE1 1UL, United Kingdom*

SUMMARY:

The developmental rationale for therapies utilized in the management of patients with Alzheimer's disease will be reviewed. In Alzheimer's disease (AD), pyramidal neurons of the neocortex, entorhinal cortex, and hippocampus are lost. The loss of these neurons and tangle formation correlate with the degree of dementia and could be a potential treatment target. In AD, it is hypothesized that glutamate neurotransmission is dysfunctional as a consequence of both reduced glutamate release and reduced glutamate uptake. The result of this is considered to be increased glutamatergic "noise" and decreased "signal" at NMDA receptors. In addition to the glutamatergic system, cholinergic neurotransmission is recognized to play critical roles in cognitive processing, especially attentional processing.

No. 20B
FORMULATING A CLINICAL PRACTICE CARE PLAN FOR THE DIAGNOSIS AND ASSESSMENT OF ALZHEIMER'S DISEASE

Warachal E. Faison, M.D., *Medical University of South Carolina, 5900 Core Road, Suite 203, N. Charleston, SC 29406*

SUMMARY:

Dementia is characterized by declining cognitive and behavioral function severe enough to interfere with activities of daily living. Approximately 50% to 70% of dementias are attributable to Alzheimer's disease (AD). One of the major factors impacting the management of AD is accurate diagnosis of the condition. The clinical manifestations of AD from early to late stages will be discussed. There will be a special emphasis on the differential diagnosis of AD. Tools specifically designed to meet the needs of practitioners that can accurately assess function, cognition, and global change will be reviewed.

No. 20C
UTILIZING ADVANCED IMAGING AND SURROGATE MARKERS ACROSS THE SPECTRUM OF ALZHEIMER'S DISEASE

Mark A. Mintun, M.D., *Department of Radiology, Campus Box 8123, Washington University Medical Center, 510 South Kingshighway Boulevard, St. Louis, MO 63110*

SUMMARY:

The definitive diagnosis of AD currently depends on the demonstration of amyloid plaques and neurofibriliary tangles at autopsy. Evidence suggests the plaques begin to form many years prior to clinical symptoms of dementia. The amyloid-beta protein found in plaques is strongly implicated in the etiology of the disease, making amyloid deposition a target for drug therapy. Our work focuses on in vivo quantitation of amyloid plaque load in the human brain using PET tracers we developed for this purpose. These tracers could help identify subjects with presymptomatic amyloid deposits and evaluate the efficacy of recently developed anti-amyloid therapies for AD.

No. 20D
RATIONALIZING THERAPEUTIC APPROACHES IN ALZHEIMER'S DISEASE

George T. Grossberg, M.D., *Department of Psychiatry, St. Louis University School of Medicine, 1221 South Grand Boulevard, 2nd Floor, St. Louis, MO 63104-1016*

SUMMARY:

As our scientific understanding of the pathological basis of Alzheimer's disease (AD) improves, so does our therapeutic approach to pharmacological management. Clinical researchers have tried to define possible clinical outcomes of Alzheimer's disease (AD) treatment, whether it is symptomatic benefit, disease modification, or neuroprotection. This lecture will examine the pharmacological basis and clinical outcomes of FDA-approved treatments of AD. The AD disease model will be discussed with an emphasis on different stages and different therapeutic treatment approaches. Importantly, AD is not an inevitable consequence of aging, but both a diagnosable and treatable condition.

No. 20E
BEHAVIORAL AND NEUROPSYCHIATRIC OUTCOMES IN ALZHEIMER'S DISEASE

Jeffrey L. Cummings, M.D., *Department of Neurology, UCLA Alzheimer's Disease Center, 710 Westwood Plaza, Ste. 2238, Los Angeles, CA 90095*

SUMMARY:

Treatment of both cognitive and non-cognitive manifestations of Alzheimer's disease (AD) is necessary to ensure maximum benefit to the patient. Behavioral disturbances are a major management issue in patients with moderate to severe dementia. Many studies indicate that behavioral disturbances emerge across the course of dementing disorders and are most frequent in the more advanced stages. Agitation is a particularly common and challenging late state phenomenon. We are slowly beginning to understand the type of behavioral disturbances in this patient population and how best to measure them. It is important to determine if there are pathophysiologic changes, behavioral alterations, or drug responses unique to the population of AD patients.

REFERENCES:

1. Francis PT: Glutamatergic systems in Alzheimer's disease. Int J Geriatr Psychiatry 2003; 18(Suppl 1):S15–21.

2. Grossberg GT: Diagnosis and treatment of Alzheimer's disease. J Clin Psychiatry 2003; 64 [suppl 9]:3–6.
3. Klunk WE, Engler H, Nordberg A, Wang Y, et al: Imaging brain, amyloid in Alzheimer's disease with Pittsburgh Compound-B. Annals of Neurology 2004; 55:306–319.
4. Doraiswamy MP: Non-Cholinergic strategies for treating and preventing Alzheimer's disease. CNS Drugs 2002; 16(12):811–824.
5. Swanberg MM, Tractenberg RE, Mohs R, et al: Executive dysfunction in Alzheimer disease. Arch Neurol 2004; 61(4):556–60.

INDUSTRY-SUPPORTED SYMPOSIUM 21—ANXIETY DISORDERS: UNDERSTANDING THE INTERCONNECTION BETWEEN EMOTIONAL AND PHYSICAL SYMPTOMS

Supported by Wyeth Pharmaceuticals

EDUCATIONAL OBJECTIVES:

By the end of this symposium, the audience should have an increased understanding of the interconnection between emotional and somatic symptoms across the entire spectrum of anxiety disorders, based on discussion of evidence from epidemiologic, neurobiologic, and clinical treatment studies.

No. 21A
WORRIED SICK: HOW PATIENTS EXPERIENCE GAD

R. Bruce Lydiard, M.D., *Department of Psychiatry, South East Health Consultants, 1 Poston Road, Suite 150, Charleston, SC 29407*

SUMMARY:

Generalized anxiety disorder (GAD) affects 5% of individuals in the United States at some point, and occurs twice as frequently in women as in men. Disability associated with GAD is equal to major depression, and if untreated it persists. GAD is also a risk factor for and is highly comorbid with depression and other anxiety disorders. There is evidence that early intervention for GAD can reduce the likelihood of subsequent depression. The DSM-IV diagnostic system revision emphasized the importance of cognitive-psychic aspects of GAD as core features of the disorder (uncontrolled worry, irritability, difficulty concentrating). The diagnostic criteria retained some somatic symptoms (restlessness/keyed up, muscular tension, and sleep disturbance. Many GAD patients do not perceive their symptoms as a mental condition and present with somatic symptoms. Examples of common somatic complaints in patients with GAD include fatigue, cardiovascular complaints (palpitations, chest pain, or discomfort), headache, urinary frequency, dry mouth and gastrointestinal distress (abdominal pain, nausea, heartburn, and altered bowel habits), sexual dysfunction, and neurological symptoms. One large survey of 1,000 HMD enrollees showed that approximately one third of patients presenting with chest pain, fatigue, headache, insomnia, or abdominal pain were due to initially unrecognized anxiety disorders. In another survey, over 50% of GAD patients had completed thorough cardiovascular assessments (ECG, holter monitor, treadmill stress test). In patients with irritable bowel syndrome, up to 50% have concurrent GAD. Patients with GAD have been shown to have immunodepression subjective stress vulnerability. Unrecognized and untreated GAD could theoretically have adverse long-term health consequences, suggesting that individuals with GAD can literally "worry themselves sick." Optimal treatment is important, and treatment options will be reviewed.

No. 21B
ADDRESSING THE FULL SPECTRUM OF SYMPTOMS OF SOCIAL ANXIETY DISORDER

Nathalie Maullin, M.D., *Department of Psychiatry, Cedars Sinai, 8730 Alden Drive, Thaliens-C311, Los Angeles, CA 90048*

SUMMARY:

Social anxiety disorder (SAD) is a common, underrecognized disorder that causes substantial impairment in functioning and quality of life. SAD commonly has an early age of onset and, untreated, has a chronic course. The combination of psychologic and somatic symptoms, including social and performance fears, avoidance behaviors, and physical manifestations of anxiety such as tachycardia, flushing, and tremulousness can make SAD challenging to treat. However, the constellation of signs and symptoms has been responsive to various pharmacotherapies and cognitive-behavioral therapy. It is not surprising that few patients with the disorder successfully access treatment: the reasons for this are being actively explored.

Studies suggest that for pharmacotherapy of SAD, a longer course of treatment may be needed for full response. However, few data exist about treatment of patients who respond partially or not at all to initial treatment, or how best to order or combine treatments. The goal for treatment of SAD should be to resolve the physical and psychologic components of the disorder, without causing functional impairment. Data available to optimize the recognition and treatment for the full spectrum of SAD symptoms will be discussed.

No. 21C
PHARMACOTHERAPY AND PSYCHOTHERAPY IN THE TREATMENT OF PTSD

Barbara Rothbaum, Ph.D., *Department of Psychiatry, Emory University, The Emory Clinic 1365 Clifton Road, Atlanta, GA 30322*

SUMMARY:

Posttraumatic stress disorder (PTSD) is typified by a complex interplay between physiological symptoms and complex emotional reactions. It is frequently difficult for clinicians to disentangle these signs and symptoms to develop a coherent treatment plan. The results of recent medication trials in the treatment of PTSD will be briefly reviewed. All controlled SSRI trials will be included. While SSRIs have demonstrated efficacy in treating PTSD, no randomized, double-blind, placebo-controlled trial of a serotonin-norepinephrine reuptake inhibitor (SNRI) has been reported. A very recent unpublished trial comparing a SNRI and a SSRI will be presented. In this trial, 538 adults with chronic PTSD were randomly assigned to receive placebo, a SNRI, or a SSRI for 12 weeks. Results indicated that both active treatments were more effective than placebo on changes in Clinician Administered PTSD Scale Scores. Week 12 remission rates, symptom-free days, and cluster scores will be presented. Results from a recent study combining a SSRI and cognitive-behavior therapy (CBT) for PTSD will be presented, and effective CBT techniques will be discussed. In particular, prolonged exposure therapy, in which patients are assisted in confronting the trauma-related memories and cues in a therapeutic manner, will be presented.

No. 21D
PANIC DISORDER: THE INTERCONNECTION BETWEEN EMOTIONAL AND PHYSICAL SYMPTOMS

Mark Rapaport, M.D., *Department of Psychiatry, Cedars-Sinai Medical Center, 8730 Alden Dr. Suite C301, Los Angeles, CA 90048*

SUMMARY:

Panic disorder is one of the most disabling of the anxiety disorders. One of the reasons for this disability and quality of life dysfunction is the complex interplay between emotional and physical signs and symptoms. Individuals with panic disorder not only suffer from spontaneous panic attacks characterized by palpitations, shortness of breath, nausea, and tremulousness, but also feel as if they are out of control, going to die, or "go crazy" during such attacks. Even more problematic is the anxiety sensitivity and anticipatory anxiety that individuals with panic disorder have. This anxiety sensitivity manifests itself in a variety of different ways: sometimes as a hypersensitivity to the effects of medication, while other times it presents as an overinterpretation of normal physiological responses to exertion, unexpected stimuli, or a change in position. The lives of individuals with panic disorder frequently are paralyzed by worry about having another panic attack. This anticipatory anxiety leads to self-imposed restrictions in social activities and work activities and greatly diminishes function and quality of life. In this presentation, we will review the complex interplay between emotional and physical symptoms and describe pharmacological and psychological interventions that can be used to ameliorate these treatment challenges. We will particularly emphasize newer data investigating the effects of pharmacotherapy on this interplay of symptomotology. At the end of the presentation, the audience will be familiar with existing data describing the interplay between emotions and physical symptoms in panic disorder, and what treatment interventions seem to work most effectively in ameliorating these conditions.

REFERENCES:

1. Kroenke K, Spitzer RL, Williams JB, et al: Physical symptoms in primary care. Predictors of psychiatric disorders and functional impairment. Arch Fam Med 1994; 3:774–9.
2. Van Ameringen M, Allgulander C, Bandelow B, Greist JH, Hollander E, Montgomery SA, Nutt DJ, Okasha A, Pollack MH, Stein DJ, Swinson RP: World Council of Anxiety. WCA recommendations for the long-term treatment of social phobia. CNS Spectr 2003; 8(8 Suppl 1):40–52.
3. Foa EB, Rothbaum BO: Treating the Trauma of Rape: A Cognitive-Behavioral Therapy for PTSD. Guilford, New York, 1998.
4. Kessler RC, Stang PE, Willchen H-U, Ustun TB, Roy-Burne PP, Walters EE: Lifetime panic depression comorbidity in the National Comorbidity Study. Arch Gen Psychiatry 1998; 55:801–808.

INDUSTRY-SUPPORTED SYMPOSIUM 22—RELAPSE PREVENTION IN SCHIZOPHRENIA: DEFINING A PATH FROM PHARMACOLOGIC INTERVENTION TO LONG-TERM FUNCTIONAL RECOVERY

Supported by Janssen Pharmaceutica and Research Foundation

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to understand the current state of the science with regards to the neurochemistry of relapse in schizophrenia.

No. 22A
THE NEUROBIOLOGY OF RELAPSE IN SCHIZOPHRENIA: IMPLICATIONS FOR DISEASE COURSE AND PATIENT OUTCOMES

Robert B. Zipursky, M.D., *Department of Psychiatry, University of Toronto Clarke Institute, 250 College Street, Room 732, Toronto, ON M5T 1R8, Canada*

SUMMARY:

Efforts to understand the neurobiology that underlies the process of psychotic relapse in schizophrenia have focused on the perturbations observed in the dopamine system as psychosis evolves and resolves. Current evidence suggests that medications that result in dopamine D_2 receptor blockade play a critical role in bringing about the resolution of psychotic symptoms. However, the degree and duration of dopamine D_2 receptor blockade required for prevention of relapse remains an important focus of current research. In contrast to the relatively narrow range of time over which antipsychotic medications begin to act to resolve psychotic symptoms, the time course over which psychotic relapse occurs following medication discontinuation is highly variable. The mechanism that underlies this asymmetry between the onset and termination of action of antipsychotic medications is not yet well understood. Recent interest has also focused on the potential for the return of psychosis to impact in a detrimental way on the integrity of brain structure in schizophrenia and in turn on the longer-term course of illness. The extent to which brain changes are progressive over the course of schizophrenia and the degree to which this can be related to the presence of a persisting psychotic state will be reviewed.

No. 22B
DEFINING THE KEY CLINICAL PARAMETERS THAT CONTRIBUTE TO RELAPSE IN SCHIZOPHRENIA

Stefan M. Leucht, M.D., *Department of Psychiatry, Technishe Universitat Munchen, Klinikum rechts der Isar Ismaning erstr. 22, Munich 81675, Germany*

SUMMARY:

Relapse prevention is a crucial issue in the treatment of patients with schizophrenia. It is a major hope that the new generation of antipsychotics, due to their lower risk of EPS compared with high-potency conventional compounds, will improve compliance and reduce relapse rates. A meta-analysis of randomized studies showed that the new-generation antipsychotics have the potential to decrease relapse rates in patients with schizophrenia. A subsequent systematic review also showed a statistically significantly lower risk of tardive dyskinesia with new-generation antipsychotics. However, a number of methodological problems were identified. Furthermore, it is unclear whether the advantage in terms of relapse prevention was partly mediated by improved adherence to treatment. Recent large-scale retrospective studies overall showed that new-generation antipsychotics do improve compliance compared with conventional compounds; still the non-adherence rates even with the new compounds were often high. In addition, it seems that psychiatrists tend to overestimate their capability to know which of their patients are compliant and which are not.

No. 22C
CAN RELAPSE BE PREVENTED THROUGH PHARMACOLOGIC INTERVENTION?

John M. Kane, M.D., *Department of Psychiatry, Zucker Hillside Hospital, 75-59 263rd Street Kaufmann Boulevard, Glen Oaks, NY 11004-1150*

SUMMARY:

Soon after the introduction of medications that were found to be effective in diminishing the positive signs of schizophrenia, the question arose as to the ability of these medications to control symptoms and prevent relapse over long periods of time. Numerous studies have demonstrated the effectiveness of antipsychotic medication in this context. A number of issues remain unresolved. How do we

explain relapses that occur among those patients receiving medication? In some cases there is poor or partial adherence, but in others relapse occurs despite adequate pharmacotherapy. The new-generation antipsychotic medications have been associated with significant reductions in relapse rates in comparison to conventional antipsychotic medications. This difference appears not to be adequately explained by increased adherence and may be due at least in part to the neuropharmacologic properties of these agents. Much remains to be learned about the cascade of social and biological factors that lead to relapse vulnerability. This presentation will discuss the profiles of existing pharmacologic agents and how they relate to the neurobiology of relapse and the implications for optimizing therapeutic choices.

No. 22D
REMISSION AND FUNCTIONAL RECOVERY IN SCHIZOPHRENIA: RAISING THE BAR FOR CLINICAL OUTCOMES

Nina R. Schooler, Ph.D., *Psychiatry, State University of New York Downstate, 450 Clarkson Avenue, Box# 1203, Brooklyn, NY 11203*

SUMMARY:

Successful treatment of schizophrenia has often been defined by the potential of the specific treatments available to us. Anti-psychotic medications focused our attention on the reduction of psychotic symptoms, the ability to return patients to the community, and the prevention of relapse. As new anti-psychotics are developed that may have a broader spectrum of effects and specific psychosocial treatments that address other targets become available, it is important to consider functional recovery in schizophrenia more broadly. This presentation will review the concept of symptom remission and its definition. It will also review operational definitions of functional recovery that incorporate symptom remission as well as successful coping with daily living tasks, community role functioning, and social interaction. Both symptom remission and functional recovery can only be examined from a long-term perspective. Thus, data from long-term studies will be used to examine the effects of treatments on these expanded outcome measures. From the clinician's perspective, assessment must be ongoing over time. Thus, the presentation will conclude with discussion of strategies for assessing these enhanced clinical goals in clinical, rather than research, settings.

REFERENCES:

1. Kapur S: Psychosis as a state of aberrant salience: a framework linking biology, phenomenology and pharmacology in schizophrenia. Am J Psychiatry 2003; 160:13–23.
2. Leucht S, Barnes TRE, Kissling W, Engel R, Correll C, Kane J: Relapse prevention in schizophrenia with new-generation antipsychotics. A systematic review and meta-analysis of randomized, controlled trials. Am J Psychiatry 2003; 160:1209–1222.
3. Leucht S, Barnes TRE, Kissling W, Engel RR, Correll C, Kane JM: Relapse prevention in schizophrenia with new-generation antipsychotics: a systematic review and explorative meta-analysis of randomized controlled trials. Am J Psychiatry 2003; 160:1209–1222.
4. Robinson G, Woerner M, McMeniman M, Mendelowitz A, Bilder R: Symptomatic and functional recovery from a first episode of schizophrenia or schizoaffective disorder. Am J Psychiatry 2004; 161:473–479.

INDUSTRY-SUPPORTED SYMPOSIUM 23—FIBROMYALGIA: A DISORDER AT THE MEDICINE AND PSYCHIATRY INTERFACE
Supported by Pfizer Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should recognize the possible pathophysiologic link between fibromyalgia, and mood and anxiety disorders, discuss the emerging evidence for the etiology of fibromyalgia, and manage patients with fibromyalgia in a psychiatric setting using both pharmacological and non-pharmacological treatments.

No. 23A
THE PATHOPHYSIOLOGICAL BASIS OF FIBROMYALGIA: EMERGING EVIDENCE

Daniel J. Clauw, M.D., *Department of Medicine, University of Michigan, 24 Frank Lloyd Wright Drive, Ann Arbor, MI 48109*

SUMMARY:

Both genetic and environmental factors probably contribute to the liability to develop fibromyalgia (FM). Fibromyalgia aggregates strongly in families (OR approximately 9), and recent preliminary genetic studies have identified an association of FM and genetic polymorphisms in serotonin-related genes. Multiple stressors (e.g. physical trauma, infection, emotional stress) seem to be capable of either triggering the develop of, or worsening pre-existing, FM. This link to stress is supported by the fact that patients with FM have disturbances in the two major interacting stress-response systems, the autonomic nervous system and the HPA axis. Perhaps the most consistent finding in fibromyalgia, though, is aberrant CNS processing of pain, and the development of hyperalgesia/allodynia. Neuroimaging studies of patients with FM have corroborated patient self-reported central augmentation of pain sensitivity in FM. Abnormalities in central monoaminergic neurotransmission may also play a role in FM, with a leading theory being that there is a reduction of serotonergic and noradrenergic-mediated descending pain-inhibitory pathways. Finally, there are limited data suggesting that although this is not an autoimmune or inflammatory disorder, that cytokines (e.g. IL-8) might play a role in this condition, perhaps via neuroimmune mechanisms.

No. 23B
MANAGEMENT OF PSYCHIATRIC COMORBIDITY IN PATIENTS WITH FIBROMYALGIA

Lesley M. Arnold, M.D., *Psychiatry Department, University of Cincinnati, 231 Albert Sabin Way, Cincinnati, OH 45267-0559*

SUMMARY:

Several lines of evidence suggest that fibromyalgia (FM) might share underlying pathophysiological links with mood and anxiety disorders. First, individuals with FM have high lifetime rates of comorbid mood and anxiety disorders. Second, a recent controlled family study found that FM aggregates in families and coaggregates with mood disorders, suggesting that FM and mood disorders might have common, possibly heritable, causal factors. Third, central monoaminergic neurotransmission is involved in mood regulation and descending pain pathways. Finally, HPA axis dysfunction may contribute to the development of mood and anxiety disorders, and FM. In patients with FM, mood and anxiety disorders are associated with persistent pain, functional impairment, more physical symptoms, greater overall ill health and more dissatisfaction antidepressants

have moderate overall efficacy in FM. Lifetime mood and anxiety disorders predicted response to treatment with venlafaxine in an open trial. In a controlled study, fluoxetine significantly improved pain and depression in FM patients. Options for the treatment of FM patients with comorbid bipolar disorder include antidepressants, gabapentin, or pregabalin, in combination with mood stabilizers. Antidepressants, gabapentin, or pregabalin may also be useful for the treatment of comorbid anxiety disorders and FM.

Supported by Wyeth, Eli Lilly & Co., Pfizer, Inc.

No. 23C
RECENT DEVELOPMENTS IN THE PHARMACOTHERAPY OF FIBROMYALGIA

Leslie J. Crofford, M.D., *University of Kentucky, 740 South Limestone, Lexington, KY 40536-0284*

SUMMARY:

Several large randomized, placebo-controlled clinical trials of novel pharmacologic agents have been recently conducted in patients with fibromyalgia (FM). Pregabalin, an alpha 2 delta ligand, was studied in a randomized, placebo-controlled, eight-week, monotherapy trial of 530 patients with FM. Compared with placebo, pregabalin 450 mg/day significantly improved pain, sleep, fatigue, global impression of change, and SF-36 domains of social functioning, bodily pain, vitality, and general health perception. A randomized, placebo-controlled, 12-week, monotherapy trial evaluated duloxetina, a dual serotonin and norepinephrine reuptake inhibitor, in the treatment of 207 patients with FM. Compared with placebo, duloxetine 120 mg/day significantly improved the overall impact of FM, the average pain severity and average interference from pain, tender point number and threshold, stiffness, clinical global impression of severity, patient global impression of improvement, and SF-36 domains of bodily pain, general health perception, mental health, physical functioning, and vitality, and the physical component score. A third randomized, placebo-controlled, 12-week, monotherapy trial evaluated milnacipran, a dual norepinephrine and serotonin reuptake inhibitor, in the treatment of 125 patients with fibromyalgia. Compared with placebo, milnacipran (flexible dose up to 200 mg/day) significantly improved pain, fatigue, stiffness, and the patient global impression of change.

Supported by Pfizer Inc., Eli Lilly & Co., Cypress Bioscience.

No. 23D
NONPHARMACOLOGICAL TREATMENT OF FIBROMYALGIA

Shay B. Stanford, M.D., *Department of Psychiatry, University of Cincinnati, 231 Albert Sabin Way, Cincinnati, OH 45267*

SUMMARY:

Aerobic exercise has beneficial effects on physical capacity and pain levels in patients with fibromyalgia (FM). However, the use of exercise in patients with FM must be carefully prescribed and supervised to reduce over-training-induced muscle microtrauma, which could lead to exacerbation of FM. Aerobic exercise could also be a physiological stressor to which some FM patients respond poorly due to decreased sympathetic response and a paradoxical fall rather than rise in cortisol levels after exercise. It is important to carefully pace the patient's activities and prescribe a program to fit the individual's level of fitness.

Cognitive-behavioral therapy has been studied in patients with FM with variable results. In a controlled study, an educational program, with or without cognitive treatment, did not improve pain intensity in patients with FM, although group education and discussion improved pain coping and pain control. Another controlled study found that behavioral treatment, which included education, relaxation training, goal setting, and activity pacing, was no better than the education control in reducing depression or pain behavior, and pain levels were not reduced in either group. A recent controlled study of acupuncture found no difference in change in pain in the acupuncture group compared with placebo.

REFERENCES:

1. Gracely RH, Perzke F, Wolf JM: Clauw DJ: Functional magnetic resonance imaging evidence of augmented pain processing in fibromyalgia. Arthritis Rheum 2002; 46:1333–43.
2. Arnold LM, Hudson JI, Hess EV, et al: Family study of fibromyalgia. Arthritis Rheum 2004; 50:944–952.
3. Crofford L, Russell IJ, Mease P, et al: Pregabalin improves pain associated with fibromyalgia syndrome in a multicenter, randomized, placebo-controlled, monotherapy trial. Arthritis Rheum 2002; 46:S613.
4. Clauw DJ, Crofford LJ: Chronic widespread pain and fibromyalgia: what we know, and what we need to know. Best Pract Res Clin Rheumatol 2003; 17:685–701.

INDUSTRY-SUPPORTED SYMPOSIUM 24—EXPLORING COGNITIVE FUNCTION: FROM BRAIN TO BEDSIDE
Supported by Cephalon, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) identify pathways in the brain that are linked to cognitive functioning (2) evaluate targeted pharmacological and non-pharmacological treatments for executive dysfunction to improve patient outcomes (3) translate the evidence related to the treatment of executive dysfunction in late-onset depression, major depressive disorder, schizophrenia, and ADHD to improved functional outcomes.

No. 24A
THE NEUROLOGY OF COGNITION: A GLIMPSE INTO THE BRAIN

Daniel R. Weinberger, M.D., *Clinical Brain Disorders, National Institute of Mental Health, 10 Center Drive, Building 10, Room 4S-235, Bethesda, MD 20892-1379*

SUMMARY:

Recent advances in neuroimaging, coupled with neuropsychological testing, provide a glimpse into the circuitry of cognition. For example, ascending monoaminergic pathways for dopamine (DA) and norepinephrine (NE) from the brainstem to the dorsolateral prefrontal cortex (DLPFC) may mediate executive function. On the other hand, ascending histaminergic (HA) pathways may regulate the sleep-wake cycle and consequently cognitive functioning. These pathways that mediate cognitive functioning continue to develop through early adulthood and decline with advanced aging. Several common psychiatric illnesses including major depression, schizophrenia, ADHD, and late-life depression are associated with cognitive dysfunction, suggesting a link between pathway malfunction and symptom expression. It may be possible through targeted pharmacotherapy directed at the frontal striatal limbic circuitry to alleviate this symptom domain since it is a strong predictor of poor outcome in our patients.

No. 24B
REMISSION IN MAJOR DEPRESSION: THE VITALITY OF COGNITION

Philip T. Ninan, M.D., *Department of Psychiatry, Emory University, 1841 Clifton Road, 4th Floor, Atlanta, GA 30329*

SUMMARY:

DSM-IV gives scant importance to cognitive dysfunction in major depressive disorder. However, negative emotional blas prominently influences the content of cognitions in MDD. The process of cognition is also impaired, evident as either uncontrolled rumination or abulla. Additional cognitive deficits in MDD occur in working memory, learning, and motor speed. Of critical importance, cognitive dysfunction has functional, prognostic, and therapeutic implications. Antidepressants, enhance cognitions, including through hippocampal naurogenesis, but also induce side effects such as apathy and amotivation. What strategies are available to enhance residual cognitive and related symptoms from current antidepressant treatments? The use of targeted pharmacotherapy with dopaminergic and prohistaminergic agents, as well as cognitive-behavioral psychotherapy techniques may enhance the likelihood of achieving cognitive benefit and durable remission.

No. 24C
CAN CLINICIANS IMPACT COGNITION IN SCHIZOPHRENIA?

Rona Hu, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Stanford, CA 94305*

SUMMARY:

Cognition in schizophrenia is a topic of major importance and steadily increasing interest. As evidence of this fact, the Mount Sinai School of Medicine Conference on Cognition in Schizophrenia has had increased attendance at each of its six meetings over the last ten years. One of the factors that has led to the increased interest in cognition is a clearer appreciation of the functional relevance of cognitive impairments.

Patients with schizophrenia demonstrate a broad spectrum of cognitive dysfunction, with impairment in the domains of executive function, verbal fluency, verbal and visual learning, memory, and attention. Studies show that well before the positive symptoms for the illness emerge, children destined to develop schizophrenia manifest subtle, but clearly identifiable abnormalities in cognition, social adjustment, and behavior. It has been argued that persistent cognitive deficits in patients with schizophrenia are responsible for the failure of many patients to rehabilitate socially even when psychotic symptoms are in remission. Improving cognition and therefore overall patient functioning should be a primary treatment goal when selecting a pharmacological treatment option for patients with schizophrenia.

No. 24D
THE COMPLEXITIES OF COGNITIVE DYSFUNCTION IN LATE-LIFE DEPRESSION

George S. Alexopoulos, M.D., *Department of Psychiatry, Cornell University, 10 Bloomingdale Road, White Plains, NY 10605*

SUMMARY:

Depressive symptoms and cognitive dysfunction frequently occur in late-life depression. Symptoms such as difficulty planning, sequencing, organizing, and abstracting have been described as depressive-executive function syndrome. Studies have shown depression, possibly due to hypercortisolemia, to be a risk factor for developing dementia. In addition, the ApoE genotype has been associated with both late-life depression and Alzheimer's dementia. The presence of cognitive dysfunction in late-life depression is a predictor of poor response to traditional antidepressants. Clinical, neuropsychological, and neuroimaging studies point to abnormalities in the frontostriatal-limbic system. These observations provide a basis for the study of novel pharmacological agents that target dopamine, norepinephrine, or histamine to treat both cognitive dysfunction as well as symptoms of apathy, fatigue, and sleepiness. Elderly patients with impairment in executive function are also at risk for poor response to pharmacotherapy and may benefit from non-pharmacological treatments such as problem-solving therapy to reduce depressive symptoms.

No. 24E
THE EVIDENCE AND RELEVANCE OF COGNITIVE DYSFUNCTION IN ADHD

Scott Kollins, Ph.D., *Department of Psychiatry, Duke University, 718 Rutherford Street, Durham, NC 27705*

SUMMARY:

Once thought to be nothing more than "bad behavior," a better understanding of attention deficit hyperactivity disorder (ADHD) emerged in the 1980's. Since then, ADHD has become recognized as a disorder represented by a model of brain dysfunctions leading to problems of attention, impulsivity, and hyperactivity. Further research has identified a possible association with neurobiological deficits in the prefrontal cortex and related subcortical systems. Indeed, neurological differences have been demonstrated in the brains of individuals with and without ADHD through structural and functional MRI. Stimulants are the traditional treatment for ADHD and have been effective, but with limitations. For example, comorbid anxiety may decrease response to stimulants.

Theoretically, ADHD's inattention, hyperactivity, and impulsivity may be due to underlying executive functioning, alerting, and orienting deficits, and the nonstimulant modafinil could be beneficial in managing symptoms of the disorder by improving these components of attention that accompany wakefulness. Functional outcomes for children include progress in school. Improved relationships with family and peers, ability to participate in collective activities, ability to play alone, and satisfaction with life.

REFERENCES:

1. Nieoulton A: Dopamine: a key regulator to adapt action, emotion, motivation, and cognition. Curr Opin Neurol 2003; 16:3–9.
2. Fave M: Symptoms of fatigue and cognitive/executive dysfunction in major depressive disorder before and after antidepressant treatment. J Clin Psychiatry 2003; 64 Suppl 14:30–4.
3. Gorman J: Taking another look at schizophrenia. CNS Spectrums 2004; 9:328–330.
4. Alexopoulos GS: Role of executive function in late-life depression. J Clin Psychiatry 2003; 64 Suppl 14:18–23.
5. Kollins SH: Comparing the abuse potential of methylphenidate versus other stimulants: a review of available evidence and relevance to the ADHD patient. J Clin Psychiatry 2003; 64[suppl 11]:14–16.

INDUSTRY-SUPPORTED SYMPOSIUM 25—BIPOLAR DISORDER: TREATING THROUGH THE ENTIRE SPECTRUM
Supported by AstraZeneca Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant will understand the concept of a spectrum of pathology in which full episodes

of mania and depression represent only the clearest starting points for treatment of an illness with a complex course.

No. 25A
THE NEUROSCIENCE OF BIPOLAR DISORDER ACROSS THE AGE SPECTRUM

Kiki D. Chang, M.D., *Child Psychiatry, Stanford University, 401 Quarry Road, Room 1105, Stanford, CA 94305*

SUMMARY:

Research in the last decade has contributed enormously to the understanding of the neurobiology underlying the clinical picture of bipolar disorder (BD). This presentation summarizes the major findings from recent neurobiological research in BD and discusses future research that may ultimately guide treatment and possibly prevention of BD across the life cycle. Studies have consistently demonstrated functional and structural abnormalities in the prefrontal cortex and in subcortical limbic regions, including amygdala, hippocampus, thalamus, and striatum. In addition, periventricular white matter disruptions have been consistently reported in adults with BD. By critical analyses of these studies, and by comparing pediatric to adult studies, conclusions can be made to support developmental hypotheses regarding the etiology and course of BD across the life cycle. In general, disruptions in either frontal/prefrontal or specific subcortical areas may affect cognitive control of emotional states. Early dysregulation of subcortical limbic areas, as indicated by structural/functional abnormalities that may be present very early in the development of BD, may lead to or reveal prefrontal or inferior frontal abnormalities of function. These findings may also explain cognitive/attention deficits in BD, kindling and treatment resistance with longer duration of BD, and eventually guide multimodal treatment of BD based on affected brain regions.

No. 25B
ISSUES IN TREATING BIPOLAR DEPRESSION

Joseph R. Calabrese, M.D., *Department of Psychiatry, University Hospital Cleveland, 11400 Euclid Avenue, Suite 200, Cleveland, OH 44106*

SUMMARY:

Bipolar depression is as debilitating as mania in bipolar disorder; however, the management of bipolar disorder has generally focused on acute treatment of mania. With compelling and often striking symptoms, such as psychosis, violence, and agitation, patients with mania frequently require rapid stabilization and acute hospitalization. It is not difficult to see why mania, which is volatile and clinically conspicuous, has long overshadowed bipolar depression, which is less raucous, and more diagnostically challenging. Further, depressive episodes comprise the majority of the symptomatic mood episodes that bipolar patients experience and have a longer mean duration than manic episodes. Patients afflicted with depressed and mixed episodes tend to have lower quality-of-life scores than those patients with manic or hypomanic episodes. Tragically, this can lead to more suicides in patients experiencing depressed and mixed episodes than in those patients with manic or hypomanic episodes. The management of depressive symptoms and major depressive episodes associated with bipolar disorder is the greatest unmet need for this disorder. Until recently, there have been very few large-scale, double-blind, placebo-controlled trials conducted in bipolar depression. Fortuitously, for those who suffer from bipolar depression and for those who care for them, there has been a recent watershed in the research concerning the treatment of bipolar depression. This groundbreaking research investigating the use of an atypical antipsychotic as monotherapy treatment for bipolar depression has the potential to revolutionize the treatment of bipolar disorder as we have known it. This presentation will identify and critically appraise these new data, as well as infer how these findings will likely refashion the current treatment paradigm of bipolar depression.

No. 25C
THE ACUTE SETTING: ACHIEVING STABILIZATION

Trisha Suppes, M.D., *Department of Psychiatry, University of Texas Southwestern, 5323 Harry Hines Boulevard, Dallas, TX 75390-9121*

SUMMARY:

Bipolar disorder is a fluctuating illness that is treated in stages, with each stage presenting its own set of unique challenges for the treating clinician. Frequently, during an acute episode, patients with bipolar disorder present with behavioral disturbances that can have serious consequences. Rapid control of symptoms and mood stabilization are important, as patients with bipolar disorder who are acutely ill can be unpredictable, uncooperative, and even violent. Further, clinicians must remain vigilant through each stage of treatment regarding the risk of suicide or impulsive actions. As symptoms improve and behavioral problems decrease, the intensity and type of treatments change. The general goals of treatment are symptomatic remission, full return to psychosocial functioning, and prevention of relapse and recurrences. The treatment of acute mania associated with bipolar disorder has rapidly evolved and expanded. This evolution is based, in part, on recent evidence supporting the use of new and traditional medications, as well as common clinical practices and experience. This presentation will outline and describe current treatments for mania associated with bipolar disorder, as well as achieving stabilization in the acute setting.

No. 25D
FROM ACUTE TO MAINTENANCE THERAPY

Gary S. Sachs, M.D., *Department of Psychiatry, Harvard-Massachusetts General Hospital, 50 Staniford Street, Suite 580, Boston, MA 02114*

SUMMARY:

Traditionally, the maintenance phase of treatment for patients with mood disorder was conceptualized as therapeutic target separate from the acute and continuation phase. Most randomized, clinical trials demonstrating prophylactic treatment benefit, however, use an "enriched design." Rather than randomizing already recovered patients to start study medications, enriched designs begin with subjects who have met criteria for acute response while already exposed to the study drug. The success of this design feature supports continuation of successful acute treatment and/or the integration of potential maintenance-phase treatments into the acute-phase managements plan. Guidelines and examples for the Systematic Treatment Enhancement Program for Bipolar disorder (STEP-BD) will be presented.

REFERENCES:

1. Chang KD, Barnea-Goraly N, Adleman N, Ketter TA: Brain imaging in bipolar disorder. Contemp Psychiatry 2000; 1:1–10.
2. Muzina DJ, Calabrese JR: Recent placebo-controlled acute trials in bipolar depression: focus on methodology. Int J Neuropsychopharm 2003; 6:285–291.
3. Suppes T, Dennehy EB, Swann AC, et al: Report of the Texas Consensus Conference Panel on Medication Treatment of Bipolar Disorder 2000. J Clin Psychiatry 2002; 63(4):288–99.
4. Bowden CL, et al: A placebo-controlled, 18-month trial of lamotrigine and lithium maintenance treatment in recently manic or hypomanic patients with bipolar I disorder. Arch Gen Psychiatry 2003; 60:392–400.

INDUSTRY-SUPPORTED SYMPOSIUM 26—UNTANGLING DEPRESSION AND ANXIETY: A CHALLENGE FOR SCIENTISTS AND CLINICIANS

Supported by Forest Laboratories, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the neurobiological underpinnings of depression and anxiety, recognize comorbid anxiety and depression, and administer proper treatment for these disorders.

No. 26A
GENETIC MODELS OF DEPRESSION AND ANXIETY

Rene Hen, Ph.D., *Neurobiology, Columbia University, 722 West 168th Street, Annex 725, New York, NY 10032*

SUMMARY:

Anxiety and depression are linked to atrophy and/or loss of neurons in the hippocampus, a brain region that is acutely responsive to stress. Antidepressants influence the birth of neurons in the hippocampus and it appears that this effect may be important for the clinical response to this class of therapeutic drugs. Based on clinical studies, the hippocampus undergoes a substantial amount of structural change even in adulthood, including alterations in synapse formation, axon elongation, and dendritic elaboration. Furthermore, aversive experiences decrease the production of new neurons by inhibiting the proliferation of neuronal precursors and, therefore, the number of new hippocampal neurons. The use of antidepressant medications appears to protect the hippocampus from depression-associated damage. For example, recent preclinical data show that blocking the formation of hippocampal neurons inhibits the behavioral effects of antidepressants. This finding lends new credence to the proposed role of neurogenesis in lifting mood. It also helps to explain why there is a delayed onset of efficacy for antidepressants. These findings strengthen the case that neurogenesis contributes to the effects of antidepressants and suggest that strategies aimed at stimulating hippocampal neurogenesis could provide novel avenues for the treatment of anxiety and depressive disorders. Neuronal abnormalities underlying depression and anxiety will be emphasized in this talk.

No. 26B
SEROTONERGIC TARGETS AS MEDIATORS OF ANXIETY

Alexander Neumeister, M.D., *Department of Psychiatry, Yale University, 950 Campbell Avenue, West Haven, CT 06516*

SUMMARY:

The advent of a genetic knock-out mouse model that does not express the serotonin 1A receptor shows that as adults the mice exhibit anxiety-related traits. Serotonin 1A knock-out mice are less active than normal animals in open spaces, balk at entering elevated mazes, and are slower to begin eating in novel environments. Researchers examined which of two populations of serotonin receptors, one in the forebrain and another in the brainstem, was responsible for the expressed behaviors. Receptor knock-out mice were crossbred with mice engineered to turn receptor expression on and off in specific brain regions. The resulting transgenic line of animals showed that only the forebrain receptors are rescued from the gene knockout. This "rescue" line of mice behaved normally when tested for the anxiety-like behaviors, suggesting a key role for the serotonin 1A receptor in forebrain circuits mediating anxiety. These data are intriguing in light of data from postmortem clinical studies suggesting a potentially important role for brainstem serotonin 1A receptors in depression and suicide, and in light of recent in vivo PET imaging studies in patients with mood and anxiety disorders suggesting trait abnormalities of serotonin 1A receptors in patients with major mood disorders and panic disorder. In this talk, the latest preclinical and clinical data regarding the role of serotonin in anxiety will be emphasized.

No. 26C
NEUROANATOMICAL PATHWAYS UNDERLYING MAJOR DEPRESSION AND ANXIETY DISORDERS

John H. Krystal, M.D., *Department of Psychiatry, Yale School of Medicine, VA Medical Center, 950 Campbell Avenue, West Haven, CT 06516*

SUMMARY:

Neuroimaging studies in humans and animals implicate amygdala and related anatomical circuits in the pathophysiology of mood and anxiety disorders. In the depressed phase of major depressive disorder (MDD), glucose metabolism in the amygdala and other limbic regions is increased, and hemodynamic responses to sad stimuli are abnormally persistent. Amygdala metabolism is positively correlated with depression severity and stressed plasma cortisol concentrations. Antidepressants decrease amygdala metabolism in treatment responders, and elevate amygdala metabolism during remission. The relationship between activity in specific PFC regions is inverse, indicating that these areas play roles in modulating emotional expression and experience. These cortical regions are affected by reductions in tissue volume, synaptic markers, and glial cells that persist across illness phases. In anxiety disorders, the same circuits are implicated, but the pattern of abnormalities differs. In posttraumatic stress disorder (PTSD), resting amygdala metabolism appears normal, but hemodynamic responses to emotional stimuli are exaggerated. Medial PFC regions fail to normally activate in response to trauma-related stimuli. Neuroreceptor imaging studies implicate functionally related systems in mood and anxiety disorders, but with differences in the pattern of abnormalities. Serotonin 1A receptor binding is reduced in MDD, bipolar, and panic disorder, but not in PTSD. Reductions in benzodiazepine receptor binding are demonstrated in panic disorder and PTSD, but not in MDD. Together, these data suggest a neural model in which dysfunction of specific limbic PFC structures and/or neurotransmitter systems leads to abnormal processing of emotional stimuli. Antidepressant drugs may compensate for this dysfunction by inhibiting pathological limbic activity in mood and anxiety disorders.

No. 26D
PRESENTATION AND DIAGNOSIS OF COMORBID MDD AND ANXIETY DISORDERS

Naomi Simon, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WANG ACC 815, Boston, MA 02114*

SUMMARY:

There has been growing interest and concern about the high rates of comorbidity of anxiety disorders and depression, now well documented in both epidemiologic and clinical samples. The presence of comorbidity has been shown to have a negative impact on course, including greater severity of the primary disorder, greater impairments in social and occupational functioning, elevated rates of suicidality, and poorer response to treatment. For example, a study in a primary care sample found that while the odds of suicidal ideation

in patients with major depression alone was five times that of patients with no psychiatric disorder, patients with panic disorder comorbid with major depression had triple that (OR=15.4). As the chronicity of these disorders has been recognized, focus has shifted toward lifetime comorbidities and potential etiologic explanations for this overlapping risk. For example, the role of life stressors, and the order of onset for depression and anxiety disorders and its implications have been studied. These high rates of comorbidity have also raised questions about our psychiatric nosology, and an alternate spectrum approach has been suggested to help understand the clinical implications of overlapping symptoms at or below diagnostic thresholds. In addition, similarities and differences in anxiety comorbidity with major depression compared with bipolar disorder have begun to be explored. The incidence and nature of depression and anxiety comorbidity, potential explanations for the high rates of comorbidity, and its clinical impact will be examined in this presentation.

No. 26E
MAKING TREATMENT DECISIONS FOR COMORBID MDD AND ANXIETY DISORDERS

Martin Keller, M.D., *Department of Psychiatry, Brown University, 345 Blackstone Boulevard, Providence, RI 02906*

SUMMARY:

The medications often used to treat anxiety symptoms are anxiolytics. Some of the difficulties with this class of drugs are their potential for tolerance, physical dependence, and the likely recurrence of panic and anxiety symptoms after medication cessation. Because anxiety is often associated with depressive disorders, it is essential to treat the underlying depression along with the anxiety disorder. When depression is ameliorated, symptoms of anxiety often diminish. Resolution of anxiety early in the course of treatment improves patients' compliance with antidepressant regimens and reduces the likelihood of premature discontinuation from treatment. Depending on the patient's level of anxiety, monotherapy with an antidepressant that has shown measurable anxiolytic effects (including TCAs, MAOIs, and SSRIs) is a suitable option for the clinician. Controversy exists about the joint use of benzodiazapines and antidepessants for severe anxiety and when, if ever should a benzodiazepine be started first. Cognitive-behavioral therapy (CBT), other structured psychotherapies such as CBASP (cognitive-behavioral analysis system of psychotherapy), and interpersonal psychotherapy (IPT), may be considered in severely depressed patients whose symptoms respond poorly to an adequate antidepressant trial, who are intolerant of antidepressants, have contraindications to pharmacotherapy, or who refuse medication. A combination of these psychotherapies and antidepressants may also be beneficial in some patients. The standard current approach to most anxiety disorders in adults is a combination of these structured psychotherapies with medications, typically an SSRI or, less commonly, a tricyclic antidepressant. Interestingly, a 2001 study suggested that SSRIs and psychotherapy affected the same regions of the brain, which indicates they have similar mechanisms of action. Alleviating comorbid depression and anxiety using pharmaco- and structured psychotherapies will be stressed in this talk.

REFERENCES:

1. Santarelli L, Saxe M, Gross C, Surget A, et al: Requirement of hippocampal neurogenesis for the behavioral effects of antidepressants. Science 2003; 301:805–809.
2. Neumeister A, Bain E, Nugent AC, Carson RE, Bonne O, Luckenbaugh DA, Eckelman W, Herscovitch P, Charney DS, Drevets WC: Reduced serotonin type 1A receptor binding in panic disorder. J Neurosci 2004; 24(3):589–91.
3. Drevets WC: Neuroimaging abnormalities in the amygdala in mood disorders. Ann N Y Acad Sci 2003; 985:420–44.
4. Simon NM, Smoller JW, Fava M, Sachs G, Racette SR, Perlis R, Sonawalla S, Rosenbaum JF: Comparing anxiety disorders and anxiety-related traits in bipolar disorder and unipolar depression. J Psychiatr Res 2003 37:187–92.
5. Keller MB: Past, present, and future directions for defining optimal treatment outcome in depression: remission and beyond. JAMA 2003; 289(23):3152–60.

INDUSTRY-SUPPORTED SYMPOSIUM 27—ADHD THROUGH THE LIFECYCLE: NEW FINDINGS AND CLINICAL IMPLICATIONS
Supported by Shire US, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participants should be able to (1) discuss the long-term studies in children with ADHD, (2) recognize the response and tolerance to mixed amphetamine salts in children with ADHD; (3) understand the effect of mixed amphetamines, used long-term, in adults with ADHD, (4) recognize and appreciate the functional impairments commonly seen in adults with ADHD and understand their implications for diagnosis (5) understand the developmental relationship of ADHD and SUD, the course of substance abuse in ADHD individuals, preventive influence of ADHD medications on later SUD, and empirically based treatment strategies for patients with ADHD and SUD.

No. 27A
ADULT ADHD DIAGNOSTIC AND SELF-REPORT SYMPTOM SCALES: ASSESSMENT METHODOLOGY FOR DIAGNOSING AND MONITORING TREATMENT OF ADULTS WITH ADHD

Craig B. Surman, M.D., *Department of Psychiatry, Massachusetts General Hospital, 185 Alewife Brook Parkway, Suite 2000, Cambridge, MA 02138*

SUMMARY:

The symptom assessment and diagnosis of adult ADHD remains controversial. This difficulty has arisen from the child-oriented language in DSM-IV. In addition, to properly diagnose adult ADHD, the clinician must be able to probe context. For example, one is likely to get a less than valid response from simply asking about inattention. If the clinician asks about the ability to pay attention in a long meeting, in detailed projects, or reading dense material, the validity of the response is heightened. This presentation will review details of diagnosis and rating symptom severity in adults. Dr. Sunnan will review the use of diagnostic and rating instruments with adult-specific prompts and the Adult ADHD Self Report Scale (ASRS), which corresponded to the 18 items in DSM-IV. The adult instruments have been shown to be highly valid and accurate in diagnosing and assessing adult ADHD. Additionally, the actual scale will be described, along with the diagnostic predictive ranges based on scores for the ASRS. The implications of the utility of these instruments will also be explained.

No. 27B
FUNCTIONAL IMPAIRMENTS IN ADULT ADHD: IMPLICATIONS FOR DIAGNOSIS

Stephen V. Faraone, Ph.D., *Dept. of Psych. and Behavioral Services, SUNY Upstate Medical University, 750 East Adams St, Syracuse, NY 13210;* Joseph Biederman, M.D.

SUMMARY:

Although prior studies have described functional impairments in adult ADHD, more work is needed to understand their scope and their implications for resolving diagnostic uncertainties. We will address these issues with new data from two studies. The first used a telephone survey to compare 500 ADHD adults with 501 gender- and age-matched non-ADHD adults. The second used structured interviews and psychometric testing to compare 285 ADHD adults and 123 non-ADHD adults recruited through advertisements. Both studies found ADHD adults to be impaired in multiple domains: academic achievement, occupational achievement, neuropsychological functioning, and social functioning. The direct interview data examined two types of diagnostic dilemmas; the patient with onset of ADHD after age 7 and the patient who cannot recall sufficient symptoms to meet DSM-IV criteria in childhood. We found that many cases of late-onset ADHD show the same pattern of impairment as early-onset cases, suggesting that the age at onset criterion in DSM-IV is too strict. In contrast, we found less evidence for the validity of diagnosing patients with ADHD who could not recall sufficient symptoms in childhood. We use receiver operating curve analyses to determine what symptom thresholds would be useful for clinicians when diagnosing such patients.

No. 27C
NEW RESEARCH ON ADHD AND SUBSTANCE USE DISORDERS

Timothy E. Wilens, M.D., *Department of Child Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 725, Boston, MA 02114*

SUMMARY:

Objective: The co-occurrence of ADHD and substance use disorders (SUD) in adults has been shown in both clinical and epidemiological settings and is known to be associated with substantial impairment. This presentation will systematically evaluate existing literature depicting the relationship of ADHD and SUD and treatment implications for prevention and intervention of these comorbid patients.

Methods. A systematic review of prospective, retrospective, and survey studies was completed. Recent controlled data relevant to treatment and appropriate use of medications in ADHD individuals are presented.

Results. Studies in ADHD adolescents growing up as well as those in adults with ADHD demonstrate an increased risk and more persistent course of SUD in those with continued ADHD. While ADHD pharmacotherapy reduces the ultimate risk for SUD in ADHD youth growing up, controlled data from multiple studies fails to support that ADHD pharmacotherapy will reduce SUD in active substance abusing adults with ADHD. Very recent data suggest that diversion and misuse of immediate release stimulants continue in a minority of adolescents and young adults with comorbid ADHD and conduct or SUD. Candidate treatment strategies and ADHD medications for patients with ADHD plus SUD will be described.

Conclusions. ADHD is a risk factor for SUD with important clinically relevant developmental associations and treatment implications.

No. 27D
LONG-TERM TOLERABILITY AND EFFECTIVENESS OF ONCE-DAILY MIXED AMPHETAMINE SALTS IN CHILDREN WITH ADHD

Thomas J. Spencer, M.D., *Department of Psychiatry, Mass General Hospital, 15 Parkman Street, WACC 7251, Boston, MA 02114*

SUMMARY:

Since attention-deficit/hyperactivity disorder (ADHD) is a chronic condition requiring extended treatment, there is increasing interest in long-term studies. Dr. Spencer will present the results of a large multi-center study that evaluated the long-term tolerability and effectiveness of extended release mixed amphetamine salts (MAS XR) in children with ADHD. This was a 24-month, open-label study of MAS XR in children with ADHD aged 6 to 12 years. Subjects (N = 568) were treated with doses from 10 to 30 mg/d once daily of MAS XR. Effectiveness was assessed with analysis of quarterly Conners' Global Index Scores, Parents' version (CGIS-P). Tolerability was assessed by monitoring adverse events (AEs), vital signs, physical examinations, and serial laboratory tests. Significant improvements (> 30%, $p < .001$) in CGIS-P scores were maintained during long-term treatment. Treatment was well tolerated. The most frequently reported drug-related AEs included anorexia, insomnia, and headache. Changes in laboratory values and vital signs were modest and not clinically meaningful in children with ADHD, once-daily 10 mg-30 mg MAS XR was well tolerated and significant behavioral improvements were consistently maintained during 24 months of treatment.

No. 27E
LONG-TERM OUTCOME OF ADULTS TREATED WITH EXTENDED-RELEASE MIXED AMPHETAMINE SALTS

Joseph Biederman, M.D., *Department of Psychiatry, Massachusetts General Hospital, 55 Fruit Street, Warren Building 705, Boston, MA 02114;* Thomas J. Spencer, M.D.

SUMMARY:

A 24-month, open-label extension study of a prior double-blind study was conducted to collect data about the long-term safety of Adderall XR® in the treatment of adults with ADHD. Subjects started on a daily dose of Adderall XR® 20 mg for a week. Upward titration was then permitted to Adderall XR® 40 mg for a week, and then if required, to a maximum of Adderall XR® 60 mg. Subsequent dose adjustments between doses of 20 mg, 40 mg, and 60 mg were permitted at the investigator's discretion. Two hundred and twenty-three subjects were enrolled. The mean length of drug exposure was 141.1 days, with a range of five to 304 days. For all subjects, the mean ADHD-RS score at endpoint was 12.2 (±9.95), compared to 20.2 (±12.34) at baseline, for a decrease (improvement) of 8.0 (±12.74). This change was statistically significant ($p<0.001$). Overall, the majority of AEs were mild or moderate; there was evidence of a relationship between Adderall XR® dose and AE incidence for some AEs but not for others. The current safety analysis indicates that Adderall XR®, dosed at 20 mg, 40 mg, and 60 mg daily, is safe treatment for adults with ADHD.

REFERENCES:

1. Adler L, Cohen J: Diagnosis and evaluation of adults with ADHD, in Adult ADHD. Edited by Spencer T. Psychiatric Clinics of North America 2004; 2712:187–201.
2. Faraone SV, Spencer T, Montano CB, Biederman J: Attention deficit hyperactivity disorder in adults: a survey of current practice in psychiatry and primary care. Archives of Internal Medicine, in press.
3. Spencer T, Biederman J, Wilens T, Harding M, O'Donnell D, Griffin S: Pharmacotherapy of ADHD across the lifecycle: A Literature Review, J Am Acad Child Adolesc Psychiatry 1996; 35(4):409–432.
4. Spencer T, Biederman J, Wilens T: Stimulant treatment of adult attention-deficit hyperactivity disorder, in Adult ADHD. Edited by Spencer T. Psychiatric Clinics of North America, Philadelphia: W.B. Saunders, 2004, pp 361–372.

5. Wilens T: ADHD and substance abuse. Psychiatr Clin North Am 2004; 27(2)283–301.

INDUSTRY-SUPPORTED SYMPOSIUM 28—EMERGING BEST PRACTICES IN THE MANAGEMENT OF BEHAVIORAL EMERGENCIES
Supported by Bristol-Myers Squibb Company and Otsuka America Pharmaceutical, Inc.

EDUCATIONAL OBJECTIVES:

- Appreciate the putative distinction between agitation as a symptom and agitation as a precursor of a behavioral emergency
- Appreciate the current practice standard (including the appropriate level of lab oratory/medical assessments) in the evaluation of the acutely agitated patient
- Discuss management options for behavioral emergencies that are consistent with consumers' medical needs and preferences
- Evaluate the emerging role of atypical antipsychotics in behavioral emergencies and discuss mechanism of action for early-onset antipsychotic effect
- Appreciate the emergent role and clinical impact of oral dissolvable and acute intramuscular formulations of second-generation antipsychotics in the acute management of agitation and aggression

No. 28A
IS AGITATION INEVITABLY A PRECURSOR TO AGGRESSION?

Rosalind A. Spells, M.D., *Department of Psychiatry & Health Behavior, Medical College of Georgia, 3523 Crawfordville Drive, Augusta, GA 30909-9437*

SUMMARY:

Agitation is a prominent feature of the acute presentation of many psychiatric illnesses, including dementia, anxiety, major mood and psychotic disorders. Agitation can predispose a patient to combativeness and aggressive behavior, putting the patient and others at risk of injury. Although relatively infrequent, aggression represents a significant concern for patients, families, and communities in patients with serious mental illness. Recognition of this risk and providing access and continuity of care should be the major goal in the management of agitated psychotic patients. However, our field remains perplexed as to whether agitation represents a behavioral manifestation in its own right or whether, moving along a continuum of severity, agitation is a behavioral precursor of aggression. This is an important distinction since this clinical interpretation will reinforce decision making processes for the evaluating clinician as to both the immediacy and selection of treatment choices. This presentation will address the clinical features of agitation and the clinicians' ability to prevent its progression to aggression and violence.

No. 28B
ASSESSMENT OF THE ACUTELY AGITATED PATIENT WITH PSYCHOSIS

Joseph P. McEvoy, M.D., *Department of Psychiatry, Duke University, Box 3950 DUMC, Durham, NC 27710*

SUMMARY:

Clinicians assessing an acutely agitated patient with psychosis must determine quickly if the patient can cooperate with the assessment and if the patient is at imminent risk for becoming violent. Agitated psychosis is a behavioral emergency because it is associated with an increased risk for violence, and because it can interfere with the identification of underlying medical conditions that require immediate treatment. Adequate staff must be available during the assessment to assure safety and containment should the patient become violent.

Clinicians can predict violence only to a modest degree, even for the short term. Errors tend to be false-positive predictions that certain individuals will behave dangerously, but these individuals prove not to do so. This may, in part, reflect successful clinical management following a determination of risk.

Factors associated with risk for violence include a prior history of violence and/or comorbid substance use disorder currently unmedicated psychosis, current violent impulses, and/or current intoxication or withdrawal. Patients may be able to report attributes of the environment that they perceive to be provocative and to suggest interventions to help them retain behavioral control. Early treatment with an antipsychotic can preempt violence and permit thorough evaluation of the patient's condition.

No. 28C
CONSIDERING CONSUMER CHOICE DURING THE MANAGEMENT OF BEHAVIORAL EMERGENCIES

Michael H. Allen, M.D., *Department of Psychiatry, University of Colorado, North Pavillion, 4455 E.12th Avenue, #A011-95, Denver, CO 80220*

SUMMARY:

Managing behavioral emergencies has become increasingly controversial as public awareness of the hazards has increased. The term "chemical restraint," introduced to distinguish safer medication strategies from more dangerous physical management, is now viewed as inappropriate in some regulatory schemas. The central issue in behavioral emergencies is power: who will choose what to do and how will they choose? Choice will be important to consumers no matter what alternatives are available. However, the importance of the choice has been exaggerated by the poor alternatives for managing agitation historically. In fact, providers need to understand that consumers often view their treatment in these situations as traumatic. This program will offer a consumer perspective on behavioral emergencies, which begins with the premise that consumers have relevant experience and credible ideas about their difficulties and how to manage them but have difficulty communicating them in the midst of a crisis. A number of strategies will be offered for improving communication, beginning with a therapeutically informed approach to speaking with individual patients. If that is not possible, consumers advocate the use of advance directives and collateral informants. However, in some cases there will be no information available for particular consumers. Providers then serve as proxy decision makers. To guide those decisions, the preferences of consumers as a group may be a useful guide. Consumer survey data will be presented regarding modifiable elements of restraint, seclusion, and emergency medication.

No. 28D
DO ATYPICAL ANTIPSYCHOTICS WORK FAST ENOUGH IN BEHAVIORAL EMERGENCIES?

Robert B. Zipursky, M.D., *Department of Psychiatry, University of Toronto Clarke Institute, 250 College Street, Room 732, Toronto, ON M5T 1R8, Canada*

SUMMARY:

Rapid control of agitation is a priority in the emergency management of patients with psychosis. Agitated patients with psychosis are often managed with a combination of sedative and antipsychotic medications. This requires titration of medications to achieve control of both agitation and psychosis as well as an appreciation of the time frame over which these effects can be achieved. While psychotic symptoms can be expected to resolve over a much longer time frame than agitation itself, the precise time course over which psychotic symptoms can be expected to resolve is not clear. It has been standard teaching that antipsychotic response occurs with a latency of three to four weeks following initiation of antipsychotic medication. However, recent evidence suggests that the rate of improvement in psychotic symptoms is actually greatest in the first two weeks of treatment, with improvement accumulating over subsequent weeks. Furthermore, recent data derived from a study of atypical antipsychotics suggest that antipsychotic response can be detected in the first 24 hours of treatment, long before achieving steady-state antipsychotic levels. Studies utilizing positron emission tomography to investigate the time course of dopamine D2 receptor occupancy by antipsychotic medications have provided new insights into how these medications bring about antipsychotic response.

No. 28E
ACUTE STABILIZATION WITH ATYPICAL ANTIPSYCHOTICS: NEW THERAPEUTIC OPTIONS

Peter F. Buckley, M.D., *Department of Psychiatry, Medical College of Georgia, 1515 Pope Avenue, Augusta, GA 30912-3800*

SUMMARY:

Until relatively recently, acute management of aggression favored conventional antipsychotics, especially mid- to high-potency agents, because of their efficacy, ease of use, and availability in multiple (tablet, liquid, and intramuscular) forms. Now there is greater experience with as-needed dosing and with acute titration dosing of atypical antipsychotics. In addition, several atypicals are now available in rapidly dissolving, oral concentrate, and acute intramuscular formulations. These agents are rapidly becoming treatments of choice in behavioral emergencies. Available data confirm the efficacy of atypical antipsychotics in acute stabilization of behavioral emergencies. These studies range from naturalistic emergency room studies to "elegant," intensive (24-hour), placebo-controlled, double-blind designs. The advantage of low incidence of extrapyramidal symptoms (EPS) during acute stabilization with atypical antipsychotics is compelling, particularly since acute EPS are so deleterious to the long-term therapeutic alliance. Additionally, the weight gain and metabolic disturbances associated with atypical antipsychotics are more of a longer-term consideration. Thus, the risk-benefit ratio of atypical vs conventional antipsychotics is more favorable in the acute setting. This presentation will provide the latest information on the use of atypical antipsychotics in multiple formulations to achieve acute stabilization of behavioral emergencies.

REFERENCES:

1. Buckley PF, Smith DA, et al: Treatment of the psychotic patient who is violent. Psych Clin N America 2003; 20:231–272.
2. Allan MH, Carpenter D, Sheets J. et al: What do consumers say they want and need during a psychiatric emergency? J Psych Practice 2003; 9:39–58.
3. Allen MH, Carpenter D, Sheels J, et al: What do consumers say they want and need during a psychiatric emergency? J Psychiatr Pract 2003; 9:39–58.
4. Agid O, Kapur S, Arenovich T, Zipursky RB: Delayed-onset hypothesis of antipsychotic action: a hypothesis tested and rejected. Arch Gen Psychiatry 2003; 60:1228–1235.
5. Buckley PF, Noffsinger SG, Smith DA, Hrouda DR, Knoll JL 4th: Treatment of the psychotic patient who is violent. Psychiatr Clin North Am 2003; 26:231–272.

INDUSTRY-SUPPORTED SYMPOSIUM 29—BEYOND NEUROCHEMISTRY: THE IMPLICATIONS OF NEUROCIRCUITRY FOR UNDERSTANDING AND MANAGING PSYCHIATRIC DISORDERS
Supported by Eli Lilly and Company

EDUCATIONAL OBJECTIVES:

Practitioners have become familiar with neurotransmitters and synapses but generally know less about the regional brain neuroanatomy and neural circuitry implicated in psychiatric disorders. It is becoming apparent that psychiatrists will need to know the anatomy of our organ of interest—the brain—like other physicians know theirs. In fact, recent advances in brain cytoarchitectural research, brain imaging, and genetics are rapidly providing new understanding of the anatomical pathophysiology of psychiatric disorders. Still, there is little opportunity for the practicing psychiatrist to access this new knowledge. The presenters will discuss disturbances of brain regions and interconnencting neural circuitry that appear unique to each psychiatric disorder, which may generate new insights into diagnostic and treatment possibilities. Dr. Trzepacz will present a high-level overview of neuroanatomy related to behavior, including the prefrontal cortex, limbic structures, thalamic-prefrontal-subcortical circuits, white matter pathways, ascending neurotransmitter pathways, thalamus, and cytoarchitecture of human fetal brain development. Dr. Lewis will discuss neural circuit abnormalities of schizophrenia. Dr. Mayberg will discuss the evidence from multiple sources for limbic, subcortical, and frontal cortex circuitry involved in major depressive disorder including innovative work using PET and fMRI. Dr. Bush will review evidence implicating frontostriatal network abnormalities as the likely cause of attention-deficit/hyperactivity disorder (ADHD) and how functional, biochemical, and structural imaging tools may be used now and in the future for diagnostic purposes and drug development. Dr. Kaye will discuss brain regions and serotonin neural pathways implicated in symptoms of anorexia nervosa, in particular, anxiety. In summary, this symposium will place a strong emphasis on discussing concepts in neurocircuitry and making the presentations informative, and even entertaining, for the practicing clinician.

No. 29A
NEUROANATOMY OF BEHAVIOR 101

Paula T. Trzepacz, M.D., *Neuroscience Research Department, Eli Lilly and Company, Lilly Corporate Center, Indianapolis, IN 46285*

SUMMARY:

There has been an explosion of research about brain regions and neural circuitry that subserve cognition and behavior. Journal articles increasingly include research about how neuroanatomical areas relate to psychiatric disorders. However, many psychiatrists are uncomfortable in their level of knowledge about the brain anatomy, in part because many of us were taught more in medical school about the primary motor and sensory and language regions of the brain with little emphasis on the regions and pathways related to behavior, perception, and cognition. This presentation will do a high-level overview of brain areas relevant to psychiatrists, including prefrontal cortices, thalamus, temporal-limbic structures (accumbens, amygdala, and hippocampus), cingulate gyrus, polymodal sensory association area, basal ganglia, white matter pathways, and key circuits

such as frontal-subcortical-thalamic and fornix. Brief mention of normal function or clinical conditions resulting from dysfunction of these regions will be made throughout. In addition, cytoarchitectural fetal development of the human prefrontal cortex will be described because of its relevance to psychiatric disorders such as depression, schizophrenia, and bipolar disorder.

No. 29B
NEUROCIRCUITRY OF SCHIZOPHRENIA

David A. Lewis, M.D., *Department of Psychiatry, University of Pittsburgh School of Medicine, 3811 O'Hara Street, W1650 BST, Pittsburgh, PA 15213-2593*

SUMMARY:

Over the past decade, a growing number of in vivo imaging and postmortem studies have revealed convergent findings that may provide an anatomical substrate for the clinical features that characterize schizophrenia. For example, deficits in certain critical cognitive functions, which appear to represent core features of schizophrenia, reflect disturbances in the circuitry of the dorsolateral prefrontal cortex and interconnected brain regions. This presentation will review the organizational principles that govern the functional properties of these neural networks in the normal brain and the alterations, at both the macro- and microcircuitry levels, that are present in schizophrenia. The potential relationship between these abnormalities and disturbances in the circuitry that may contribute to altered auditory information processing, including psychosis, in individuals with schizophrenia, will also be considered. These findings will be discussed in the context of how they improve our understanding of both the pathogenesis and pathophysiology of schizophrenia and their implications for the development of novel treatment interventions.

No. 29C
NEUROBIOLOGICAL SUBSTRATES OF ADHD

George Bush, M.D., *Psychiatric Department, Massachusetts General Hospital, Building 149, 13th Street, CNY 9117, Charlestown, MA 02129*

SUMMARY:

Attention-deficit/hyperactivity disorder (ADHD) is characterized by developmentally inappropriate symptoms of inattention, impulsivity, and motor restlessness. ADHD affects approximately 5% of school-age children and persists to a lesser degree into adulthood. Given the great morbidity associated with the disorder, including persistent neuropsychological impairments, determining the underlying neurobiology of ADHD is of great importance. Recent reviews of data from neuroimaging, neuropsychological, genetic, and neurochemical studies have generally implicated frontostriatal network abnormalities as the likely cause of ADHD. In particular, the dorsal anterior cingulate cortex, dorsolateral prefrontal cortex, caudate, corpus callosum, and cerebellum have been shown to display morphological and functional abnormalities that may lead to the clinical pathology observed in this disorder. This presentation will review the convergent evidence from structural and functional neuroimaging studies relevant to ADHD. For the clinician, this presentation will also place the neuroimaging work in the context of other forms of research to provide an understanding of how functional, biochemical, and structural imaging tools may be used now and in the future for diagnostic purposes and drug development.

No. 29D
IN SEARCH OF DEPRESSION CIRCUITS

Helen S. Mayberg, M.D., *Department of Psychiatry, Emory University School of Medicine, 101 Woodruff Circle, WMRB Suite 4313, Atlanta, GA 30322*

SUMMARY:

Converging clinical, postmortem, and neuroimaging evidence suggests that depression is unlikely a disease of a single brain region or neurotransmitter system. Rather, it is now often conceptualized as a multidimensional, systems-level disorder affecting discrete but integrated pathways involving select cortical, subcortical, and limbic sites and their related neurotransmitter and molecular mediators. In support of this hypothesis, a synthesis of PET and fMRI studies performed in patients with depression will be presented and interpreted in the context of a theoretical limbic-cortical network depression model. In this model, a major depressive episode is considered the net result of maladaptive functional interactions among a highly integrated network of limbic/paralimbic (amygdala, hippocampus, cingulate, insula), subcortical (brainstem, hypothalamus, basal ganglia, thalamus), and frontal (orbital, medial, dorsolateral) regions, normally responsible for maintaining homeostatic emotional control in response to cognitive and somatic stress. Network dysfunction, combined with variable intrinsic compensatory processes, is further seen to explain the heterogeneity of depressive symptoms observed clinically, as well as variations in pretreatment scan patterns described experimentally. Selective modulation of specific nodes linking these dysfunctional pathways are, in turn, targets of various treatments. Converging findings will be reviewed from these perspectives highlighting disease, state, and treatment-specific effects.

No. 29E
NEURAL PATHWAYS AND BEHAVIOR IN ANOREXIA NERVOSA

Walter H. Kaye, M.D., *Department of Psychiatry, University of Pittsburgh, 38114 O'Hara Street, Suite 600, Iroquis Bldg., Pittsburgh, PA 15213*

SUMMARY:

Anorexia nervosa (AN) is a relatively homogenous disorder in terms of age of onset, gender distribution, and patterns of symptoms. The consistency of many of the symptoms, such as food refusal, body image distortion, anxiety and obsessions, and ego-syntonic neglect, raises the possibility that these symptoms reflect disturbed brain function that contributes to pathophysiology of this illness. Recent brain imaging studies have identified altered activity in frontal, cingulate, temporal, and parietal cortical regions in AN. Importantly, such disturbances are present when subjects are ill and persist after recovery, suggesting that these may be traits that are independent of the state of the illness. Emerging data point to a dysregulation of serotonin-dopamine pathways in cortical and limbic structures that may help understand aymptoms such as anxiety, behavioral inhibition, or body image distortions. Moreover, alterations of these cirduits may affect the motivating and hedonic aspects of feeding behavior. Finally, imaging studies may shed light on why SSRI medications are not effective in the ill state and offer insights into pharmacology and even psychotherapy approaches.

REFERENCES:

1. Tranel D: Functional neuroanatomy: neuropsychological correlates of cortical and subcortical damage, in The American Psychiatric Publishing Textbook of Neuropsychiatry and Clinical Neurosciences, 4th edition. Edited by Yudofsky SC, Hales RE. Washington, DC, American Psychiatric Publishing, Inc., 2002, pp. 71–113.

2. Lewis DA, Lieberman JA: Catching up on schizophrenia: natural history and neurobiology. Neuron 2000; 28:325–334.
3. Bush G, Frazier JA, Rauch SL, Seidman LJ, Whalen PJ, Jenike MA, Rosen BR, Biederman J: Anterior cingulated cortex dysfunction in attention-deficit/hyperactivity disorder revealed by fMRI and the Counting Stroop. Biol Psychiatry 1999; 45:1542–1552.
4. Mayberg HS: PET Imaging in depression: a neurosystems perspective. Neuroimaging Clin NA 2003; 13(4):805–815.
5. Bailer UF, Price JC, Meltzer CC, Mathiis CA, Frank GK, Weissfeld L, McConaha CW, Henry SE, Brooks-Achenbach S, Barbarich NC, Kaye WH: Altered 5-HT_{2A} receptor activity after recovery from bulimia-type anorexia nervosa: relationships to harm avoidance and drive for thinness. Neuropsychopharmacology, in press.

INDUSTRY-SUPPORTED SYMPOSIUM 30—FROM MOLECULAR INSIGHT TO CLINICAL OUTCOMES: RECENT ADVANCES IN SCHIZOPHRENIA TREATMENT
Supported by Pfizer Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: (1) differentiate among the conventional and atypical antipsychotic agents with respect to their effects on neurotransmitter systems and will be able to discuss their pulative differences in effect on mood symptoms in patients with schizophrenia. (2) address the importance of evaluating new options in the contest of "real-world" scientific studies, such as the highly innovative CATIE, which is examining both patient and clinician choices among a range of antipsychotic medications.

No. 30A
HOW ANTIPSYCHOTICS WORK: FROM RECEPTORS TO REALITY

Shitij Kapur, M.D., *Department of Research, University of Toronto, 33 Russell Street, Toronto, ON M55 251, Canada*

SUMMARY:

The clinical hallmark of schizophrenia is psychosis—an experience at the phenomenological level while most theories about how antipsychotics work focus on a receptor—a neurochemical entity expressed at a single cell level. How can one relate these findings at receptor level to the reality of the patient? It has becn proposed that dopamine firing has a role in detection of novel unpredicted rewards (Schultz et al) and that dopamine release, particularly within the mesolimbic system, has a central role in mediating the "salience" of the environment and its internal representations (Berridge et al). We propose a dysregulated hyperdopaminergic state (whatever its primary origins) leads to a process of abnormal sense of novelty and abnormal assignment of salience. Delusions are a cognitive effort by the patient to make sense of these aberrantly salient experiences and associations, whereas hallucinations reflect a direct experience of the aberrant salience of internal representations. Antipsychotics, in this framework, exert their anti-"psychotic" effect by "dampening" the motivational salience of these abnormal experiences and associations—and by doing so provide a platform for psychological resolution of symptoms. This idea runs counter to the well accepted "delayed onset" of antipsychotic action and data will be provided which tests this hypothesis. Other predictions of this hypothesis—particularly regarding the possibility of synergy between psychological and pharmacological therapy will be presented.

No. 30B
CLINICAL EFFECTIVENESS OF ATYPICAL ANTIPSYCHOTIC THERAPY

Thomas S. Stroup, M.D., *Department of Neuroscience, UNC Chapel Hill School of Medicine, CB#7160 101 Manning Drive, Chapel Hill, NC 27599-7160*

SUMMARY:

Since clozapine was approved for use in the U.S. in 1990, five other atypical antipsychotics have been approved for use and they have come to dominate the market. The atypicals have clear advantages in terms of extrapyramidal side effects. Advantages of atypicals in reduction of positive symptoms, negative symptoms, cognitive dysfunction, and relapse prevention have been reported but remain controversial. Metabolic side effects of atypical antipsychotics have recently drawn attention. The overall effectiveness of the drugs is a function of their efficacy, safety, and tolerability in typical patients and settings. The presentation will review current evidence of the drugs' effectiveness, including the latest data from clinical trials.

No. 30C
COGNITIVE EFFECTIVENESS OF ATYPICAL ANTIPSYCHOTIC THERAPY

Philip D. Harvey, Ph.D., *Department of Psychiatry, Mt. Sinai Medical Center, 1425 Madison Avenue, New York, NY 10029*

SUMMARY:

Cognitive enhancement has been demonstrated with novel antipsychotic medications. These studies have been plagued by methodological problems; short duration of the studies, or use of nonblinded methodology. This lecture will present the results of recent, more sophisticated studies.

Five separate clinical trials will be reported. Each involved direct comparison of newer antipsychotic medications to each other or to older medications. A newer study of cognitive enhancement with novel strategy, alpha-2 antagonism, will also be described.

Treatment with newer antipsychotic medications was associated with wide-ranging cognitive functioning changes relative to treatment with older medications. Improvements were found in learning and memory, vigilance, executive functioning, and visuomotor skills. Perhaps more important, the rate of skills learned and practice-related improvement in information processing were notably better in patients treated with newer antipsychotic medications. Lastly, patients treated with newer antipsychotics plus alpha-2 agonist manifested improvements in working memory and vigilance, while patients on low-doses of haloperidol plus alpha-2 agonist did not improve.

These data suggest that cognitive functioning, the most consistent predictor of functional outcome in schizophrenia, is markedly improved by treatment with newer antipsychotics compared with conventional medications. These data indicate that use of older antipsychotic medications should be reconsidered, especially in light of previous findings that these medications are not associated with improvement in functional outcome relative to the early days of the 20^{th} century.

No. 30D
ENHANCING CLINICAL CARE IN SCHIZOPHRENIA: PRIMARY HEALTH CARE NEEDS

Gail L. Daumit, M.D., *Department of Medicine, Johns Hopkins University, 2024 East Monument Street 2-500, Baltimore, MD 21205*

SUMMARY:

Individuals with schizophrenia have a high burden of comorbid somatic conditions compared with the general population, including diabetes mellitus, chronic obstructive pulmonary disease, hypertension, and coronary artery disease, liver disease, and HIV. Many of these conditions are potentially preventable or ameliorable through reduction in the behavioral risk factors of smoking, diet, exercise, and substance abuse. In addition, these somatic conditions are chronic and require ongoing medical care for optimal treatment. Although persons with schizophrenia in mental health treatment are likely to have a primary care physician, they may not receive appropriate care.

A study by Dickerson and Dixon in two Maryland outpatient mental health clinics showed patients with SMI who are engaged in mental health treatment often do have a general medical provider and regular physical exams, yet participants were less likely to have had their cholesterol level checked or to receive a mammogram. Further, participants reported significant barriers to accessing primary care. Challenges in delivering high-quality primary care to persons with schizophrenia may be due to patient factors, provider factors, health system factors, or a combination. Preliminary evidence suggests coordination of care between psychiatry and primary care can lead to improved physical health outcomes. An evidence-based review of the needs for and quality of primary care in schizophrenia will be presented in addition to a new paradigm for enhancing primary care for this population.

No. 30E
TRANSLATING SCIENTIFIC RESEARCH INTO CLINICAL PRACTICE

Jeffrey A. Lieberman, M.D., *Department of Psychiatry, Columbia University Medical Center, 1051 Riverside Drive, Unit 4, New York, NY 10032*

SUMMARY:

Translating scientific research into clinical practice is becoming increasingly challenging as state-of-the-art neuroscientific studies in molecular genetics, molecular neuropathology, neurophysiology, in vivo brain imaging, and psychopharmacology improve our understanding of the schizophrenic process and begin to uncover the molecular basis of schizophrenia. Yet, unique therapies are charged with proving their value in the context of heightened cost containment and patient acceptance. Few studies are constructed to compare the agents of a new class in typical clinical populations and settings. The NIMH CATIE trial is designed to provide extensive information about antipsychotic drug effectiveness over at least 18 months. The innovative protocol of this large, multisite study allows for patients who receive a study drug that is not effective to receive subsequent treatment within the study. The primary outcome is all-cause treatment discontinuation, which reflects both clinician and patient judgments about efficacy and tolerability. This presentation will review the scientific approach of the CATIE study, its relevance to real-world clinical practice, and hypothesized outcomes.

REFERENCES:

1. Kapur S: Psychosis as a state of aberrant salience: a framework linking biology, phenomenology, and pharmacology in schizophrenia. American Journal of Psychiatry 2003; 160:13–23.
2. Davis JM, Chen N, Glick I: A meta-analysis of the efficacy of second-generation antipsychotic drugs. Archives of General Psychiatry 2003; 50:553–564.
3. Harvey PD, Keefe RS: Studies of cognitive changes inpatients with schizophrenia following novel antipsychotic treatment. Am J Psychiatry 2001; 158:176–184
4. Dickerson FB, McNary SW, Brown CH, Kreyenbuhl J, Goldberg RW, Dixon LB: Somatic health care utilization among adults with serious mental illness who are receiving community psychiatric services. Med Care 2003; 41(4):560–570.
5. Miyamoto S, et al: Recent advances in the neurobiology of schizophrenia. Mol Interv 2003; 3:27–29.

MONDAY MAY 23, 2005

INDUSTRY-SUPPORTED SYMPOSIUM 31—AGITATION AND PSYCHOSIS IN ALZHEIMER'S DISEASE AND PARKINSON'S DISEASE, PART 1
Supported by AstraZeneca Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the diagnosis and assessment of agitation and psychosis in patients with Alzheimer's disease and Parkinson's disease; understand the strengths, and weaknesses of pharmacologic agents in the management of psychosis and agitation in patients with Alzheimer's disease and Parkinson's disease; understand how to use atypical antipsychotics to treat symptoms of psychosis in Parkinson's disease.

No. 31A
DIAGNOSIS AND ASSESSMENT OF PARKINSON'S DISEASE AND ALZHEIMER'S DISEASE

Daniel Weintraub, M.D., *Geriatric Psychiatry Division, University of Pennsylvania, 3535 Market St, Philadelphia, PA 19104*

SUMMARY:

Psychosis and agitation occur frequently in Parkinson's disease (PD), Alzheimer's disease (AD), and related dementias, such as mixed dementia and dementia of Lewy bodies (DLB). They frequently co-occur and may have a number of contributing factors, including progressive cognitive impairment, comorbid psychiatric conditions, concurrent medical illness, pain, insomnia, and medication side effects.

Assessment of neuropsychiatric complications in dementia begins with a careful history to both classify the specific dementia type and to characterize the presentation and course of psychiatric symptoms. Although inter-individual variability is common, disease-specific patterns are reported. For instance, isolated hallucinations are common in PD, whereas more complex psychotic and comorbid behavioral symptoms are typical in AD. Several diagnostic instruments for psychosis and agitation are available for use in neuropsychiatric diseases, including the Neuropsychiatric Inventory (NPI), the Cohen-Mansfield Agitation Inventory (CMAI), the Brief Psychiatric Rating Scale (BPRS), and the Parkinson's Psychosis Rating Scale (PPRS).

This talk will focus on similarities and differences in the presentation of psychosis and agitation in common neurodegenerative diseases, how best to assess and evaluate these symptoms, and the utility of commonly used diagnostic instruments for psychosis and agitation in clinical research and routine clinical care.

No. 31B
IMAGING AND NEUROBIOLOGICAL UNDERPINNINGS: PSYCHOSIS AND AGITATION

David L. Sultzer, M.D., *Department of Psychiatry, VA Greater Los Angeles Health Care System, 11301 Wishire Boulevard 3South Room 3424, Los Angeles, CA 90073*

SUMMARY:

Psychosis and behavioral disturbances contribute substantially to the morbidity and caregiver stress of Alzheimer's disease (AD) and other neurodegenerative disorders. Despite the importance of these symptoms, the mechanisms involved in their expression are not well understood.

Recently, studies have revealed neurobiological factors that likely contribute to psychosis and agitated behavior among patients with these disorders. Neuroimaging studies using PET or SPECT in vivo have demonstrated dysfunction in critical frontal cortex regions, particularly in the right hemisphere, among patients with AD and delusions. Regional neuropathology studies have shown that neurofibrillary tangles in frontal cortex and anterior cingulate post-mortem are linked to psychosis and agitation over the course of illness. Assays of serotonergic, cholinergic, and dopaminergic activity suggest regional alterations in these neurochemical markers among patients with psychosis or aggression. Finally, specific genetic polymorphisms appear to contribute to the risk for psychosis in AD. These factors may confer risk for individual clinical features, may be state or trait biomarkers for specific symptoms, or may modulate the qualitative expression of symptoms.

These findings help to define the substrate for psychiatric symptoms in neurodegenerative illnesses, and can aid understanding of symptom profiles and treatment opportunities. Treatment strategies that target neurobiological underpinnings, in concert with environmental interventions, can improve patient care.

No. 31C
TREATMENT OF PSYCHOSIS IN PARKINSON'S DISEASE

Jeffrey L. Cummings, M.D., *Department of Neurology, UCLA Alzheimer's Disease Center, 710 Westwood Plaza, Ste. 2238, Los Angeles, CA 90095;* Daniel Weintraub, M.D., Jeanne Jackson-Siegel, M.D., Pierre N. Tariot, M.D., David L. Sultzer, M.D.

SUMMARY:

Parkinson's disease (PD) is characterized by the triad of bradykinesia, rigidity, and rest tremors; symptoms are responsive to treatment with dopaminergic agents. The neurobiology of PD involves loss of pigmented cells in the substantia nigra and other brainstem nuclei, Lewy bodies in affected cells, and dopaminergic deficits. Serotonergic abnormalities are present in patients with PD and depression; cortical Lewy bodies, and cholinergic deficits are noted in patients with PD and dementia. Psychosis is present in approximately 30% of patients with PD. It occurs in association with dopaminergic therapy in patients rendered vulnerable to the psychotomimetic effects of dopamine by the presence of cognitive impairment, depression, and more severe disability. Sleep disturbances and hallucinations commonly precede the delusions. Atypical antipsychotics are the agents most commonly used to reduce symptoms of psychosis in PD. Clozapine has been shown to significantly reduce delusions and hallucinations without increasing parkinsonism in a randomized controlled trial. Olanzapine and risperidone are effective treatment alternatives; they may increase parkinsonism. Quetiapine is safe and effective in reducing psychosis in PD. Few data are available regarding the use of aripiprazole or ziprasidone in this setting. Guidelines optimizing the use of these agents in PD are based on evidence of effectiveness, safety, and tolerability.

REFERENCES:

1. Aarsland D, Cummings JL, Larsen JP: Neuropsychiatric differences between Parkinson's disease with dementia and Alzheimer's disease. Int J Geriatr Psychiatry 2001; 16: 184–191.
2. Sultzer DL, Brown C, Mandelkern MA: Delusional thoughts and regional frontal/temporal cortex metabolism in Alzheimer's disease. Am J Psychiatry 2003; 160:341–349.
3. Schneider LS, Tariot PN, Lyketsos CG, et al: National Institute of Mental Health Clinical Antipsychotic Trials in Intervention Effectiveness (CATIE)—Alzheimer's Disease Trial Methodology. Am J Geriatr Psychiatry 2001; 9:346–360.

INDUSTRY-SUPPORTED SYMPOSIUM 32—MANAGING THE SPECTRUM OF BIPOLAR DISORDER: MINIMIZING THE BURDEN OF DISEASE, PART 1

Supported by Bristol-Myers Squibb Company and Otsuko America Pharmaceutical, Inc.

EDUCATIONAL OBJECTIVES:

- discuss the latest research on pathophysiology of bipolar disorder, and identify key problems in the differential diagnosis of bipolar disorders (type I, type II, and other affective disorders).
- effectively utilize pharmacotherapy in management of patients with acute mania and differentiate between atypical antipsychotics and mood stabilizers with respect to their efficacy, tolerability, and safety profiles, integrating the long-term clinical implications of adverse effects.

No. 32A
PRACTICAL APPROACHS TO THE DIAGNOSIS OF BIPOLAR DISORDER

Claudia F. Baldassano, M.D., *Department of Outpatient Psychiatry, University of Pennsylvania, 3535 Market Street, 2nd Floor, Philadelphia, PA 19104-3309*

SUMMARY:

The distinction between bipolar type I and type II disorders and the discrimination of both from other affective disorders can be problematic. Bipolar type I disorder involves manic or mixed episodes with or without depressive ones; bipolar type II disorder involves depressive episodes and at least one hypomanic episode. The differentiation of bipolar from unipolar depression may be difficult, and the definition of hypomania, a key element of bipolar type II disorder, has been the subject of controversy. Regardless of type, the pathophysiology of bipolar disorder is still largely unknown. Recent research suggests that the pathophysiology of bipolar (as well as unipolar) depression involves a deficiency in brain-derived neurotrophic factor and abnormalities in mitochondrial function. The pathophysiology of mania may involve alterations in intracellular signaling cascades as well as impairments of cellular plasticity and resilience in critical neuronal circuits. Among the affected circuits may be those involving dopamine and serotonin. This possibility is suggested by the efficacy in bipolar disorder of antipsychotic drugs, which are known to act at dopamine and serotonin receptors.

No. 32B
OPTIMIZING PHARMACOTHERAPY IN THE TREATMENT OF ACUTE MANIA

Terence A. Ketter, M.D., *Department of Psychiatry, Stanford University, School of Medicine, 401 Quarry Road, Room 2124, Stanford, CA 94305-5723*

SUMMARY:

Management strategies for acute mania have evolved considerably in the last several years with several agents receiving FDA approval for this indication. Recent clinical trials demonstrate the utility of atypical antipsychotics for the management of acute mania either alone or in combination with mood stabilizers. The current APA guideline recommends treating mild-to-moderate manic or mixed episodes with an atypical antipsychotic or a mood stabilizer, and managing severe or breakthrough episodes with a combination of the two. The atypical antipsychotics as a class appear effective in acute mania, offering rapid onset of action and a broad efficacy spectrum. However, these agents differ from one another with respect to their tolerability and safety profiles, which have significant clinical implications, particularly with chronic administration. Integrating such efficacy and tolerability considerations is crucial in optimizing pharmacotherapy of acute mania.

REFERENCES:

1. Evens DL: Bipolar disorder: diagnostic challenges and treatment considerations. J Clin Psychiatry 2000; 61(suppl 13):26–31.
2. Yatham LN: Acute and maintenance treatment of bipolar mania: the role of atypical antipsychotics. Bipolar Disord 2003; 5 Suppl 2:7–19.

INDUSTRY-SUPPORTED SYMPOSIUM 33—ADVANCES IN THE TREATMENT OF MOOD AND ANXIETY DISORDERS IN WOMEN, PART 1
Supported by Wyeth Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to demonstrate increased knowledge of mood and anxiety disorders in women, particularly with regard to gender differences and the impact of reproductive events on presentation and treatment.

No. 33A
ANXIETY DISORDERS IN WOMEN

Teresa A. Pigott, M.D., *Department of Psychiatry, University of Florida, 2970 Hartley Road, Suite 202, Jacksonville, FL 32257*

SUMMARY:

Women have higher overall prevalence rates for anxiety disorders than men. Women are also much more likely than men to meet lifetime criteria for each of the specific anxiety disorders: GAD, OCD, SAD, PTSD, simple phobia, panic disorder, and agoraphobia. Anxiety disorders remain under-recognized and under-treated, despite considerable evidence of their association with severe functional impairment and increased morbidity and mortality rates. Significant gender differences have been identified in the onset and clinical course of anxiety disorders, especially for OCD, GAD, SAD, and PD. In addition, female reproductive hormone cycle events appear to have a significant influence on the time of anxiety disorder onset, course, and risk of comorbid conditions throughout the female lifecycle. There is also emerging evidence suggesting that pharmacological treatment response in the anxiety disorders, e.g., in PTSD, may also be significantly impacted by gender. Further investigations concerning the unique features present in women with anxiety disorders are clearly needed and may well represent the best strategy to increase identification and optimize treatment interventions for women afflicted with these long neglected psychiatric disorders. These issues will be discussed and reviewed; in brief, during this presentation.

No. 33B
ANTIDEPRESSANT TREATMENT OF PMS AND PMDD

Susan G. Kornstein, M.D., *Department of Psychiatry, Virginia Commonwealth University, 3805 Cutshaw Avenue, Suite 504, Richmond, VA 23230*

SUMMARY:

While PMS affects as many as 30% to 50% of women, only about 5% meet criteria for premenstrual dysphoric disorder. PMS may be manifest by either mood or physical symptoms that may or may not cause functional impairment. In contrast, a diagnosis of PMDD requires the presence of severe mood disturbance that significantly interferes with daily functioning. Antidepressants are the first-line treatment strategy for PMDD. Among the antidepressants, the SSRIs and venlafaxine have been shown to be efficacious. Although treatment research has focused primarily on PMDD, there are encouraging data to support antidepressant use for moderate to severe PMS as well. Antidepressant dosing strategies that have been shown to be effective include continuous daily dosing throughout the menstrual cycle and intermittent dosing during only the luteal phase of the cycle. In addition, preliminary data suggest that symptom-onset dosing may be a useful and practical approach. This talk will provide an overview of assessment and treatment of PMS and PMDD, with an emphasis on the use of antidepressants to improve both symptoms and quality of life.

No. 33C
PERINATAL CONSEQUENCES OF MOOD AND ANXIETY DISORDERS

Kimberly A. Yonkers, M.D., *Department of Psychiatry, Yale University School of Medicine, 142 Temple Street, Suite 301, New Haven, CT 06451*

SUMMARY:

Preterm delivery and low birth weight complicate over 12% of deliveries annually in the United States. Approximately two thirds of all infant deaths occur among neonates that are born < 2500gms. While factors such as race, smoking, and infection contribute to low birth weight, preterm delivery, and intrauterine growth retardation, a growing body of evidence finds that psychosocial issues are important contributors to these adverse perinatal outcomes. Although stress has been most highly investigated, some data suggest that depressive and anxiety disorders may increase the risk of adverse perinatal outcomes. The risk of delivering a low birth weight infant was increased nearly four-fold in one study, while another investigation found depressive symptoms doubled the risk of preterm delivery. Patient-identified stressful and traumatic events have also been found to increase the risk of preterm delivery. Additionally, pregnancy-induced hypertension has been associated with anxiety and stress in some studies. In this presentation, existing data regarding the impact of mood and anxiety disorders on birth outcomes, including preterm delivery, low birth weight, pre-eclampsia, and pregnancy-induced hypertension will be reviewed.

REFERENCES:

1. Yonkers KA, Bruce SE, Dyck IR, Keller MB: Chronicity, relapse, and illness—course of panic disorder, social phobia, and generalized anxiety disorder: findings in men and women from 8 years of follow-up. Depress Anxiety 2003; 17(3):173–9.
2. Steiner M, Born L: Psychiatric aspects of the menstrual cycle, in Women's Mental Health: A Comprehensive Textbook. Kornstein SG, Clayton AH (eds.) Guilford Press, 2002, pp 91–113.

INDUSTRY-SUPPORTED SYMPOSIUM 34—BIPOLAR DISORDER MANAGEMENT: A NEW EDITION
Supported by GlaxoSmithKline

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to appraise various antidepressants, mood stabilizers, anticonvulsants, and atypical antipsychotics in bipolar depression, make optimal use of drug combinations, examine bipolar disorder in youth and its treatment, and illustrate efficacy of psychotherapy in combination with medication toward relapse prevention and medication compliance.

No. 34A
WHEN AND HOW TO USE ANTIDEPRESSANTS FOR BIPOLAR DEPRESSION

S. Nassir Ghaemi, M.D., *Department of Psychiatry, Cambridge Health Alliance/Harvard, 1493 Cambridge St, Cambridge, MA 02139*

SUMMARY:

Bipolar disorder is frequently difficult to diagnose and treat. Antidepressants are sometimes necessary and effective for short-term treatment of severe, acute, major depressive episodes. However, when routinely used in long-term treatment, they do not possess evidence of preventive efficacy. Further, it appears that they can act as mood destabilizers, worsening the course of bipolar illness. Mood stabilizers, especially lithium and lamotrigine, remain the mainstay of treatment for bipolar disorder, with atypical neuroleptics and novel anticonvulsants also useful primarily as adjuncts. This presentation will review evidence for the relatively frequent misdiagnosis or underdiagnosis of bipolar depression, present data from an ongoing randomized study of modern antidepressants with regard to mood destabilization, and outline clinical scenarios in which antidepressants may or may not be effective.

No. 34B
CLINICAL STRATEGIES FOR BIPOLAR DEPRESSION

Terence A. Ketter, M.D., *Department of Psychiatry, Stanford University, School of Medicine, 401 Quarry Road, Room 2124, Stanford, CA 94305-5723*

SUMMARY:

Management of bipolar depression is a considerable clinical challenge. Most therapies "stabilize mood from above," as they maximally impact mood elevation aspects of bipolar disorders. Thus, lithium, divalproex, and carbamazepine tend to yield higher response rates in mania (up to about 2/3) than in depression (up to about 1/3). In contrast, lamotrigine may "stabilize mood from below," as it maximally impacts depressive symptoms in both acute and maintenance treatment. Other newer anticonvulsants are not as a class generally effective as primary treatments for bipolar disorders, but may be useful adjuncts for mood or comorbid symptoms in depressed bipolar disorder patients. For example, gabapentin appears effective for some anxiety and pain disorders, and topiramate may be useful for obesity, eating disorders, alcoholism, and migraine. Emerging data suggest that atypical antipsychotics may have utility in bipolar depression. For both acute and maintenance therapy, olanzapine monotherapy appears to have robust antimanic and modest antidepressant properties, suggesting it "stabilizes mood from above." Quetiapine monotherapy may have robust activity, not only in acute mania, but also in acute depression. Integration of knowledge of the varying efficacy and adverse-effect profiles of these agents with individual patient characteristics is crucial for effective management of bipolar depression.

No. 34C
HOW TO COMBINE MEDICATIONS FOR LONG-TERM STABILIZATION

Frederick K. Goodwin, M.D., *Psychiatry, George Washington University, 2150 Pennsylvania Ave, Washington DC, DC 20037*

SUMMARY:

Controlled data on the efficacy of putative mood stabilizers in bipolar disorder come primarily from monotherapy trials, whereas in actual practice, the great majority of bipolar patients seem to require more than one medication. Thus, a gap has developed between what is known and what is generally done.

Recently, more studies of combined treatment have begun to appear and the gap is beginning to close. This presentation will focus on what this emerging literature can teach us about the benefit-to-risk ratio of various combinations, as well as the practical aspects using mood stabilizers together. In interpreting this literature, it is important to note that most combined treatment studies start with patients already identified as non-responders or partial responders to monotherapy, thereby limiting the generalizability of the results. Although most combined treatment regimens are arrived at this way (following monotherapy failure), we will highlight situations in which a particular drug combination may be recommended at the outset. Related to this issue are new data on differential as well as overlapping effects of some mood stabilizers on postsynaptic signal transduction sites. These findings provide a novel rationale for certain combinations de novo.

No. 34D
RECOGNIZING AND TREATING BIPOLAR DISORDER IN CHILDREN

Gabrielle A. Carlson, M.D., *Department of Psychiatry, Stony Brook University, Putnam Hall South Campus, Stony Brook, NY 11794-8790*

SUMMARY:

This presentation will highlight some of the important findings regarding juvenile-onset bipolar disorder that have been published in recent years. Topics covered include the impact of definition on understanding epidemiological studies of early-onset bipolar disorder, comorbidity, developmental risk factors, switching and medication response, family studies, and treatment. Some of the controversy surrounding bipolar disorder in youth diminishes if bipolar disorder is viewed as a spectrum, and children may fit along the spectrum without meeting full criteria for classic bipolar I disorder.

No. 34E
NEW UNDERSTANDING OF PSYCHOLOGICAL ISSUES AND OF EFFECTIVE PSYCHOTHERAPY

Kay Redfield Jamison, Ph.D., *Department of Psychiatry, Johns Hopkins University, 600 North Wolfe Street, Baltimore, MD 21287*

SUMMARY:

This presentation will review recent research on those psychological issues of greatest relevance to the treatment of bipolar disorder. Special attention will be given to the often overlooked area of the positive experiences associated with mild manic states that can complicate treatment compliance. Emphasis will also be given to those

medication side effects most likely to contribute to noncompliance, especially the neurocognitive effects associated with some, but not all, mood stabilizers; and the extent and clinical consequences (including suicide) of medication noncompliance. Second, we will review the results of recent studies of the efficacy of psychotherapy in improving clinical outcome and the role of enhanced compliance in achieving such outcomes. And finally, data on the benefits of including the family in the therapeutic process will be highlighted, including the importance of educating patients and their family members about the symptoms, course, and treatment of bipolar illness.

REFERENCES:

1. Keller TA, Calabrese JR: Stabilization of mood from below versus above baseline in bipolar disorder: proposal for a new nomenclature. J Clin Psychiatry 2002; 63:146–151.
2. Goodwin FK: Rationale for long-term treatment of bipolar disorder and evidence for long-term lithium treatment. J Clin Psychiatry 2002; 63(suppl 10).
3. Meyer SE, Carlson GA: Bipolar disorder in youth: an update. Current Psychosis & Therapeutics Reports 2003; 1:79–84.
4. Goodwin FK, Jamison KR: Manic-Depressive Illness. New York, Oxford University Press, 1990, 2005.
5. Ghaemi SN, Ko JY, Goodwin FK: Cade's disease and beyond: misdiagnosis, antidepressant use, and a proposed definition for bipolar spectrum disorder. Can J Psychiatry 2002; 47:125–134.

INDUSTRY-SUPPORTED SYMPOSIUM 35—DUAL DIAGNOSIS: THE SCOPE OF THE PROBLEM
Supported by AstraZeneca Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the common co-occurrence of alcohol and other substance abuse in patients with psychiatric disorders, the implication of this co-occurrence on outcome for these patients, and potential treatment approaches to address both the alcohol/substance use and the psychiatric disorder.

No. 35A
PREVALENCE AND CONSEQUENCES OF DUAL DIAGNOSIS

Peter F. Buckley, M.D., *Department of Psychiatry, Medical College of Georgia, 1515 Pope Avenue, Augusta, GA 30912-3800*

SUMMARY:

Substance abuse comorbidity with schizophrenia, bipolar disorder, and other psychiatric disorders is a common and difficult-to-treat complication in mental health systems of care. According to findings from the 2002 National Survey on Drug Use and Health, over 23% of adults suffering from serious mental illness in the U.S. were dependent on or abused alcohol or illicit drugs. By contrast, the rate of abuse (dependence among adults without serious mental illness) was 8.2%. Among adults with substance abuse or dependence, 20.4% also had a serious mental illness. These figures underscore the high co-occurrence of substance abuse comorbidity with serious mental disorders of which schizophrenia and bipolar disorder are most noteworthy. The high prevalence of substance abuse comorbidity has prompted exploration and consideration of mechanistically-based explanations for this common association. Additionally, substance abuse comorbidities in schizophrenia and bipolar disorder exert devastating effects on patients and their relatives since they are associated with long-term disability and impairment, heightened mortality, and increased risk of suicidal and violent behaviors. In recent years, these comorbidities have become a focus of neurobiologic, treatment, and health services research, as emphasized in the President's New Freedom Commission report. This presentation will highlight the prevalence and etiopathogenic mechanisms of substance abuse comorbidity in schizophrenia and bipolar disorder.

No. 35B
ADOLESCENT SUBSTANCE ABUSE AND PSYCHIATRIC COMORBIDITIES

Deborah Deas, M.D., *Department of Psychiatry, Medical University of South Carolina, 67 President Street, P.O. Box 250861, Charleston, SC 29425*

SUMMARY:

Adolescent substance abuse is a major public health problem in America. Alcohol is the most common substance of abuse among adolescents, although marijuana is the most common illicit substance of use. Adolescents' perceived risk of harmfulness of these substances has waned over the past years. This presentation will focus on the prevalence of adolescent substance use and the multiple comorbid factors that place adolescents at risk for substance use. Comorbidities among adolescents are the rule rather than the exception. Comorbid factors include psychological and psychiatric influences (psychiatric and substance use disorders), as well as peer, environmental, and family factors. The impact of these factors may be moderated by other influences such as family history, previous substance use experience, and gender. Special focus will be placed on comorbid psychiatric disorders and the importance of a comprehensive assessment as well as how treatment outcome may be impacted.

No. 35C
PSYCHOSOCIAL INTERVENTION FOR DUAL DIAGNOSIS

Mary F. Brunette, M.D., *Research Center, NH-Dartmouth Psychiatry, 105 Pleasant Street, Main Building, 2nd Floor, Concord, NH 03301;* Robert Drake, M.D., Kim T. Mueser, Ph.D., Greg McHugo, Ph.D.

SUMMARY:

Co-occurring substance abuse disorders are related to treatment nonadherence, symptom exacerbation, hospitalization, incarceration, homelessness, and increased medical problems in people with schizophrenia. Separate treatment of each disorder is ineffective, but integrated treatment for the mental illness and the substance use disorder, whereby the same clinician provides different stage-specific services over time, is effective. In the engagement stage, clients are engaged into services with outreach, practical help, crisis intervention, and assessment. After a therapeutic relationship has been established and the client is regularly attending treatment in the persuasion stage, clinicians educate clients about substances, provide skills training, and utilize motivational interviewing techniques to explore the impact of substance use in their lives. Once a client has decided to change her substance use, she is in the action stage, and cognitive-behavioral counseling is used to learn to reduce and stop substance use. Vocational and social skills training as well as self-help strategies are also important. Once a client has stopped using substances, clinicians help clients develop and implement relapse prevention plans to further their recovery to other aspects of their lives. Individual, group, and family interventions may be utilized with the perspective that services need to be individualized and available over the long term.

No. 35D
TREATMENT OF BIPOLAR DISORDER AND SUBSTANCE ABUSE

E. Sherwood Brown, M.D., *Department of Psychiatry, UT Southwestern Medical Center, 5323 Harry Hines Boulevard, Dallas, TX 75390-8849*

SUMMARY:

Bipolar disorder has the highest rates of substance abuse of any axis I disorder. A community-based study found 61% of people with bipolar I disorder and 48% with bipolar II disorder had a lifetime history of a substance-related disorder. When present, substance abuse appears to be a risk factor for hospitalization, treatment nonadherence, and violence toward self and others. Thus, the treatment of patients with bipolar disorder and comorbid substance abuse is of great importance to mental health professionals. The treatment of substance abuse in persons with bipolar disorder will be reviewed, including data from pharmacotherapeutic and psychosocial intervention studies. Findings from randomized, controlled studies support the use of lithium, carbamazapine, and quetiapine in patients with mood disorders and substance-related disorders. Uncontrolled reports suggest that lamotrigine and valproic acid may be useful in this population. Very recent findings from our group on the use of aripiprazole and quetiapine for substance use in persons with bipolar disorder will be presented. The limitations of the existing literature and directions for future research will be highlighted.

No. 35E
TREATMENT OF SCHIZOPHRENIA AND SUBSTANCE ABUSE

Alan I. Green, M.D., *Department of Psychiatry, Dartmouth Medical School, One Medical Center Drive, Lebanon, NH 03756*

SUMMARY:

Alcohol and other substance use disorders are common in patients with schizophrenia and dramatically worsen the outcome of these patients, with increased hospitalization, violence, and treatment noncompliance. We have proposed that patients with schizophrenia have a dysfunction in their mesocorticolimbic dopamine-mediated reward circuitry that underlies the use of substances. Typical antipsychotic medications, which are effective in treating the symptoms of schizophrenia, appear to have minimal beneficial effect on the co-occuring substance use, and may even cause an increase in use. Clozapine, however, an atypical antipsychotic, has been shown by our group and others to decrease alcohol and cannabis use in patients with schizophrenia, and we have demonstrated that clozapine, but not haloperidol, will also decrease alcohol drinking in rodents. We have suggested that the broad neuropharmacological profile of clozapine's action, including its effects on dopaminergic, and particularly noradrenergic systems, may be related to its ability to decrease alcohol and other substance use in patients and in animals. We will review the data regarding the potential effects of the available atypical antipsychotic medications, as well as other agents (including naltrexone, disulfiram, and antidepressants) on alcohol and other substance use in patients with schizophrenia.

REFERENCES:

1. Mueser KT, Noordsy DL, Drake RE, Fox L: Integrated treatment for dual-diagnosis disorders: a guide to effective practice. New York, Guildford Press, 2003.
2. Deas D, Thomas S: Comorbid psychiatric factors contributing to adolescent alcohol and other drug use. Alcohol Res Health 2002; 26:116–121.
3. Drake RE, Mueser KT, Brunette MF, McHugo G: A review of treatment for clients with severe mental illness and co-occurring substance use disorder. Psychosocial Rehabilitation Journal 2004; 27:360–374.
4. Brown ES, Suppes T, Adinoff B, Thomas NR: Drug abuse and bipolar disorder: comorbidity or misdiagnosis? J Affect Disord 2001; 65:105–115.
5. Green AI, Salomon MS, Brenner MJ, Rawlins K: Treatment of schizophrenia and comorbid substance use disorder. Curr Drug Target CNS Neurol Disord 2002; 1:129–139.

INDUSTRY-SUPPORTED SYMPOSIUM 36—INSOMNIA IN SPECIAL POPULATIONS: IS THIS INSOMNIA OR SOMETHING ELSE?
Supported by Sepracor, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the impact of insomnia in the elderly, in depressed patients, and among subgroups of women; to learn about treatment options.

No. 36A
INSOMNIA IN THE ELDERLY

Sonia Ancoli-Israel, Ph.D., *Psychiatry Department, University of California, San Diego, 116A VasDHS 3350 La Jolla, San Diego, CA 92161*

SUMMARY:

It has long been recognized that complaints of sleep problems increase with increasing age. Recent epidemiologic data tell us that the prevalence of chronic insomnia increases from 15% to 25% in the adult population, to approximately 50% in the elderly. Sleep maintenance problems predominate in the elderly, with the most common complaints being frequent nocturnal awakenings and waking up too early in the morning.

Although older adults have more subjective complaints of insomnia, they do not exhibit objective characteristics of poorer sleep to account for their sleep complaints. Various factors affect sleep in the elderly; circadian rhythm disturbances, diagnosis of a primary sleep disorder, medical and psychiatric illness, concomitant medications and dementia, can all lead to complaints of insomnia in the elderly.

Due to the number of interrelated factors that affect sleep in the elderly, management of insomnia in this population segment requires an integrative approach to optimize sleep. This presentation will review existing data on pharmacologic and non-pharmacologic treatment options for older adults suffering from insomnia.

No. 36B
INSOMNIA IN DEPRESSED PATIENTS

Ruth M. Benca, M.D., *Department of Medicine, University of Wisconsin Medical School, 6001 Research Park Boulevard, Madison, WI 53719-1176*

SUMMARY:

Patients with insomnia who also have depression are particularly difficult to treat. This population appears to be at higher risk for experiencing difficulty sleeping and is more likely to experience chronic insomnia, sleep maintenance problems, and/or non-restorative sleep. Worsening insomnia may exacerbate other somatic and psychological symptoms and vice versa. Insomnia or disturbed sleep predicts an increased risk of new-onset depression and relapse, pre-

cedes the onset of depression, often persists during periods of remission, and is a risk factor for suicide. Studies have shown that in the general population, the odds of developing depression if insomnia was experienced during the preceding year were extremely high (almost a 40-fold increased risk), whereas the odds were 1.6 if insomnia resolved during that time. Conversely, there is evidence that appropriate recognition and management of the sleep complaint may alleviate other symptoms related to the associated condition and help interrupt this vicious cycle. The goal of treating the patient with insomnia and depression is to improve symptoms of both conditions. While improvement in insomnia may accompany improvement in depression, pharmacotherapy for insomnia should also be considered, since insomnia can persist even after remission of depression. This presentation will review existing data on pharmacologic and non-pharmacologic treatment options for depressed patients suffering from insomnia.

No. 36C
INSOMNIA IN WOMEN: AN OVERLOOKED EPIDEMIC?

Claudio N. Soares, M.D., *Department of Psychiatry, Mass General Hosp. Center for Women's Health, 15 Parkman Street, WAC 812, Boston, MA 02114*

SUMMARY:

Insomnia is a common and significant health care problem that affects a large percentage of women seen by primary care physicians, obstetrician-gynecologists, and psychiatrists in the U.S. Many specific risk factors for insomnia may be gender related, including the presence of higher prevalence rates of depression and anxiety among females, environmental and social factors, as well as difficulties associated with menstrual changes such as those occurring during the menopausal transition. The presence of sleep problems has been associated with significant adverse impact on daily activities and sense of well-being, resulting in impaired functioning.

This presentation will address the prevalence, clinical characteristics, and potential consequences of insomnia in women. Treatment options including benzodiazepines, non-benzodiazepines, nonprescription sleep aids, and non-pharmacologic interventions such as sleep hygiene measures will be critically reviewed.

Health care providers should be aware of the variety of pharmacologic and non-pharmacologic options for treatment of insomnia in women. A more efficacious approach for insomnia should take into consideration the efficacy of different treatment options and the risks of developing side effects and next-day sedation, and, in particular, be able to weigh their efficacy against the risks of side effects and next-day sedation.

No. 36D
NOVEL STRATEGIES TO TREAT INSOMNIA

John W. Winkelman, M.D., *Psychiatry Sleep Center, Brigham & Women's Hospital, 1400 Centre Street, Suite 109, Newton Center, MA 02459*

SUMMARY:

The clinical management of patients with insomnia may offer many difficulties, including special considerations when insomnia occurs in older adults, in subjects with depression or chronic pain, or is accompanied by various somatic symptoms (e.g., during the menopausal transition). Population surveys indicate that almost 30% of the subjects who report sleep problems may suffer from these symptoms for more than one year. The distinction between short-term or chronic insomnia is therefore essential to establish an adequate therapy. Lastly, the cost of insomnia is high, accounting for annual total direct costs of approximately $4 billion and total indirect costs (lost productivity and accidents) of approximately $80 billion. Subjects with insomnia are twice as likely as those without insomnia to be hospitalized.

As most patients with insomnia have sleep maintenance difficulties, treatment goals should include facilitating both sleep continuity and sleep onset at minimal risk of next-day sedation or impaired function. This presentation will review the existing pharmacologic and non-pharmacologic strategies for the treatment of insomnia, including data on the efficacy and safety of new non-benzodiazepine agents.

REFERENCES:

1. Ancoli-Israel S: Insomnia in the elderly: a review for the primary care practitioner. Sleep 2000; 23 Suppl 1:S23–S30.
2. Benca RM, Ancoli-Israel S, Moldofsky H: Special considerations in insomnia diagnosis and management: depressed, elderly, and chronic pain populations. J Clin Psychiatry 2004; 65 Suppl 8:26–35.
3. Soares CN, Poltras JR, Prouty J: Effect of reproductive hormones and selective estrogen receptor modulators on mood during menopause. Drugs Aging 2003; 20(2):85–100.
4. Ancoli-Israel S, Benca RM, Edinger JD, Krystal AD, Mendelson W, Moldofsky H, Petrie J, Roth T, Walsh JK, Winkelman J: Changing how we think about insomnia. J Clin Psychiatry 2004; 65 Suppl 8:S:44–46.

INDUSTRY-SUPPORTED SYMPOSIUM 37—INSULIN RESISTANCE AND METABOLIC SYNDROME IN NEUROPSYCHIATRY
Supported by Bristol-Myers Squibb Company and Otsuka America Pharmaceuticals, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to examine preclinical data on pathophysiology of metabolic syndrome; understand prevalence of metabolic syndrome in patients with affective disorders, schizophrenia, and Alzheimer's disease; describe current metabolic data for medications used to treat psychiatric illness; discuss clinical implications of metabolic syndrome, weight gain, insulin resistance and lipid disorders.

No. 37A
THE INSULIN RESISTANCE SYNDROME: WHAT IS IT? WHY IS IT IMPORTANT?

Gerald Reaven, M.D., *Cardiovascular Medicine, Stanford University, 300 Pasteur Drive, Stanford, CA 94305*

SUMMARY:

Insulin-mediated glucose disposal varies widely in the population at large, with approximately 50% of the variability related to differences in lifestyle, and the remaining 50% likely to be genetic in origin. Failure to secrete enough insulin to overcome the insulin resistance results in type 2 diabetes. Although most insulin-resistant individuals can sustain the degree of hyperinsulinemia needed to remain nondiabetic, they are likely to be somewhat glucose intolerant, dyslipidemic, with a high plasma triglyceride and low high-density lipoprotein cholesterol concentration; and have essential hypertension. In 1988, it was emphasized that this cluster of abnormalities significantly increased cardiovascular disease risk, and the term Syndrome X was proposed as a phrase to refer to the abnormalities

associated with insulin resistance/hyperinsulinemia. Since the introduction of the concept of Syndrome X, the list of abnormalities more likely to occur in insulin resistant/hyperinsulinemic individuals has greatly expanded, as has the number of clinical syndromes associated with the defect in insulin action. Given these developments, it seems more reasonable to substitute the term Insulin Resistance Syndrome (IRS) for Syndrome X, and this presentation will review the abnormalities and clinical syndromes that make up the current version of the IRS.

No. 37B
INSULIN RESISTANCE AND METABOLIC RISK DURING ANTIPSYCHOTIC TREATMENT

John W. Newcomer, M.D., *Department of Psychiatry, Washington University School of Medicine, 660 South Euclid Avenue, Box 8134, St. Louis, MO 63110–1002*

SUMMARY:

Individuals with schizophrenia have an increased prevalence of obesity, type 2 diabetes mellitus (T2DM), and cardiovascular disease (CVD) compared with the general population. A range of evidence, including randomized clinical studies, suggests that antipsychotic treatment can increase risk of insulin resistance, hyperglycemia, dyslipidemia, and T2DM. Interpretation of evidence concerning treatment effects has been complicated by reports of insulin resistance in untreated schizophrenia, with likely contributions from altered nutrition and activity. Research concerning the role of adiposity in the development of insulin resistance, the metabolic syndrome, T2DM, and CVD, may increase our understanding of antipsychotic treatment effects. Drug effects on insulin sensitivity and secretion can be sensitively measured with various techniques, and fat mass can be quantified with direct measures like dual energy x-ray absorptiometry and magnetic resonance imaging. Increased adiposity in schizophrenia is associated with decreases in insulin sensitivity, leading to potential increases in plasma glucose and lipid levels and increases in inflammatory markers. These metabolic changes may contribute to the development of metabolic syndrome, increasing the risk of T2DM and cardiovascular disease. The results of studies in this area can be used to target basic research, identify potential therapeutic approaches, and guide clinical and regulatory decision making.

No. 37C
RISK, ASSESSMENT, AND MANAGEMENT OF INSULIN RESISTANCE IN AFFECTIVE DISORDERS

H. Brent Solvason, M.D., *Psychiatry Department, Stanford University, 401 Quarry Road, Room 94305, Stanford, CA 94305*

SUMMARY:

Relative to schizophrenia, there has been a paucity of information on the metabolic syndrome in affective disorders (bipolar and unipolar disorders). The high lifetime prevalence of affective disorders in the general population, coupled with the epidemic of diabetes, dictates the need to have a greater understanding of these disorders. The relative risk factors for glucose intolerance, i.e., insulin resistance/insulin deficiency, risk of morbidity and mortality, and the role of pharmacologic treatments, including conventional mood stabilizers, atypical antipsychotics, antidepressants, and augmentation medications, will be reviewed. Guidelines in risk assessment, management, and prevention will be presented.

No. 37D
INSULIN RESISTANCE AND COGNITIVE DISORDERS

Suzanne Craft, Ph.D., *Geriatric Research, University of Washington, 1660 South Columbian Way, Seattle, WA 98108*

SUMMARY:

An emerging body of evidence suggests that an increased prevalence of insulin abnormalities and insulin resistance in Alzheimer's disease, vascular dementia, and other neurodegenerative and psychiatric disorders, may contribute to disease pathophysiology and clinical symptoms. Insulin is essential for energy metabolism in the periphery, and convergent findings have begun to demonstrate that insulin also plays a role in energy metabolism and other aspects of CNS function. It has recently been demonstrated that insulin-sensitive glucose transporters are localized to regions of the brain that support memory and that insulin, in fact, plays a role in memory functions. Insulin may also play a role in regulating the amyloid precursor protein and its derivative beta-amyloid (Abeta), which is associated with senile plaques, a neuropathological hallmark of Alzheimer's disease. Our recent studies show that administration of insulin improves cognitive performance. The role of insulin in normal brain function will be described. Then, a review of the mechanisms through which hyperinsulinemia and insulin resistance may impair recognition will be presented, including the possible contribution to the pathogenesis of late-life disease.

No. 37E
INSULIN RESISTANCE: THE LINK BETWEEN AFFECTIVE DISORDERS AND ALZHEIMER'S DISEASE

Natalie L. Rasgon, M.D., *Psychiatry and Behavioral Sciences, Stanford School of Medicine, 401 Quarry Road, Room 2360, Palo Alto, CA 94305-5723*

SUMMARY:

Insulin resistance commonly occurs in both affective disorders (ad) and Alzheimer's disease (AD). This impaired glucose metabolism and reduced insulin sensitivity can lead to cognitive and memory impairment, and potentially other long-term sequelae.

Research regarding the possible association between ad and AD has yielded mixed results. Various neurophysiologic factors have been implicated as common biological markers for these disorders. We will review evidence suggesting that abnormal glucose metabolism (i.e., insulin resistance) is a missing link in the pathophysiology of both ad and AD.

REFERENCES:

1. Reaven G: The metabolic syndrome or the insulin resistance syndrome? Different names, different concepts, and different goals. Endocrinol Metab Clin North Am 2004; 33(2):283–303.
2. Casey DE, Haupt DW, Newcomer JW, et al: Antipsychotic-induced weight gain and metabolic abnormalities: Implications for increased mortality in patients with schizophrenia. J Clin Psychiatry 2004; 65(Suppl 7):4–18.
3. Kendall DM, Harmel AP: The metabolic syndrome, type 2 diabetes, and cardiovascular disease: understanding the role of insulin resistance. Am J Manag Care 2002; 8(20 Suppl): S635–53.
4. Craft S, Watson GS: Insulin and neurodegenerative disease: shared and specific mechanisms. Lancet Neurology 2004; 3:169–178.
5. Rasgon N, Jarvik L: Insulin resistance, affective disorders, and Alzheimer's disease: review and hypothesis. J Gerontology 2004; 59A(2):178–183.

INDUSTRY-SUPPORTED SYMPOSIUM 38—OVERCOMING TRADITIONAL DILEMMAS IN TREATING DEPRESSIVE ILLNESSES: EVIDENCE-BASED UPDATES

Supported by Wyeth Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe evidence-based updates about long-standing uncertainties on how to best achieve and maintain wellness for depressive illnesses. The uncertainties include which medications to choose, whether combinations (polypharmacy) work better, how to handle comorbidities, whether we can be successful in preventing recurrences, and whether new brain stimulation strategies offer anything valuable to clinicians.

No. 38A
IMPROVED REMISSION RATES: DO ANY ANTIDEPRESSANTS STAND OUT?

Linda L. Carpenter, M.D., *Department of Psychiatry, Brown Medical School, Butler Hospital, 345 Blackstone Boulevard, Providence, RI 02906*

SUMMARY:

Untreated depression commonly evolves into a chronic or recurring state, often with subsyndromal residual symptoms persisting throughout the intervals between clinically significant depressive episodes. Long-term prospective follow-up investigations now consistently demonstrate that patients who achieve remission of depression, marked by full resolution of emotional, physical, and functional symptoms and impairments, are at significantly decreased risk of depression relapse and experience longer intervals of wellness between episodes. While remission has been the recommended goal of treatment for a number of years, achieving it for some patients may require careful initial drug selection; patients are likely to be less adherent with complex regimens involving dose titration, augmentation, and/or drug switching. During the last decade, clinical trials began to examine remission rates with various types of antidepressant monotherapies. Enough evidence has accumulated to enable comparisons of remission rates among a number of commonly prescribed antidepressant medications, including sertraline, paroxetine, citalopram, and venlafaxine. Resolution of the full range of depressive symptoms remains the only sound goal, and evidence-based treatment selection is the roadmap for achieving this goal.

No. 38B
INFLUENCE OF COMORBIDITY ON THE TREATMENT OF DEPRESSION

David L. Dunner, M.D., *Department of Psychiatry, University of Washington, 4225 Roosevelt Way NE, 306C, Seattle, WA 98105-6099*

SUMMARY:

Various types of comorbidities can exist in patients with major mood disorders. These comorbidities include medical comorbidity, substance use and abuse comorbidity, other psychiatric comorbidities, and co-occurrence with personality disorders. All of these comorbidities have been shown to negatively impact the treatment of depression. Furthermore, selection of treatment—medication, psychotherapy or the combination—may be heavily influenced by the type of comorbidity that a patient experiences. For example, a patient with chronic cardiovascular disease on multiple medications may encounter specific drug interactions when treated with some antidepressant agents. Patients with anxiety disorders, for example panic disorder, are more sensitive to SSRI treatment initially, but may respond optimally to serotonergic agents in comparison to other treatments because serotonergic antidepressants have beneficial effects for both mood anxiety disorders. Substance abuse comorbidity severely complicates treatment. Axis II comorbidity increases severity of mood ratings in depressed patients. The evidence for treatment selection for comorbid disorders will be reviewed and presented.

No. 38C
COMBINING ANTIDEPRESSANT TREATMENTS FOR BETTER EFFICACY: WHAT DOES THE LITERATURE SAY?

Thomas L. Schwartz, M.D., *Department of Psychiatry, SUNY Upstate Medical University, 713 Harrison Street, Syracuse, NY 13210*

SUMMARY:

Treating major depressive disorder is often a complex task. Over two-thirds of patients fail to respond fully to their first agent and often must have their medication changed or other medications added in a polypharmacy manner. Combining drug treatments is common practice in adult psychiatry. However, there are very little data to support this standard of care. Most drugs are FDA approved in monotherapy settings with subjects who have limited, and non-comorbid, depressive illness. There are very few randomized and controlled studies in regards to combining psychotropics to improve depression efficacy rates. There are slightly more, smaller, open-label studies that suggest reasonable efficacy and tolerability when multiple agents are used. This lecture will attempt to review the current standards of care where polypharmacy is concerned in major depressive disorder and also review the literature that is present in support of polypharmacy.

No. 38D
BRAIN STIMULATION IN PSYCHIATRIC TREATMENT: STATE OF THE EVIDENCE

Sarah H. Lisanby, M.D., *Department of Biological Psychiatry, Columbia University, 1051 Riverside Drive, NYSPI #126, New York, NY 10032-2695*

SUMMARY:

Recent years have seen a rapid increase in the development of techniques to stimulate the brain, both noninvasively and invasively. The value of these approaches to alter brain function for the treatment of psychiatric disorders is under active study for a variety of psychiatric and neurological conditions. Electroconvulsive therapy (ECT) remains a mainstay in the treatment of resistant depression, but its role in treatment algorithms may change as newer treatment strategies are developed that may have an improved risk/benefit ration. Transcranial magnetic stimulation (TMS) involves the use of magnetic fields to noninvasively stimulate the brain. Higher strength magnetic fields, as used in magnetic seizure therapy (MST) can induce more targeted seizures than those obtained with ECT. Deep brain stimulation (DBS) is an invasive means of stimulating the brain that has shown great promise in movement disorders. Vagus nerve stimulation (VNS) alters brain function through the stimulation of vagal afferents, and it is currently under review by the FDA for the treatment of depression. The evidence for and against the efficacy of each approach will be reviewed, and the potential role of each relative to ECT will be discussed.

No. 38E
EFFECTIVENESS OF ANTIDEPRESSANT TREATMENTS FOR PREVENTING RECURRENCES: SEVERAL DECADES OF EVIDENCE

John F. Greden, M.D., *Department of Psychiatry, University of Michigan Medical Center, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0999*

SUMMARY:

Untreated depression is a chronic disorder marked by recurrences that generally become more frequent and severe over time. Recurrences arguably are the most important contributor to depression's high disability rates. Evidence-based comparisons of different strategies for preventing recurrences have been slowly accumulating for several decades. Their conclusiveness has remained incomplete because of design shortcomings, such as inadequate agreement about operational definitions for relapse, recurrence, remission and response, limited time durations rarely exceeding several years, small sample sizes, and different dosage regimens. Despite shortcomings, a growing pool of evidence is leading to some clinical consensus. Data will be presented that support the value of full-dose, extended maintenance programs for high-risk groups, combinations of maintenance medications and psychotherapy whenever possible, treating comorbidities concomitantly, emphasizing adherence, ensuring chronobiological stability, forming treatment partnerships with family members or friends, discontinuing medications only if necessary and then gradually, and using incremental or new approaches such as brain stimulation treatments if others fail after an adequate trial. Our clinical goal must become prevention of new episodes, not just treatment of the current one. Growing evidence confirms this goal is generally achievable.

REFERENCES:

1. Lam RW, Kennedy SH: Evidence-based strategies for achieving and sustaining full remission in depression: focus on metaanalyses. Can J Psychiatry 2004; 49(3 Suppl 1): 17S–26S.
2. Dunner DL: Management of anxiety disorders—the added challenge of comorbidity. Depression and Anxiety 2001; 13:57–71.
3. Lam RW, Wan DD, Cohen NL, Kennedy SH: Combining antidepressants for treatment-resistant depression: a review. Journal of Clinical Psychiatry 2002; 63(8):685–93.
4. Montgomery SA, Entsuah R, Hackett D, et al. for the Venlafaxine 335 Study Group: Venlafaxine versus placebo in the preventive treatment of recurrent major depression. J Clin Psych 2004; 65:328–336.
5. Lisanby SH (Volume Editor): Brain Stimulation in Psychiatric Treatment. Volume 23 of the Review of Psychiatry Series. Oldham, J.M. (Series Editor) American Psychiatric Publishing, Inc. 2004.

TUESDAY, MAY 24, 2005

INDUSTRY-SUPPORTED SYMPOSIUM 31—AGITATION AND PSYCHOSIS IN ALZHEIMER'S DISEASE AND PARKINSON'S DISEASE, PART 2
Supported by AstraZeneca Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the diagnosis and assessment of agitation and psychosis in patients with Alzheimer's disease and Parkinson's disease; understand the strengths and weaknesses of pharmacologic agents in the management of psychosis and agitation in patients with Alzheimer's disease and Parkinson's disease; understand how to use atypical antipsychotics to treat symptoms of psychosis in Parkinson's disease.

No. 31A
EFFICACY AND TOLERABILITY OF ATYPICAL ANTIPSYCHOTICS IN AGITATION AND PSYCHOSIS: RESEARCH RESULTS

Pierre N. Tariot, M.D., *Department of Psychiatry, University of Rochester, Monroe Hospital, 435 East Henrietta Road, Rochester, NY 14620*

SUMMARY:

Until now, the clinical trials guiding treatment of patients with dementia have included three published studies with risperidone, one with olanzapine, one abstract regarding quetiapine, and three abstracts regarding aripiprazole. Essential findings from these studies will be reviewed briefly to set the stage for a more in-depth presentation of new research findings. A multicenter, double-blind, placebo-controlled, fixed-dose, 10-week study of quetiapine for treatment of agitation associated with dementia in nursing home residents has been completed. Quetiapine was titrated to either 100 mg/d or 200 mg/d. Of the 333 patients enrolled, 81% had Alzheimer's, 66% of patients completed the study. Quetiapine 200 mg/d was effective for relief of agitation as measured by the PANSS-EC ($P = .02$) and Clinical Global Impression Scale ($P = .002$). The incidence of falls, postural hypotension, and deaths were low and similar for all treatment groups. No CVAEs were reported in the quetiapine groups. These results will be complemented by available data from the CATIE-Alzheimer's disease trial, which concluded in 12/2004. The 2004 Expert in Consensus Guidelines will be discussed in light of these new findings. New data continue to point toward modest efficacy of atypicals, with varying safety and tolerability concerns among the different agents, which may impact practice significantly.

No. 31B
EFFICACY AND TOLERABILITY OF ATYPICAL ANTIPSYCHOTICS IN AGITATION AND PSYCHOSIS: CLINICAL APPLICATIONS

Jeanne Jackson-Siegel, M.D., *Department of Psychiatry, Geriatric & Adult, 60 Washington Avenue, Suite 203, Hamden, CT 06518*

SUMMARY:

Accumulating data on antipsychotics reveal considerable differences in tolerability and side-effect profiles. Melding this information with individual patient characteristics compels higher levels of decision making for the practitioner. This symposium focuses on individual patient comorbidities and risk factors that might influence a clinician's specific antipsychotic choice. At times the option may stem primarily from choosing a particular antipsychotic with side effects that might benefit the patient. Other specific antipsychotics may be chosen as a result of attempts to avoid specific drugs due to the patients' inability to tolerate those particular side effects of the medications. We will review how determining a patient's risk factors requires methodical data gathering including such components as vital signs, weight, multiple laboratory values, gait assessment, and past medical history. Multiple monitoring strategies for efficacy and tolerability will be examined to aid the clinician in determining effectiveness.

REFERENCES:

1. Gray KF: Managing agitation and difficult behavior in dementia. Clin Geriar Med 2004; 20:69–82.
2. Parkinson Study Group: Low-dose clozapine for the treatment of drug-induced psychosis in Parkinson's disease. N Engl J Med 1999; 340:757–763.

INDUSTRY-SUPPORTED SYMPOSIUM 32—MANAGING THE SPECTRUM OF BIPOLAR DISORDER: MINIMIZING THE BURDEN OF DISEASE, PART 2
Supported by Bristol-Myers Squibb and Otsuka America Pharmaceutical, Inc.

EDUCATIONAL OBJECTIVES:

- discuss the latest research on pathophysiology of bipolar disorder, and identify key problems in the differential diagnosis of bipolar disorders (type I, type II, and other affective disorders).
- effectively utilize pharmacotherapy in management of patients with acute mania and differentiate between atypical antipsychotics and mood stabilizers with respect to their efficacy, tolerability, and safety profiles, integrating the long-term clinical implications of adverse effects.

No. 32A
THE IMPACT OF SAFETY AND TOLERABILITY ON PATIENT SATISFACTION WITH THERAPY

Paul E. Keck, Jr., M.D., *Biological Psychiatry Department, University of Cincinnati, Medicine, 231 Albert Sabin Way, ML559, Cincinnati, OH 45267-0559*

SUMMARY:

Bipolar disorder is a chronic disorder that requires long-term treatment. Success thus depends on a patient's treatment adherence. Patients with bipolar disorder have a tendency toward nonadherence, which can be exacerbated by drug-induced adverse effects (AEs). In particular, sedation, weight gain, sexual dysfunction, extrapyramidal symptoms (EPS), and tardive dyskinesia (TD). Weight gain is more frequent with lithium, valproate, and some atypical antipsychotics (notably olanzapine and clozapine), while sexual dysfunction, EPS, and TD are more frequent with typical antipsychotics. Based on emerging data, the suitability of an agent for long-term maintenance also depends on metabolic AEs, including not only weight gain, but hyperglycemia, hyperlipidemia, and an increased risk of type 2 diabetes mellitus. In addition to reducing adherence, metabolic AEs impair patients' overall health. The bipolar therapeutic agents most frequently associated with metabolic AEs are atypical antipsychotics. According to a recent consensus panel headed by the American Psychiatric Association (APA) and the American Diabetes Association (ADA), the greatest risk of metabolic AEs occurs with olanzapine and clozapine; less risk occurs with risperidone and quetlapine, and the least risk with ziprasidone and aripiprazole. The APA/ADA consensus will be reviewed at this symposium, as will the role of psychiatrists in monitoring metabolic AEs.

No. 32B
IMPACT OF BIPOLAR MAINTENANCE THERAPY ON PATIENT OUTCOMES

Lori L. Altshuler, M.D., *Department of Psychiatry, University of California at Los Angeles, 300 Medical Plaza, Suite 1544, Los Angeles, CA 90024*

SUMMARY:

Maintenance therapy in bipolar disorder may involve the prevention of depressive as well as manic episodes. Depressive episodes are a defining characteristic of bipolar type II disorders and a frequent occurrence in bipolar type I disorders. Lithium and anticonvulsant drugs are more effective in relieving and preventing manic episodes than depressive ones. Several recent trials have shown long-term bipolar efficacy from treatment with atypical antipsychotics, whether used as monotherapy or in combination with mood stabilizers for manic and depressive episodes. Given a diagnosis of bipolar rather than unipolar depression, antidepressants are the treatment of choice for acute episodes, but little data exist regarding long-term maintenance efficacy versus risk of precipitated manic episodes. To improve patient outcomes in the real world, effective drugs must be combined with strategies to maintain treatment adherence. Both drug efficacy and strategies for adherence will be discussed in this symposium.

REFERENCES:

1. American Diabetes Association/American Psychiatric Association: Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes. Diabetes Care 2004; 27(2):596–601.
2. American Psychiatric Association: Treatment Recommendations for Patients With Bipolar Disorder. Am J Psychiatry 2002; 159 (4 suppl): 1–50.

INDUSTRY-SUPPORTED SYMPOSIUM 33—ADVANCES IN THE TREATMENT OF MOOD AND ANXIETY DISORDERS IN WOMEN, PART 2
Supported by Wyeth Pharmaceuticals

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to demonstrate increased knowledge of mood and anxiety disorders in women, particularly with regard to gender differences and the impact of reproductive events on presentation and treatment.

No. 33A
MENOPAUSAL TRANSITION: IMPACT ON MOOD, SLEEP, AND QUALITY OF LIFE

Claudio N. Soares, M.D., *Department of Psychiatry, Mass General Hosp. Center for Women's Health, 15 Parkman Street, WAC 812, Boston, MA 02114*

SUMMARY:

Recent data have shown a significant increase in the female population in the United States (around 146.7 million in 2002). The U.S. census also suggests that more than 1.4 million women are reaching menopause each year in the U.S. Two prospective, community-based studies have identified the transitioning to menopause as a period of heightened risk for some women to develop clinically significant depressive symptoms. The menopausal transition is also known to be accompanied by significant physical changes, including vasomotor symptoms, sleep disruption, sexual dysfunction, and cognitive difficulties. It is noteworthy that the occurrence of somatic and psychological changes during the menopausal transition may lead to a significant compounded burden of illness, and affect considerably a woman's functioning and well being. This presentation will examine existing evidence on the prevalence, clinical characteristics, and risk factors associated with somatic and psychological complaints during the menopausal transition. Given the recent controversy involving long-term use of hormone therapy, the efficacy of novel hormonal

and non-hormonal strategies for menopause-related symptoms will be critically reviewed.

No. 33B
MANAGING BIPOLAR DISORDER IN WOMEN

Lesley M. Arnold, M.D., *Psychiatry Department, University of Cincinnati, 231 Albert Sabin Way, Cincinnati, OH 45267-0559*

SUMMARY:

Bipolar disorder manifests differently in women than it does in men. Bipolar disorder may begin later in women, and women more often have a seasonal pattern of the mood disturbance. Women experience depressive episodes, mixed mania, and rapid cycling more often than men. Bipolar II disorder, which is predominated by depressive episodes, also appears to be more common in women than men. Comorbidity of medical and psychiatric disorders is more common in women and adversely affects recovery from bipolar disorder more often in women. There is no evidence that sex affects treatment response to mood stabilizers. However, women may be more susceptible to delayed diagnosis and treatment. Pregnancy neither protects nor exacerbates bipolar disorder. The postpartum period is a time of high risk for onset and recurrence of bipolar disorder in women. Individualized risk/benefit assessments of pregnant and postpartum women with bipolar disorder are required to promote the health of the woman and avoid or limit exposure of the fetus or infant to potential adverse effects of medication.

REFERENCES:

1. Orr S, James S, Prince CB: Maternal prenatal depressive symptoms & spontaneous preterm births among African-American women in Baltimore, MD. American Journal of Epidemiology 2002; 156(9):797–802.
2. Soares CN, Poltras JR, Prouty J: Effect of reproductive hormones and selective estrogen receptor modulators on mood during menopause. Drugs Aging 2003; 20(2):85–100.
3. Arnold LM: Gender differences in bipolar disorder. Psychiatr Clin N Am 2003; 26:595–620.

INDUSTRY-SUPPORTED SYMPOSIUM 39—SEASONAL AFFECTIVE DISORDER: NEW CONCEPTS, PRACTICAL STRATEGIES
Supported by GlaxoSmithKline

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to diagnose a common but under-recognized disorder by describing the neurochemical changes that may be responsible for the symptoms of SAD and how these aberrant systems may suggest useful treatment strategies, including light therapy, pharmacologic therapy, cognitive-behavioral therapy, or combined therapy.

No. 39A
THE CLINICAL PICTURE AND EPIDEMIOLOGY OF SEASONAL AFFECTIVE DISORDER

Norman E. Rosenthal, M.D., *Department of Psychiatry, Georgetown University Medical School, 11110 Stephalee Lane, Rockville, MD 20852-3656*

SUMMARY:

Seasonal affective disorder (SAD) is a condition of recurring depressions in fall and winter, alternating with non-depressed periods in spring and summer. Winter depressions affect women more than men by a ratio of about 7:3, can be severe, and are typically characterized by lethargy, oversleeping, overeating and weight gain, as well as the usual mood-related symptoms of depression. The prevalence of SAD varies with latitude and is estimated at 1.5% in Florida and up to 9% in the northern United States. Evidence suggests that SAD is under-diagnosed. Differential diagnoses include flu, hypothyroidism and chronic fatigue syndrome. Seasonal exacerbations are common in patients with other conditions, notably other recurrent mood disorders and eating disorders and are important to recognize insofar as they suggest additional treatment options.

No. 39B
PATHOPHYSIOLOGY OF SEASONAL AFFECTIVE DISORDER

Thomas A. Wehr, M.D., *Intramural Department, National Institute of Mental Health, 10 Cedar Lane, MSC1390, Bethesda, MD 20892-1390*

SUMMARY:

An enormous amount of work has been done on the pathophysiology of SAD and mechanisms of action of light therapy. This talk will cover evidence for involvement of melatonergic, serotonergic, dopaminergic, and noradrenergic pathways in SAD. Melatonin, a widespread transducer of seasonal changes in animals, varies seasonally in SAD patients, but not controls. Serotonin levels in the blood and hypothalamus vary, respectively, seasonally and in response to daily light levels. SAD patients respond abnormally to stimulation of serotonergic systems, and tryptophan depletion reverses the beneficial effects of light therapy. Dopaminergic involvement in SAD is suggested by decreased behavioral engagement, and abnormal eye blink rates and electroretinogram (ERG) responses. Circadian rhythm changes have been implicated in the mechanism of action of light therapy, with earlier shifts associated with stronger responses. Recent genetic and neuroimaging data will also be discussed. In summary, an abundance of research data suggests useful treatment strategies in SAD, notably drugs affecting melatonin, serotonin, and dopamine systems. Light therapy may also work via these systems inter alia.

No. 39C
LIGHT TREATMENT FOR WINTER DEPRESSION: STATUS REPORT

Raymond W. Lam, M.D., *Department of Psychiatry, University of British Columbia Hospital, 2255 Wesbrook Mall, Vancouver, BC V6T 2A1, Canada*

SUMMARY:

The concept of seasonal affective disorder (SAD, winter depression) has been closely linked with light therapy, a novel psychiatric treatment consisting of exposure to bright, artificial light. There is now considerable evidence illustrating the efficacy of light therapy for SAD. Large placebo-controlled trials, meta-analyses, and systematic reviews have consistently shown that bright light can be used to treat symptoms of winter depression. Adverse effects associated with light treatment are minimal. Light therapy appears to be safe for long-term use, although patients with ocular risk factors should have ophthalmologic evaluation and periodic monitoring prior to and during treatment. The gold-standard device for light treatment is the 10,000 lux fluorescent light box. Important parameters for administering light include intensity, wavelength, duration, and timing of light exposure. Newer light devises (e.g., light emitting diodes, head-mounted devices, dawn simulators) show promise for reducing the inconvenience associated with daily use of light therapy.

No. 39D
MEDICAL TREATMENT INCLUDING MECHANISM OF ACTION, NEW STUDY DATA

Jennifer K. Pennell, M.D., *547 Keisler Drive, Suite 103, Cary, NC 27511*

SUMMARY:

Seasonal affective disorder (SAD) affects an estimated 2% to 10% of Americans. Light therapy is considered to be the treatment of choice. However, pharmacologic intervention may be necessary when there is incomplete response to light therapy, comorbidity, or patient preference to drug treatment. The purpose of this presentation is to review the current literature supporting medications in the treatment of SAD and their mechanism of action.

Research has shown that tryptophan depletion and catecholamine depletion worsen depressive symptoms in patients with SAD, suggesting that SSRIs and possibly noradrenergic agents could be used to treat SAD. Previously published studies have investigated the efficacy of fluoxetine, sertraline, citalopram, beta blockers, and moclobemide in the treatment of SAD. Ongoing studies are investigating the use of bupropion and propanolol. Most of the previously published studies have investigated only a small number of participants over a short period of time, so the data must be interpreted with caution. However, despite study limitations, medications do have a role in the treatment of SAD.

No. 39E
INTEGRATING COGNITIVE-BEHAVIORAL THERAPY INTO SEASONAL AFFECTIVE DISORDER TREATMENT

Kelly J. Rohan, Ph.D., *Department of Clinical Psychiatry, Uniform Services University, 4301 Jones Bridge Road, Bethesda, MD 20814-4799;* K.A. Roecklein, B.A., Lindsey K. Tierney, M.S., Leigh G. Johnson, B.S., Robert D. Lippy, B.S., Timothy J. Lacy, M.D.

SUMMARY:

Studies suggest that cognitive and behavioral factors may be involved in SAD, including automatic thoughts, dysfunctional attitudes, low rates of positive reinforcement, and rumination. Therefore, cognitive-behavioral therapy (CBT), which effectively targets these cognitions and behaviors, may be an appropriate treatment option. Our research group conceptualized and developed a manual for a novel, SAD-tailored version of CBT. In this symposium, we will provide an overview of our CBT intervention and present efficacy data from two preliminary randomized clinical trials. Initially, we conducted a pilot/feasibility study (Rohan et al., 2004) comparing standard light therapy, CBT, and their combined synergistic effects in treating a current SAD episode. The second trial was a larger, multi-year study comparing the three active treatments to a minimal-contact/delayed light therapy control group. Findings across both trials are consistent: CBT, light therapy, and their combination all improved depressive symptoms to a comparable degree across the trial; the combination group demonstrated the highest remission rate and the most complete response; and CBT confers significant prophylactic benefits regarding episode recurrence one year later. In conclusion, SAD patients who do not remit with light therapy alone or who cannot adhere to the daily light therapy regimen may benefit from alternative or supplementary CBT.

REFERENCES:

1. Neumeister A, et al: Monoamines, in Seasonal Affective Disorder: Practice and Research. Edited by Partonen T, Magnusson A. Oxford University Press; 2000: pp. 201–217.
2. Lam RW, Levitt AJ (eds): Clinical Guidelines for the Treatment of Seasonal Affective Disorder. Vancouver, BC, Clinical & Academic Publishing; 1999.
3. Neumeister A, et al: Effects of tryptophan depletion vs. catecholamine depletion in patients with seasonal affective disorder in remission with light therapy. Arch Gen Psychiatry 1998; 55:524–530.
4. Rohan KJ, Tierney-Lindsey K, Roecklein KA, Lacy TJ: Cognitive-behavioral therapy, light therapy, and their combination in treating seasonal affective disorder: A pilot study. J Affect Disord 2004; 80:273–283.

INDUSTRY-SUPPORTED SYMPOSIUM 40—ALCOHOLISM: TRANSLATING EMERGING SCIENCE INTO CLINICAL PRACTICE
Supported by Alkermes

EDUCATIONAL OBJECTIVES:

At the conclusion of this program, participants should be able to recognize the importance of animal models as predictive factors for clinical efficacy of alcohol pharmacotherapies, translate into practice the importance of craving in the treatment of alcoholism and which treatment options are efficacious, interpret the results of randomized clinical trials of pharmacologic therapy in alcoholism and evaluate the new formulations that are on the horizon, identify the complexities in treating patients with alcoholism who are dual-diagnosed with other psychiatric disorders and recognize the importance of concomitant therapy.

No. 40A
ANIMAL MODELS POINT THE WAY TO NOVEL THERAPIES

George F. Koob, Ph.D., *Department of Neuropharmacology, Scripps Research Institute, 10550 North Torrey Pines Road, CVN7, La Jolla, CA 92037*

SUMMARY:

Animal models for various stages of the alcohol abuse cycle have been developed and provide a rational basis for medication development for alcoholism treatment. Animal models of excessive drinking include selective breeding of strains for alcohol preference, post-stress drinking, drinking following abstinence and withdrawal, and drinking during protracted abstinence in animals with a history of dependence. Animal models of relapse include reinstatement of alcohol-taking behavior following stress, conditioned cues, and drug intake. Human parallels exist for each of these relapse inducers. Medications that block various components of the addiction cycle associated with alcoholism reinstatement or relapse can be tested in human laboratory studies and subsequent clinical trials. Naltrexone and acamprosate—medications currently in clinical use—are effective in these models, and a host of new medications have shown promise in animal models and early human testing. These include several GABA modulators, an antagonist of corticotrophin-releasing factor, and a cannabinoid receptor antagonist. Knowledge of the basic neurobiology of alcoholism can inform the animal models: the animal models can inform the clinical situation; and the clinical situation can, in turn, help refine the animal models, leading to more promising medications with low toxicity and high likelihood of reducing relapse in human alcoholics.

No. 40B
BRAIN IMAGING OF CRAVING AND THE EFFECTS OF ANTI-CRAVING MEDICATIONS

Charles P. O'Brien, M.D., *Department of Psychiatry, University of Pennsylvania, 3900 Chestnut Street, Philadelphia, PA 19104-6178*

SUMMARY:

Recent studies involving noninvasive brain imaging in human subjects have elucidated the parts of the brain involved in the phenomenon of drug craving. Using a variety of techniques for studying regional brain activation including functional magnetic resonance imaging (MRI) and positron emission tomography (PET), several laboratories have found activation of limbic structures when patients are presented with stimuli that provoke intense drug craving. The use of C-11 labeled raclopride as a competition ligand in PET studies can also determine when the neurotransmitter dopamine is released in response to craving for food and for drugs. Anatomical studies have reported decreased neuronal cell density and decreased blood flow in frontal lobes consistent with reduced inhibitory control and increased impulsive behavior in patients exhibiting substance abuse. Recent human laboratory studies have utilized medications in an attempt to suppress drug craving and the brain activation that is thought to underlie this phenomenon. This presentation will compare and contrast animal studies of the biology of craving, human laboratory studies, and clinical trials with medications that both suppress craving and relapse to the compulsive use of alcohol and other drugs.

No. 40C
ADVANCES IN THE PHARMACOTHERAPY OF ALCOHOLISM

Helen M. Pettinati, Ph.D., *Department of Psychiatry, Treatment Research Center, 3900 Chestnut Street, Philadelphia, PA 19104*

SUMMARY:

The approval of naltrexone in the 1990s began a new era in alcoholism treatment. This presentation will review the more than 20 randomized, clinical trials worldwide that have shown naltrexone's efficacy in reducing relapse among alcoholics. We will also review negative studies and compare the batting average for naltrexone with that of antidepressants. An exciting development is recent evidence that response to nalrexone is great among alcoholics with high alcohol craving and a family history of alcoholism. A major problem in the pharmacologic treatment of alcoholism, however, has been the lack of patient adherence to medication. In at least two positive studies of oral naltrexone, the drug's superiority to placebo was dependent on measurement of medication adherence. A major development is the arrival of a long-acting naltrex-one preparation that delivers therapeutic levels of drug for 30 days after a single injection and has minimal side effects. One extended-release formulation that is well advanced in the FDA approval process was recently found to be effective in reducing heavy drinking in actively drinking alcoholics, especially men. This presentation will review the use of different doses of naltrexone and specific psychosocial interventions that facilitate relapse prevention in combination with medication.

No. 40D
TREATMENT OF ALCOHOLISM COMBINED WITH OTHER MENTAL DISORDERS

Hugh Myrick, M.D., *Department of Psychiatry, Medical University of South Carolina, 67 President Street, Charleston, SC 29425*

SUMMARY:

Epidemiological studies suggest that 40%–60% of alcoholics have a comorbid psychiatric diagnosis. Alcoholism is commonly combined with a variety of other mental disorders including major depressive disorder, bipolar disorder, a variety of anxiety disorders, and schizophrenia. Moreover, the risk of suicide for any psychiatric disorder is greatly increased by the co-occurrence of alcoholism and other forms of substance abuse. Currently, treatment is not well designed to cope with dual diagnosis, nor are most psychiatrists trained to treat both substance abuse and an additional mental disorder. Medications that improve the outcome of "pure" alcoholism, such as naltrexone, disulfiram, and acamprosate, generally can be combined with medications for mood stabilization, anxiety, schizophrenia, and depression. This presentation will review data showing the proportion of alcoholics with dual diagnosis as well as the available literature dealing with psychosocial interventions and medication combinations that have shown efficacy for this complex clinical problem. Finally, the presentation will describe a model treatment program that integrates the treatment of alcoholism with management of other mental disorders in a dual-diagnosis clinic.

REFERENCES:

1. Koob GF, Le Moal, M: Drug abuse: hedonic homestatic dysregulation. Science 1997; 278:52–58.
2. Childress AE, Mozley PD, McElgin W, Fitzgerald J, Reivich M, O'Brien CP: Limbic activation during cue-induced cocaine craving. Am J Psychiatry 1999; 156(1):11–18.
3. Kiefer F, Jahn H, Tarnaske T, et al: Comparing and combining naltrexone and acamprosate in relapse prevention of alcoholism: a double-blind, placebo-controlled study. Arch Gen Psychiatry 2003; 60(1):92–99.
4. Moak DH, Anton RF, Latham PK, Voronin KE, Waid RL, Durazo-Arvizu R: Sertraline and cognitive behavioral therapy for depressed alcoholics: results of a placebo-controlled trial. J Clin Psychopharm 2003; 23(6):553–562.

INDUSTRY-SUPPORTED SYMPOSIUM 41—ADVANCES IN CHOLINERGIC THERAPY: ALZHEIMER'S DISEASE AND BEYOND
Supported by Eisai, Inc. and Pfizer Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the impact of cholinergic therapy beyond symptomatic treatment for AD; recognize the potential role of AChEis in neuroprotection; describe the benefits of magnetic resonance imaging in assessing AD; discuss the outcome of recent clinical trials in mild cognitive impairment; describe the rationale for cholinergic treatment of schizophrenia; treat behavioral disturbances associated with AD.

No. 41A
REVISITING THE CHOLINERGIC HYPOTHESIS: ARE CHOLINESTERASE INHIBITORS MORE THAN SYMPTOMATIC TREATMENTS FOR ALZHEIMER'S DISEASE?

Norman Relkin, M.D., *Department of Neurology, Weill-Cornell, 428 East 72nd Street, Suite 500, New York, NY 10021*

SUMMARY:

The cholinergic hypothesis attributes the symptoms of Alzheimer's disease (AD) to degeneration of the nucleus basalis of Meynert, the brain's major cholinergic nucleus. This hypothesis, which was first proposed in the early 1980s, has fallen out of favor relative to theories implicating the amyloid beta protein in AD's pathogenesis. Nevertheless, cholinesterase inhibitors became the first generation of approved treatments for mild to moderate AD, and have proven

beneficial in controlled trials as well as clinical practice. Prevailing dogma is that the clinically relevant mechanism of action of cholinesterase inhibitors in AD is prolongation of the lifetime of acetylcholine at brain synapses. It is also widely held that cholinesterase inhibitors are purely "symptomatic" therapies that temporarily ameliorate some of the symptoms of AD without changing the underlying disease process. Recent evidence from clinical and pre-clinical studies seriously challenges these views. In addition to slowing the hydrolysis of acetylcholine, cholinesterase inhibitors have been documented to exert a variety of other biological effects that may contribute to their long-term benefits in treating AD and other disorders. Evidence is emerging that cholinesterase inhibitors have neuroprotective effects and/or may alter certain elements of AD pathology. These and other observations suggest that treatment with cholinesterase inhibitors may be more efficacious when initiated very early in the disease, possibly during pre-symptomatic stages, and then used persistently throughout its course.

No. 41B
THE ROLE OF IMAGINING IN THE STUDY AND TREATMENT OF DEMENTIA

K. Ranga R. Krishnan, M.D., *Department of Psychiatry, Duke University Medical Center, Box 3950 DUMC, Durham, NC 27710*

SUMMARY:

Alzheimer's disease (AD), a progressive neurodegenerative dementia, is associated with hippocampal atrophy and loss of cortical neuron function. Hippocampal volume loss occurs faster in AD patients, so volume measures may have prognostic value. N-Acetylaspartate is accepted as a marker of functional and structural integrity of neurons. New imaging techniques allow for a more quantitative evaluation of structural and metabolic changes. When dementia is confirmed, computed tomography (CT) scan or magnetic resonance imaging (MRI) appears very useful to define the etiology of dementia or acute deterioration during evolution. Specifically, the use of MRI allows for measurement of hippocampal volumes, while proton magnetic resonance spectroscopy is useful in the measurement of brain concentrations of N-acetylaspartate. In a recent study, MRI measures of neuronal function and hippocampal atrophy were used to assess the effects of donepezil, a cholinesterase inhibitor, on N-acetylaspartate concentration and hippocampal volume in patients with mild to moderate AD. Imaging results demonstrate a possibility that cholinesterase inhibitors have a beneficial effect on brain structure. Donepezil was found to be associated with significantly increased N-acetylaspartate concentrations in two brain regions, less hippocampal volume reduction, and significant cognitive improvements. Donepezil may also slow the short-term progression of hippocampal atrophy in AD.

No. 41C
CLINICAL TRIALS IN MILD COGNITIVE IMPAIRMENT

Ronald C. Peterson, M.D., *Department of Neurology, Mayo Clinic, 200 First Street, N.W., Rochester, MN 55905*

SUMMARY:

Amnestic mild cognitive impairment (MCI) represents a transitional state between the cognitive changes of normal aging and in very early Alzheimer's disease. This presentation will discuss the essential features of the diagnosis of amnestic MCI and compare it with other subtypes of MCI. The recent clinical trials completed in MCI will be discussed in brief. The outcome of the clinical trial MCI sponsored by the Alzheimer's Disease Cooperative Study will be discussed in detail. The study involved a three-arm, parallel-group, placebo-control trial of vitamin E, donepezil, and placebo. The primary outcome measure was the clinical progression to probable Alzheimer's disease. Implications for clinical practice will be discussed.

No. 41D
PHARMACOLOGICAL TREATMENT OF COGNITIVE IMPAIRMENTS IN SCHIZOPHRENIA

Robert W. Buchanan, M.D., *Department of Psychiatry, Maryland Psychiatric Research, PO Box 21247, Baltimore, MD 21228-5567*

SUMMARY:

Patients with schizophrenia are characterized by a broad range of cognitive impairments, including attention/information processing, processing speed, reasoning/problem-solving, social cognition, verbal and visual learning and memory, and working memory. These impairments are major determinants of poor social and occupational functioning. Conventional antipsychotics have limited effects on these impairments. Second-generation antipsychotics may have modest benefits for cognitive function, but whether these benefits represent a direct cognitive enhancing effect or an indirect effect through decreased adverse effects has not been established. The MATRICS Project was developed by the NIMH to facilitate the discovery of new pharmacological approaches for the treatment of cognitive impairments in patients with schizophrenia. The MATRICS Project is designed to identify the key domains of cognitive impairment in schizophrenia, to develop a battery to assess these domains, to identify promising pharmacological targets for the treatment of these domains, and to facilitate NIMH/FDA/industry collaborations around drug development. The cholinergic system has been proposed as a potential target system for the development of new pharmacological approaches for cognitive impairments. An overview of cognition in schizophrenia, the MATRICS project, and the rationale for the use of acetylcholinesterase inhibitors and preliminary data supporting their efficacy in schizophrenia will be presented.

No. 41E
BEHAVIORAL DISTURBANCES IN ALZHEIMER'S DISEASE: DIAGNOSIS AND TREATMENT

Helen Lavretsky, M.D., *Department of Psychiatry, UCLA-NPI, 760 Westwood Plaza, Room 37-384, Los Angeles, CA 90095*

SUMMARY:

Alzheimer's disease (AD) is the most common type of progressive dementia. AD is commonly associated with behavioral disturbances. The latest data pertaining to the diagnosis, clinical features, and underlying pathophysiology of behavioral symptoms, such as depression, delusions, hallucinations, anxiety, and agitation, will be reviewed. The role of acetylcholine and other neurotransmitters in behavioral disturbances will be discussed. The existing treatment options and novel therapeutic approaches, both pharmacologic and nonpharmacologic, will be presented, and will include the recent studies of the cholinesterase inhibitors and other agents used exclusively or in combination to treat neuropsychiatric symptoms in patients with AD.

REFERENCES:

1. Krishnan KR, et al: Randomized, placebo-controlled trial of the effects of donepezil on neuronal markers and hippocampal volumes in Alzheimer's disease. Am J Psychiatry 2003; 160:2003–2011.
2. Grundman M, Petersen RC, Ferris SH, Thomas RG, Aisen PS, Bennett DA, Foster NL, Jack CR Jr., Galasko DR, Doody R, Kaye J, Sano M, Mohs R, Gauthier S, Kim HT, Jin S, Schultz AN, Schafer K, Mulnard R, van Dyck CH, Mintzer J, Zamrini

EY, Cahn-Weiner D, Thal LJ, for the Alzheimer's Disease Cooperative Study: Mild cognitive impairment can be distinguished from Alzheimer's disease and normal aging for clinical trials. Arch Neurol 2004; 61:59–66.
3. Cummings JL: Cholinesterase inhibitors: a new class of psychotropic compounds. Am J Psychiatry 2000; 157:4–15.
4. Lavretsky H: Therapy of depression in dementia. Expert Rev Neurotherpautics 2003; 3(5):89–97.

INDUSTRY-SUPPORTED SYMPOSIUM 42—CHALLENGES AT THE INTERFACE OF PSYCHIATRIC, MEDICAL, AND SLEEP DISORDERS
Supported by Sanofi-Aventis, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to comprehend the inter-relationship between sleep disorders, psychiatric morbidity, and medical disorders, and how sleep disturbances can be detrimental to psychiatric and general medical conditions.

No. 42A
EPIDEMIOLOGICAL AND LONGITUDINAL PERSPECTIVES ON INSOMNIA AND PSYCHIATRIC ILLNESS

Daniel E. Ford, M.D., *Department of Medicine, Johns Hopkins, 2024 East Monument Street Suite 2-518, Baltimore, MD 21287*

SUMMARY:

Epidemiologic studies of insomnia and psychiatric illnesses demonstrate that psychiatric disorders are common among insomnia sufferers and that insomnia is common among patients with psychiatric disorders. Longitudinal studies show that a history of insomnia increases both the one-year and lifetime risks of developing a psychiatric illness, particularly mood, anxiety, and substance abuse disorders. Several community-based surveys have confirmed that insomnia is the symptom most predictive of future major depression. A new analysis of longitudinal data of a general population sample with a mean 12-year follow up demonstrates that individuals with baseline sleep disturbances because of worry have a two-fold higher risk for developing an alcohol-related problem, and that the risk is highest for those with co-occurring anxiety disorders or dysphoria. For patients diagnosed with major depression, the report of sleep disturbance often is the first symptom heralding a recurrence. These epidemiologic findings highlight the crucial role that identifying and treating sleep disturbances may play in reducing psychiatric morbidity. Future population studies should help elucidate the natural history and interactions of sleep disturbances and psychiatric disorders and will help evaluate the consequences of treatment.

No. 42B
CHANGING WOMEN'S SLEEP VULNERABILITIES ACROSS THE LIFE CYCLE

Lois Krahn, M.D., *Department of Psychiatry, Mayo / Scottsdale, 13400 E. Shea Blvd., Scottsdale, AZ 85259*

SUMMARY:

Across the life cycle women are more likely than men to have sleep difficulties. The perimenopause and menopause phases, when up to 60% of women experience insomnia, illustrate well the multitude of biological, behavioral, and environmental factors that modulate the quantity and quality of sleep. Several hormones including thyroid, progesterone, estrogen, and testosterone among others influence sleep. Major depressive and anxiety disorders, more commonly experienced by women than men, are associated with sleep disturbances. Primary sleep disorders, including obstructive sleep apnea, which increases in incidence post-menopausally, contribute to poor nighttime sleep and compromised daytime functioning. Furthermore, the family and professional roles that women fulfill also potentially affect sleep. This presentation will discuss the literature available on sleep in women, highlighting the recognition and management of insomnia. Therapeutic approaches depend on the etiology of the insomnia and include behavioral techniques, replacement of hormones, continuous nasal positive airway pressure, and various psychopharmacologic agents. Psychiatrists often collaborate with colleagues in primary care and obstetrics/gynecology in the effort to optimize sleep in women patients. Identifying effective solutions to sleep complaints is increasingly recognized as being an important step in reducing associated psychiatric disorders, decrease health care costs as well as improving quality of life.

No. 42C
SLEEP DISTURBANCES AND NEURODEGENERATIVE DISORDERS

Raymond R. Auger, M.D., *Department of Psychiatry, MAYO Clinic, 200 First Street S.W., Rochester, MN 55905*

SUMMARY:

Sleep disturbances commonly accompany neurodegenerative disorders such as Parkinson's disease (IPD) and Alzheimer's disease (AD). It is most dramatic in the rare prion disease, fatal familial insomnia. Alterations in sleep-wake cycle patterns, circadian rhythms, and sleep stages have been demonstrated in these disorders. Associated clinical manifestations may include marked nighttime sleep disruption and poorly sustained daytime wakefulness, nocturnal wandering and falls, and agitation and behavioral outbursts. Ultimately, these may contribute to institutionalization as families are unable to sustain round-the-clock management in the home. Primary sleep disorders, including sleep-disordered breathing, restless legs syndrome, and parasomnias may contribute further to the daytime and nighttime symptoms. REM sleep behavior disorder is associated with the alpha-synucleinopathies, which encompass IPD and the Parkinson-plus syndromes. Sleep disruption in AD is associated with APOE status. Sleep-wake cycle changes may result from medications prescribed to treat the underlying disease, as with the sudden irresistible sleep attacks encountered with dopamine-enhancing medications. This talk will review potential beneficial and deleterious sleep-related effects of medications prescribed for neurodegenerative disorders, such as dopaminergic agents, anticholinergics, and cholinesterase inhibitors. Therapeutic strategies targeting sleep-wake cycle symptoms include scheduled activity and light exposure, treatment of underlying sleep disorders, and optimization of pharmacological regimens.

No. 42D
METABOLIC CONSEQUENCES OF INSOMNIA: IMPLICATIONS FOR MEDICINE AND PSYCHIATRY

Gary S. Richardson, M.D., *Department of Medicine, Henry Ford Hospital, 2799 W Grand Boulevard CFP - 3, Detroit, MI 48202*

SUMMARY:

Patients with primary insomnia (PI) show evidence of autonomic hyperarousal, with increased activity of the sympathetic nervous system and the hypothalamic-pituitary-adrenal (HPA) axis. In its specific manifestations, this physiological hyperactivation is very

similar to that seen in major depression, a disorder that has been epidemiologically linked to PI in multiple studies. This has led us to speculate that the two disorders are related manifestations of the same underlying abnormality in the central regulation of autonomic activation (Richardson and Roth, 2001). Simultaneously, other investigators have shown that sleep restriction, even if imposed on otherwise normal subjects, can produce similar sympathetic responses to those seen in PI, and that this sympathetic activation, if sustained, may have important metabolic consequences, possibly including a link between sleep restriction and the metabolic syndrome. In combination, these studies raise important questions about the role of sleep deprivation, per se, in the pathology of PI and depression, and suggest new approaches to the treatment of these disorders. On a more speculative horizon, these findings suggest that sleep disruption may have important implications for psychiatric and medical health, and, conversely, that intervention to reverse sleep disruption may mitigate the risk for significant subsequent pathology.

No. 42E
THERAPEUTIC CHALLENGES IN TREATING INSOMNIA WITH COMORBID PSYCHIATRIC AND MEDICAL DISORDERS

David N. Neubauer, M.D., *Department of Psychiatry, Johns Hopkins Bayview Medical Center, 4940 Eastern Avenue, Suite A4 Center-456, Baltimore, MD 21224*

SUMMARY:

Patients with sleep disturbances warrant broad-based evaluations to assess the potential factors that may influence their sleep. These may include both psychological and physiological processes, and may involve a variety of psychiatric, medical, and primary sleep disorders. Habits and routines, substance use, and medication effects also may affect the amount and quality of sleep. Specific treatment approaches address these underlying disorders and processes. General insomnia treatments include sleep hygiene, behavioral, psychotherapeutic, and pharmacological interventions. Treatment efficacy studies typically have excluded subjects with significant medical or psychiatric disorders. This talk will review the emerging literature on the treatment of patients with insomnia comorbid with psychiatric and medical conditions. The discussion will include the rationale and potential therapeutic value of the wide range of medications now being investigated for use in the treatment of insomnia. Among these are extended-release benzodiazepine receptor agonists, presynaptic and postsynaptic GABA-A modulators, corticotropin releasing factor antagonists, 5-HT2A antagonists, and melatonin agonists. In the future, we will need studies with enhanced outcome measures allowing the assessment of the true effectiveness of these therapeutic interventions with patients in realistic clinical settings.

REFERENCES:

1. Ford DE, Cooper-Patrick L: Sleep disturbances and mood disorders: an epidemiological perspective. Depress Anxiety 2001; 14:3–6.
2. Moline ML, Broch L, Zak R, Gross V: Sleep in women across the life cycle from adulthood through menopause. Sleep Medicine Reviews 2003; 7:155–177.
3. Yesavage JA, et al: Sleep/wake disruption in alzheimer's disease: APOE status and longitudinal course. J Geriatr Psychiatry Neurol 2004; 17:20–24.
4. Spiegel K, Leproult R, Van Cauter E: Impact of sleep debt on metabolic and endocrine function. Lancet 1999; 354:1435–9.
5. Neubauer DN: Understanding Sleeplessness: Perspectives on Insomnia. Baltimore, Maryland, The Johns Hopkins University Press, 2003.

INDUSTRY-SUPPORTED SYMPOSIUM 43—IT'S NOT JUST FOR KIDS: ADHD IN ADOLESCENCE AND ADULTHOOD
Supported by Shire US, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the course of ADHD from adolescence into adulthood; learn the biological underpinnings that are common between youth and adults with ADHD, understand special considerations in preparing young adults with ADHD for college, learn empiric based psychotherapies and pharmacotherapies for adolescents and young adults with ADHD.

No. 43A
THE COURSE OF ADHD FROM ADOLESCENCE INTO ADULTHOOD

Christopher Kratochvil, M.D., *Psychiatry, University of Nebraska Medical Center, 515 S 26th St., Omaha, NE 68105-5584*

SUMMARY:

Attention deficit/hyperactivity disorder (ADHD) is a chronic disease that can lead to functional impairment throughout the life of an individual. Once thought to be primarily a disorder of childhood, ADHD is now known to frequently extend into adolescence and ultimately adulthood. An increased awareness of this extension into adulthood has led to further study of the presentation of this disorder during various stages of life, resulting impairment, and ultimately treatment. This information has been utilized to educate clinicians about potential presenting symptoms of the disorder in order to increase surveillance and identification of adolescent and adult ADHD. Additionally, increased public awareness has led to individuals proactively seeking care for their previously unrecognized symptoms of ADHD.

This presentation will discuss the clinical course and evaluation of ADHD symptoms from adolescence to adulthood.

No. 43B
NEUROBIOLOGICAL UPDATE ON ADHD IN ADOLESCENCE AND ADULTHOOD

Stephen V. Faraone, Ph.D., *Dept. of Psych. and Behavioral Services, SUNY Upstate Medical University, 750 East Adams St, Syracuse, NY 13210;* Joseph Biederman, M.D.

SUMMARY:

A growing body of research describes the neurobiology of ADHD in adolescence and adulthood. Behavioral genetic and molecular genetic studies show that genes influence susceptibility to ADHD. These findings suggest that the genetic mechanisms that predispose individuals to ADHD are complex. It seems likely that the disorder is caused by the combined actions of several genes interacting with environmental risk factors. Family-genetic data also suggest that cases of ADHD that persist into adolescence and adulthood may have stronger genetic underpinnings than those that remit. Neuropsychological and brain imaging studies provide objective evidence for abnormalities in brain structure and function in adolescent and adult ADHD. These studies implicate frontal-subcortical-cerebellar neural circuits in the pathophysiology of the disorder, but also point to more widespread deficits, suggesting that any theory of ADHD's pathophysiology must provide a model for understanding widely distributed brain dysfunction. Neuroimaging studies also show that ADHD is associated with increased activity of the dopamine transporter, which is the site of action of the stimulants medications.

These findings are consistent with genetic studies of the dopamine transporter gene. We discuss the implications of these findings for understanding the course of ADHD and planning treatment throughout the lifespan.

No. 43C
COLLEGE CONSIDERATIONS IN YOUNG ADULTS WITH ADHD

Sharon B. Wigal, Ph.D., *Pediatrics Department, University of California, Irvine, 19722 MacArthur Boulevard, Irvine, CA 92697-4480*

SUMMARY:

The American College of Testing estimates that one in four college students drops out before completing their sophomore year. Although relatively little research has been devoted to college students diagnosed with attention deficit/hyperactivity disorder (ADHD), clinicians and investigators have a growing awareness that this disorder of childhood continues to persist into adulthood. College students with ADHD, as compared with control students, present with more academic impairment including lower mean grade-point averages and greater academic probation (Heligenstein et al., 2000). Young adults, in general, may be ill-equipped in a variety of ways for handling the organizational demands of independent living. Such difficulty in organizing time and materials is especially apparent in the academic struggles of individuals with ADHD. However, with the proper resources and support, college students diagnosed with ADHD can meet the challenges of higher education with success. Topics to be discussed include college issues that may arise, providing organizational and test-taking strategies, and how to assist college students in advocating for themselves in order to receive accommodations in their campus environment.

No. 43D
NEW PSYCHOTHERAPIES DIRECTED AT YOUNG ADULTS WITH ADHD

Steven A. Safren, Ph.D., *Dept. of Psychiatry, Mass General Hospital, 15 Parkman St, WACC 815, Boston, MA 02118*

SUMMARY:

Published recommendations for the treatment of ADHD in adulthood call for psychosocial intervention concomitant with medications. While psychopharmacotherapy remains the first-line approach for treating this neurobiological disorder, controlled trials of stimulant, tricyclic, monoamine oxidase inhibitor, and atypical antidepressants suggest that 20% to 50% of patients are considered nonresponders, and of the responders, many experience only 50% or less of symptom reduction. Hence, psychosocial interventions for residual symptoms post-medication treatment can play a great role in reducing symptom severity and quality-of-life impairments. Young adults may be particularly at risk for impairments as they approach new, demanding tasks such as college, graduate school, or new demanding employment situations. This talk will provide an overview of cognitive-behavioral therapy for residual adult ADHD developed at Massachusetts General Hospital by the cognitive-behavioral therapy program and the ADHD treatment programs, with specific application to young adults. In a randomized, controlled trial, this treatment was compared with continued medications only and demonstrated clinically and statistically significant improvements compared with continued medications only. The sample consisted of adults with ADHD who were stabilized on medication treatment for two months but still had residual symptoms. The treatment presented includes three core modules: organizing and planning, coping with distractibility, and cognitive restructuring for promoting adaptive thinking. It also includes optional modules for issues such as procrastination and gaining assistance from family members or significant others.

No. 43E
MEDICATION CONSIDERATIONS IN YOUNG ADULTS WITH ADHD

Timothy E. Wilens, M.D., *Department of Child Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 725, Boston, MA 02114*

SUMMARY:

As children with attention deficit hyperactivity disorder (ADHD) grow up, it is increasingly common for practitioners to treat ADHD in young adults. Although medication therapy has been well studied and implemented in treating ADHD in children, the use of pharmacological treatments for young adults with ADHD remains less well established. In this presentation, the efficacy and adverse-effect profiles of the various agents investigated for child and adult ADHD will be assessed as treatments for ADHD in the young adult population. Placebo-controlled studies of stimulants, antidepressants, and norepinephrine reuptake inhibitors (NRIs) will be presented, demonstrating their relative efficacies in treating ADHD. Differences between these medications in terms of tolerability and onset of action will be considered in choosing the most appropriate treatments for this patient population. While young adults may be considered to have the same disorder as their younger counterparts, the increasing responsibilities and stresses in life that accompany increasing maturity create an even greater urgency in providing the optimal treatment for these patients.

REFERENCES:

1. Adler L: Clinical presentations of adult patients with ADHD. J Clin Psychiatry 2004; 65 [Suppl 3]:8–11.
2. Faraone SV, Biederman J: Neurobiology of attention-deficit hyperactivity disorder. Biological Psychiatry 1998; 44:951–958.
3. Safren SA, Sprich S, Chulvick S, Otto MW: Psychosocial treatments for adults with ADHD. Psychiatric Clinics of North America 2004; 27:349–360.
4. Heileigenstein E, Guenther G, Levy A, Savino F, Fulwiler J: Psychological and academic functioning in college students with attention deficit hyperactivity disorder. J Am Coll Health 1999; 47(4):46–48.
5. Wilens T, Spencer T, Biederman J, Prince J: Pharmacotherapy of ADHD in adults: a review of the literature, J Alt Disorders 2002; 5:189–202.

WEDNESDAY, MAY 25, 2005

INDUSTRY-SUPPORTED SYMPOSIUM 44—BIPOLAR DISORDER ACROSS THE LIFE CYCLE: SPECIAL CONSIDERATIONS, PART 1
Supported by GlaxoSmithKline

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to better identify bipolar disorder in children, women, and the elderly. A special emphasis on the risks and benefits of pharmacologic interventions in these special populations will be discussed.

No. 44A
BIPOLAR DISORDER IN CHILDREN: IMPORTANCE OF EARLY INTERVENTION

Karen D. Wagner, M.D., *Division of Child and Adolescent Psychiatry, University of Texas Medical Branch, 1.302 Rebecca Sealy, 301 University Boulevard, Galveston, TX 77555-0188*

SUMMARY:

There is increasing recognition that bipolar disorder often has its onset in childhood. Variations in developmental expression and comorbidity present significant diagnostic challenges. Early identification and appropriate treatment intervention may prevent significant adverse sequelae. This presentation will discuss diagnostic issues and recommend treatment guidelines for childhood bipolar disorder.

No. 44B
BIPOLAR DISORDER: IMPACT OF REPRODUCTIVE HORMONES

Natalie L. Rasgon, M.D., *Psychiatry and Behavioral Sciences, Stanford School of Medicine, 401 Quarry Road, Room 2360, Palo Alto, CA 94305-5723*

SUMMARY:

The course of bipolar disorder in women may be influenced by the menstrual cycle, pregnancy, the postpartum period, and menopause. Two-thirds of women suffering from this condition report frequent premenstrual mood disturbances and almost 20% of postmenopausal women with bipolar disorder report severe emotional disturbances during menopause. Additional areas of consideration include an increased risk of relapse during pregnancy and postpartum periods, as well as the relative risk when using lithium and mood stabilizers in pregnancy and lactation. Almost half of women diagnosed with bipolar disorder who had been pregnant report having experienced severe emotional disturbances in relation to childbearing, with close to one-third reporting episode onset during pregnancy.

REFERENCES:

1. Wagner KD: Management of bipolar disorder in children. Psychopharmacology Bulletin 2002; 36:151–159.
2. Blehar MC, DePaulo JR Jr, Gershon ES, et al: Women with bipolar disorder: findings from the NIMH Genetics Initiative sample. Psychopharmacology Bulletin 1998; 34(3):239–43.

INDUSTRY-SUPPORTED SYMPOSIUM 45—IMPACT OF STRESS AND ANXIETY ON BRAIN AND BODY
Supported by Cephalon, Inc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to familiarize participants with new advances in the understanding and treatment of stress-related conditions.

No. 45A
SICK AND TIRED: ANXIETY, STRESS, AND INSOMNIA

Murray B. Stein, M.D., *Department of Psychiatry, University of California at San Diego, 9500 Gilman Drive Mail Code 0985, La Jolla, CA 92093-0985*

SUMMARY:

Anxiety disorders are frequently associated with complaints of disturbed sleep. This presentation provides a review of the diagnostic criteria, sleep features, and treatment of sleep-related problems in patients with panic disorder, generalized anxiety disorder, and posttraumatic stress disorder. Subjective sleep complaints are most prominent in patients with posttraumatic stress disorder, panic disorder, and generalized anxiety disorder, and must be understood in the context of depressive disorders, which are commonly comorbid. Abrupt nocturnal awakenings are not uncommonly encountered in anxiety disorders such as panic disorder and posttraumatic stress disorder, where they are thought to be non-REM and REM-related phenomena, respectively. Treatments that target sleep can improve outcomes in patients with anxiety disorders. The evidence for treatments that improve anxiety also improving sleep and other health outcomes will be reviewed. Recommendations for clinical evaluation and treatment by practicing psychiatrists will be provided.

No. 45B
IMPACT OF ANXIETY ON WOMEN'S HEALTH: FOCUSING ON THE LINK BETWEEN TRAUMA AND CHRONIC PAIN

Samantha Meltzer-Brody, M.D., *Department of Psychiatry, University of North Carolina, Campus Box 7160, Chapel Hill, NC 27599*

SUMMARY:

Anxiety symptoms often present in women with somatic complaints including functional pain syndromes such as irritable bowel syndrome (IBS), fibromyalgia, headaches, and chronic pelvic pain (CPP). The somatic presentation of anxiety is often associated with a history of sexual or physical abuse, or other trauma. The long-term consequences in women of abuse include psychological sequelae such as depression and anxiety disorders, including posttraumatic stress disorder (PTSD) and adverse physical health effects including chronic pelvic pain, IBS, and fibromyalgia. In this presentation, we will examine the association of history of trauma and the development of adverse psychological and physical health consequences in women. The relationship between abuse, chronic pain, and psychiatric illness is complex and the pathophysiology remains unclear. However, more invasive and serious types of trauma and abuse have been associated with worse health status in women with functional pain syndromes such as IBS and chronic pelvic pain. We will discuss the relevance of considering the presence of trauma and PTSD in women with chronic pain syndromes and the importance of targeting treatment of these mood and anxiety states in optimizing the care of women with chronic pain complaints.

No. 45C
HEALTH EFFECTS OF EXPOSURE TO VIOLENCE IN WOMEN

Soraya Seedat, M.D., *Department of Psychiatry, University of Stellenbosch Fransie Van Zyl Drive P.O. Box 19063, Cape Town 7505, South Africa*

SUMMARY:

Despite an increasingly well-documented literature on the impact of intimate partner violence (IPV) on mental health, little epidemiologic research has focused on its long-term physical health consequences. In addition to disorders such as posttraumatic stress disorder and major depression, IPV has been linked to adverse medical health effects, and optimal management of chronic medical illness (e.g. asthma, diabetes, HIV/AIDS) may also be problematic when IPV is a confounding factor. This presentation will review the mental and physical health consequences of IPV in clinical and non-clinical

samples and examine risk factors and relationships with childhood maltreatment. Recent studies that have focused on the neurobiological and neuropsychological correlates of IPV in women will be presented. The little that is known about treatment and outcomes for women with history of IPV and IPV-related PTSD indicates the need for prevention, intervention, and treatment of this population. Certainly in women with chronic PTSD secondary to physical and sexual violence, there is evidence from randomized, controlled studies that cognitive-behavioral strategies and selective serotonin reuptake inhibitors (SSRIs) are effective. In summary, the serious health effects associated with IPV underscore the importance of identifying women who may be at risk.

No. 45D
NEUROIMAGING AND THE TRAUMATIZED BRAIN: PTSD AND EMOTION

Ruth A. Lanius, M.D., *University Campus, London Health Sciences Center, 339 Windermere Rd PO Box 5339, London, ON N6A 5A5, Canada*

SUMMARY:

The goal of this study was to compare areas of brain activation and inter-regional brain activity correlations during two different types of response (flashback/reliving and dissociative) to the recall of traumatic memories in traumatized subjects with posttraumatic stress disorder (PTSD) using standard subtraction and functional connectivity analyses.

4.0 Tesla functional magnetic resonance imaging (fMRI), subtraction and functional connectivity analyses (psychophysiological interactions (PPI) (SPM99) were used to assess inter-regional brain activity correlations during script-driven symptom provocation in traumatized subjects with (n=31) and without (n=25) PTSD.

PTSD subjects with flashback/reliving responses showed greater activation of the prefrontal cortex (BA 9, 10, 11) bilaterally, the left inferior parietal lobe (BA 40), and the left precentral gyrus (BA 6). In contrast, dissociated PTSD subjects showed greater activation in the occipital lobes (BA 19) and bilateral thalami.

Comparison of connectivity maps of PTSD patients with flashback/reliving and dissociative responses showed significant differences in brain areas involved in emotional and pain processing.

The heterogeneity of response to symptom provocation observed in PTSD may be important in further elucidating neuronal mechanisms underlying different subtypes of the disorder and thus contribute to the development of better treatment strategies for PTSD and related disorders such as chronic pain.

No. 45E
TREATMENT OF ANXIETY: THE PHARMACOTHERAPY OF PSYCHE AND SOMA

Mark H. Pollack, M.D., *Department of Psychiatry, Massachusetts General Hospital, Wang ACC-815, 15 Parkman Street, Boston, MA 02114*

SUMMARY:

Recognition that somatic as well as psychological symptoms figure prominently in the presentation and morbid distress associated with the anxiety disorders has increased. The overlap of anxiety with a variety of symptoms referable to the cardiovascular, pulmonary, gastrointestinal, and neurological systems have been well described, and recent attention has focused on additional physical symptomatology including comorbid pain and sleep complaints. As a result, evaluation of treatment effectiveness is beginning to include consideration of impact on sematic symptoms as well as the more classic measures of psychic distress. In this presentation we will cull the available data on standard and novel anxiolytic therapies to examine their impact on "soma"—the breadth of physical symptoms that often manifest prominently in anxiety patients—as well as on "psyche", review potential future directions of research in this area, and discuss the implications of these issues for practice in the clinical setting.

REFERENCES:

1. Stein MB, Mellman TA: Anxiety disorders, in Principles and Practice of Sleep Medicine, 4th Edition. Edited by Kryger MH, Roth T. Baltimore, Maryland, Williams & Wilkins, in press.
2. McCauley J, Kern DE, Kolodner K, Dill L, et al: Clinical characteristics of women with a history of childhood abuse: unhealed wounds. JAMA 1997; 277:1362–8.
3. Coker AL, Davis KE, Arias I, Desai S, et al: Physical and mental health effects on intimate partner violence for men and women. Am J Prev Med 2002; 23(4):260–268.
4. Lanius RA, Williamson PC, Densmore M, Boksman K, Neufeld RW, Gati JS, Menon RS: The nature of traumatic memories: a 4-T fMRI functional connectivity analysis. Am J Psychiatry 2004; 160:1–9.
5. Pollack MH, Smoller JW: Diagnosis and treatment of anxiety in primary care, in Massachusetts General Hospital Handbook of Psychiatry in Primary Care. Edited by Stern T, Herman J, Slavin PL. McGraw-Hill, New York, 1998.

THURSDAY, MAY 26, 2005

INDUSTRY-SUPPORTED SYMPOSIUM 44—BIPOLAR DISORDER ACROSS THE LIFE CYCLE: SPECIAL CONSIDERATIONS, PART 2
Supported by GlaxoSmithKline

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to better identify bipolar disorder in children, women, and the elderly. A special emphasis on the risks and benefits of pharmacologic interventions in these special populations will be discussed.

No. 44A
BIPOLAR DISORDER IN PREGNANCY: A CLINICIAN'S DILEMMA

Zachary N. Stowe, M.D., *Department of Psychiatry, Emory University School of Medicine, 1635 Clifton Road, NE Suite# 6100, Atlanta, GA 30322*

SUMMARY:

The treatment of women with bipolar disorder (BPD) during pregnancy and the postpartum period remains a complicated clinical dilemma. Limited data suggest that the course of BPD during pregnancy and particularly the postpartum period is tumultuous. The impact of BPD on obstetrical outcome and infant well-being remains obscure, though maternal depression and stress may have adverse effects. The FDA-approved medications for BPD include numerous medications that are known teratogens. The expansion of the pharmacological armamentarium to include atypical antipsychotic medications and additional anti-epileptic medications has provided alternative avenues for BPD during pregnancy and lactation. Information regarding the reproductive safety information on these medications, and the extent of fetal and neonatal exposure will be reviewed.

Clinical guidelines for approaching women with BPD pre-conception and during pregnancy will be discussed. These guidelines consider factors such as initial therapy in women with BPD, psychiatric history, use of multiple medications, and therapeutic monitoring of medications over pregnancy. Balancing the risk of BPD in pregnancy and lactation with the extant literature on pharmacological agents combined with the knowledge of how to monitor such medications is the cornerstone of designing management strategies to minimize the risk.

No. 44B
BIPOLAR DISORDER IN THE ELDERLY: SPECIAL TREATMENT CONSIDERATIONS

John L. Beyer, M.D., *Psychiatry and Behavioral Sciences, Duke University School of Medicine, 4098 Hospital South, Durham, NC 27710*

SUMMARY:

Although the emphasis in studies of bipolar disorder is often in young adults, bipolar disorder is a life-long illness with a variable course. As our population ages, we find a decline in the incidence of bipolar disorder in the older cohorts, but continued high admission rates to psychiatric hospitals. Understanding issues related to the course of bipolar disorder, interaction of medical comorbidities, sensitivity to medications, and the physical changes due to aging are important factors in treating this special population.

REFERENCES:

1. Yonkers KA, Wisner KL, Stowe Z, Leibenluft E, Cohen L, Miller L, Manger R, Viguera A, Suppes T, Altshuler L: Management of bipolar disorder during pregnancy and the postpartum period. Am J Psychiatry 2004; 161(4):608–20.
2. Beyer JL, Kuchibhatla M, Looney C, Engstrom E, Cassidy F, Krishnan KR: Social support in elderly patients with bipolar disorder. Bipolar Disord 2003; 5(1):22–7.

MONDAY, MAY 23, 2005

SCIENTIFIC AND CLINICAL REPORT SESSION 1—PSYCHOSOMATIC MEDICINE: INTEGRATING PSYCHIATRY AND MEDICINE

No. 2
TEACHING PSYCHOSOMATIC MEDICINE IN PRIMARY CARE RESIDENCIES: CURRENT STATUS

Hoyle Leigh, M.D., *Department of Psychiatry, University of California, 445 South Cedar Avenue, Fresno, CA 93702;* Deborah C. Stewart, M.D., Ronna Mallios, M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the status of psychosomatic training in primary care residencies, and discuss ways of enhancing it for specific primary care specialties.

SUMMARY:

Objective: Psychosomatic medicine is an important interface between psychiatry and primary care. The purpose of this study is to explore the current status of such training in family practice (FP), internal medicine (IM), obstetrics and gynecology (OB), and pediatrics (Peds) residency training programs.

Methods: A 16-item questionnaire surveying specific areas of training and perceived adequacy of current teaching was distributed to 1,365 U.S. program directors. This report concerns the specific psychosomatic issues of somatoform disorders, psychological factors affecting physical condition, physical illness affecting emotions/behavior, eating disorders, grief/bereavement, and the dying patient.

Results: The response rate was 58%. A majority of FP, IM, OB, and Peds program directors responded that all the topics are currently taught, but a majority of IM, OB, and Peds programs considered their training in all the areas to be inadequate ($p<0.001$). A majority of FP considered training to be adequate in all areas except for eating disorders, which only 50% considered adequate. For all areas, Peds programs considered their training to be least adequate and desired more compared with others. Most programs desired more training in eating disorders and somatoform/pain disorders. There were other intriguing differences among programs.

Conclusion: While most primary care residencies cover areas of psychosomatic medicine, a majority of non-FP programs consider their training to be inadequate. There is a need to enhance psychosomatic medicine training for primary care physicians, tailor made for the needs of the specialty.

REFERENCES:

1. Hodges B, Inch C, Silver I: Improving the psychiatric knowledge, skills, and attitudes of primary care physicians, 1950–2000: A review. Am J Psychiatry 2001; 158:1579–1586.
2. Leigh H (Ed): Biopsychosocial Approaches in Primary Care: State of the Art and Challenges for the 21st Century. Plenum Press, New York, 1997.

No. 3
USE OF SIMULATED PATIENTS TO ASSESS PRIMARY CARE PHYSICIANS' TREATMENT OF DEPRESSION

Steven A. Epstein, M.D., *Department of Psychiatry, Georgetown University Hospital, 3800 Reservoir Road, NW Kober-Cogan, Room 605, Washington, DC 20007;* Lisa M. Hooper, Ph.D., Kevin P. Weinfurt, Ph.D., William Hahless, Ph.D., Lisa A. Cooper, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to demonstrate an increased knowledge base regarding how primary care physicians evaluate and treat depression. Participants will also demonstrate a better understanding of how psychiatrists might more effectively collaborate with primary care physicians when treating patients who present with depression.

SUMMARY:

Introduction: Many primary care physicians (PCPs) provide suboptimal care for depression. We examined variations in care for patients with identical depression symptomatology.

Method: 408 randomly selected PCPs participated (response rate = 66%). Innovative interactive technology was used to produce CD-ROM vignettes of actors portraying depressed patients. Each PCP interacted with one patient who was clearly experiencing a major depressive episode.

Results: 98% of the PCPs diagnosed depression and 84% prescribed an antidepressant (96% chose an SSRI). Among other quality of care measures, 33% indicated that they would educate the patient about potential SSRI sexual side effects and 36% stated that they would want to know if the patient had suicidal ideation (SI). Family physicians were more likely than internists to recommend an antidepressant (92% vs. 83%) and to inquire about SI (42% vs. 29%). Board-certified PCPs were more likely to prescribe than those who were not board certified (90% vs. 69%). Multivariable models revealed that younger age of the physician was associated with increased likelihood of both inquiring about SI and educating about SSRI sexual side effects. Family physicians were more likely than internists (42% vs. 29%); and white physicians (43%) were more likely than African-American physicians (33%) and physicians of other ethnicity (24%) to inquire about SI.

Conclusions: Even when accurately diagnosing depression, many PCPs provide suboptimal depression care. Physician characteristics may also be important predictors of quality of care.

Funding Source: NIMH and the National Center on Minority Health and Health Disparities.

REFERENCES:

1. Simon GE, Von Korff M et al: Treatment process and outcomes for managed care patients receiving new antidepressant prescriptions from psychiatrists and primary care physicians. Archives of General Psychiatry 2001; 58(4):395–401.
2. Lin E, Katon WJ, et al: Achieving guidelines for the treatment of depression in primary care: Is physician education enough? Medical Care 1997; 35(8): 831–842.

No. 4
PSYCHOSOCIAL ASPECTS OF AUTOMATIC INTERNAL CARDIOVERTER DEFIBRILLATOR USE

Maryam Razavi, M.D., *Department of Psychiatry, George Washington University, 2150 Pennsylvania Avenue, Washington, DC 20037;* Vicenzio Holder-Perkins, M.D., Mehdi Razavi, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the psychosomatic aspects of the use of automatic internal cardioverter defibrillators.

SUMMARY:

Introduction: Automatic implantable cardioverter difibrillators (AICDs) have been shown to be very effective in the prevention of sudden cardiac death in patients with heart disease, and to be an important situation for a psychosomatic orientation. In 2005, the

expanded indications for AICD implantation involves an estimated 500,000 such implantations. AICD shocks can be extremely painful. Furthermore, there is no antecedent warning on most occasions, leading to anxiety and fear in many. After AICD implantation, severe psychological trauma may occur. This form of trauma is an important one for psychiatrists to develop specific interventions for in order to increase patients' continuing acceptance of their AICDs. Moreover, studying these conditions will increase our knowledge more generally about the impact of trauma in causing psychiatric disorders.

Objective: We sought to review and analyze the scientific literature on the coexistence of psychiatric disorders in cardiac patients with AICD implantation. The review also sought to identify any systematic types of psychiatric and psychological treatments for this subset of cardiac patients.

Method: We performed a MEDLINE search of English-language literature from 1966–2004 to identify reports on AICDs, with emphasis on psychiatric and psychological impact and interventions.

Results: AICD implantation can be associated with severe psychological trauma. Pre-implantation counseling and psychiatric evaluation are routine in many medical centers. This approach is recommended in order to ameliorate potentially devastating consequences in AICD recipients. However, no recommendations exist on psychiatric treatments specific to cardiac patients with AICD.

Conclusions: Systematic research studies are needed to tailor psychiatric treatments specific to cardiac patients with AICD.

REFERENCES:

1. Bourke JP, Turkington D, Thomas G, McComb M, Tynan M: Florid psychopathology in patients receiving shocks from implanted cardioverter-defibrillators. Heart 1997; 78(6):581–583.
2. Sears SF Jr, Conti JB: Understanding implantable cardioverter defibrillator shocks and storms: medical and psychosocial considerations for research and clinical care. Clinical Cardiology 2003; 26:107–111.

SCIENTIFIC AND CLINICAL REPORT SESSION 2—SUICIDE

No. 5
EXPOSURE TO SSRIS REDUCES SUICIDALITY IN ELDERLY PATIENTS WITH DEPRESSION

Yoram Barak, M.D., *Department of Psychogeriatric, Abarbanel Hospital, 15 KKL Street, Bat Yam 59100, Israel;* Ahikam Olmer, M.D., Dov Alzenberg, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to adequately evaluate the use of antidepressants and particularly SSRIs in relation to risk of suicide in elderly depressed patients.

SUMMARY:

Background: It has been suggested that treatment with selective serotonin reuptake inhibitors (SSRIs) may increase the risk of impulsive acts including suicide, leading to regulatory restrictions in some countries. In the elderly these restrictions may be inadvisable as indirect epidemiological evidence suggests an association between increased SSRIs prescription rates and decrease in suicide amongst the elderly.

Objective: The aim of this study was to evaluate exposure to antidepressants (AD) in a large cohort of elderly (65 years and older) patients suffering from major depressive disorder (MDD). The study was a retrospective, case-controlled evaluation over a 10-year period undertaken in a large university-affiliated tertiary care psychiatric hospital.

Methods: All records of admissions of MDD patients (ICD-10) were assessed. Age, gender, diagnosis, suicide attempt prior to admission, treatment with AD, and dose and duration of treatment with psychotropic medications was extracted from patients files. All patients who had attempted suicide prior to admission were defined as the index group. The case-controlled group was comprised of the next admission of a patient suffering from MDD, matched for gender and age, who did not attempt suicide.

Results: During a 10-year period (1993–2003), 101 patients (mean age 76.5 ± 6.9 years, 59% female) were diagnosed as suffering from MDD and had attempted suicide prior to admission. Controls were closely matched for age and gender (mean age 76.6 ± 6.6 years, 59% female). Elderly patients suffering from MDD who had not attempted suicide were significantly more likely to receive antidepressant treatment (58% vs., 42%). The protective effect of exposure to AD was: Odds Ratio = 1.94 (95% CI 1.1–3.4), p=0.019. The SSRIs were the most frequently prescribed antidepressant in this sample (50% of prescriptions).

Conclusion: The data presented here, which indicate a protective effect of antidepressants amongst elderly depressed patients, are in line with several published epidemiological studies. Further studies or further access to data are indicated to establish the magnitude of this effect in the elderly and the characteristics of patients who may benefit most.

This work was supported by a restricted educational grant from A/S Lundbeck.

REFERENCES:

1. Hall, et al: Association between antidepressant prescribing and suicide in Australia: 1991–2000, trend analysis. BMJ 326:1008–1013.
2. Barak Y, Mashiach M: Aggression—from basic science to real life. Isr Med Assoc J 5:667–668.

No. 6
SUICIDALITY IN YOUTH WITH BIPOLAR DISORDER: A COMMUNITY-BASED, MULTISITE INVESTIGATION

Ruby C. Castilla-Puentes, M.D., *World Wide Epidemiology, Glaxo-SmithKline, PO Box 5089, Collegeville, PA 19426;* Sandra R. Castilla-Puentes, M.D., Ivan S. Gomez, M.D., Wilma I. Castilla-Puentes, M.D., Sandra Lopez, M.D., Maria Teresa Alvarado, Ph.D., Carlos A. Sanchez-Russi, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the significance of suicidal ideation in the diagnosis of bipolar disorder in children.

SUMMARY:

Objective: To compare symptoms and risk factors of suicidality in three youth community samples with and without bipolar disorder (BPD).

Methods: A total of 614 youth, age eight to 18 years (female, 52.0%; male, 48.0%; mean age 12 years, SD=3), from a stratified random sample of schools in countries including Colombia (N=293), Argentina (N=106), and Mexico (N=215) were interviewed using the School Age Schedule for Schizophrenia and Affective Disorders (K-SADS).

Results: Ten patients (1.6%) were diagnosed with a lifetime diagnosis of BPD. These patients had higher rates of psychosis and suicide attempts compared with non-BPD patients. Depressive symptoms were found in nearly all BP patients (9/10), with mixed/cycling episodes associated with more severe depressive symptomatology. Increased energy and elated mood differentiated patients diagnosed with BPD. BPD patients were significantly more likely than non-

BP patients to have a history of suicide attempts. Rates of bipolarity, suicidality, and psychosis were similar in the three sites.

Conclusions: Youth with BPD usually have significant depressive symptoms. Suicidality and psychotic symptoms are common features. Elated mood and increased energy distinguish BPD from other psychiatric disorders. Our results parallel the results of community studies of adolescents and adults with BPD.

REFERENCES:

1. Brent DA, Perper JA, Allman CJ: Alcohol, firearms, and suicide among youth: temporal trends in Allegheny County, Pennsylvania, 1960–1983. JAMA 257:3369–3372.

No. 7
PERIPHERAL BENZODIAZEPINE RECEPTORS IN SUICIDE

Donatella Marazziti, M.D., *Department of Psychiatry, University of Pisa, Via Roma 67, Pisa 56100, Italy;* Bernardo Dell'Osso, M.D., Luciano Conti, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should have obtained information on the role of BDZ receptors, stress system, serotonin, and cholesterol in suicide.

SUMMARY:

Objective: To date, two main types of benzodiazepine (BDZ) receptors have been identified: one of these is the so-called central receptor, which is found mainly in the cortex, limbic areas, and cerebellum; the other is known as the peripheral receptor, which is found in the kidneys, lungs, ovaries, testes and adrenal glands, and blood cells, but is present also in the central nervous system, in particular, in glial cells. The presence of these last receptors in blood platelets prompted us to evaluate them in a group of suicide attempters, as compared with healthy controls, by means of the binding of ^{3}H-PK 11195, a specific ligand to label them.

Methods: Twenty subjects of both sexes, recruited consecutively following their admission because of a suicide attempt, were studies. The methods of suicide were: drug intake (n=12) and violent means (n=8). The severity of depression was assessed by the Montgomery and Asberg Depression Rating Scale and the suicidal ideation and severity were assessed by means of the Suicide Intent Scale. The control groups consisted of 20 healthy subjects who had neither a family nor a personal history of psychiatric disorders and were completely drug free.

Results: The results showed the presence of a significant decrease in the density of ^{3}H-PK 11195 in suicide attempters, as compared with healthy control subjects.

Conclusions: This finding may represent a nonspecific indicator of a condition of stress, since peripheral BDZ receptors are modulated by stress and hormones, or it may result more from an abnormal metabolism of steroid substances, whose derangement could play a pivotal role in the development of vulnerability toward suicide.

Funding Source: Department of Psychiatry, University of Pisa

REFERENCES:

1. Steegmans PH, Fekkes D, Hoes AW, Back AA, van der Does E, Grobbee DE: Low serum cholesterol concentration and serotonin metabolism in suicide. Br Med Journal 1996; 312:221–226.
2. Nudmamud S, Siripukpong P, Chindaduangratana C, Harnyutanakorn, Lotrakul P, Laarboonsarp W, Srikiathachorn A, Kotchabhakdi N: Casalotti SO: Stress, anxiety, and peripheral benzodiazepine receptor mRNA levels in human lymphocytes. Life Sci 2000; 67:2221–2231.

SCIENTIFIC AND CLINICAL REPORT SESSION 3—ISSUES IN PHARMACOTHERAPY AND PSYCHOTHERAPY

No. 8
A COMBINED TREATMENT APPROACH FOR ADULTS WITH ADHD: RESULTS OF A PILOT STUDY OF 45 PATIENTS

Anthony L. Rostain, M.D., *Department of Psychiatry, University of Pennsylvania Health System, 3535 Market Street, Philadelphia, PA 19104;* J. Russell Ramsay, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the clinical benefits and identify the major positive outcomes of a systematic approach for combining stimulant medication management and cognitive therapy for adults with ADHD.

SUMMARY:

Objectives: To measure the effects of combining stimulant medication and cognitive therapy for adults with ADHD.

Methods: Open-label, patient-directed protocol involving 45 consecutive patients seen at a university-based specialty clinic. Sample characteristics include mean age 31 years, mean education 15.8 years, 78% males and 72% with comorbid disorders. Patients were diagnosed using the SCID along with several clinical rating scales. Measures were obtained at baseline and at the end of treatment. ADDerall at titrated doses was the medication used. Cognitive therapy consisted of 16 sessions focused on patients' goals and desired outcomes. Pre- and post-treatment scores of clinical outcome measures were analyzed using a paired-samples t-test.

Results: Combined treatment was associated with statistically significant improvements in ADHD symptoms ($p < .01$, effect sizes ranging from 0.5 – 0.9). There were significant improvements in measures of depression ($p < .001$, $d = 0.9$), anxiety ($p < .01$, $d = 0.7$), and hopelessness ($p < .001$, $d = 0.4$), and there was significant improvement in ratings of overall functioning ($p < .001$, $d = 1.0$).

Conclusion: Combining stimulant medication and cognitive therapy reduces ADHD symptoms as well as comorbid anxiety and depression, and improves overall functioning in adult patients with ADHD.

REFERENCES:

1. Greenhill LL, Pliszka S, Dulcan MK, et al: Practice parameters for the use of stimulant medications in the treatment of children, adolescents, and adults with ADHD. J Amer Acad Child Adol Psych 2002; 41:26S–49S.
2. Ramsay JR, Rostain AL: A cognitive therapy approach for adult attention deficit/ hyperactivity disorder. J Cog Psychother: An Int Qtrly 2003; 17 (4): 319–334.

No. 9
CHARACTERISTICS OF DIVERSION AND MISUSE OF ADHD MEDICATIONS

Timothy E. Wilens, M.D., *Department of Child Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 725, Boston, MA 02114;* Martin Gignac, M.D., Joseph Biederman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant should be able to understand the risk of diversion and misuse of stimulant

medications in ADHD youth as well as identify specific characteristics related to the nature of the risk.

SUMMARY:

Little is known about the risks and characteristics of patients who misuse or divert their stimulant medications.

Methods: As part of a ten-year longitudinal study of boys with ADHD, we evaluated medication diversion or misuse.

Methods: We used structured psychiatric interview for diagnosis; and a self-report questionnaire regarding medication use.

Results: Within the sample of 98 subjects receiving medications (mean age of 20.8±5 yrs), 55 (56%) were ADHD subjects compared with 43 (44%) non-ADHD controls (for other conditions). We found that 11% of the ADHD subjects endorsed selling their medication compared with no subject in the control group ($z = 0.00$ $p < 0.05$); and 22% of ADHD subjects reported misusing their medications compared with 5% of the controlled subjects ($z = 1.7$ $p = 0.09$). A minority of subjects reported escalating their doses and concomitant use with alcohol and drugs. Substance abuse (SA) and conduct disorder (CD) were found to be highly comorbid among subjects diverting (SUD = 83%, CD = 50%) or misusing medications (SUD = 75%, CD = 59%). Stimulant diversion and misuse were exclusively with immediate-release, but not with extended-release stimulant preparations.

Conclusions: These findings highlight the need to monitor medication use in CD and SUD individuals, and to carefully select agents with a low likelihood of diversion or misuse in this group.

REFERENCES:

1. Wilens T: Substance abuse with ADHD: nature of the relationship, subtypes at risk, and treatment implications, Psychiatric Clinics of North America 2004;27:283–302.
2. Low K, Gendaszek A: Illicit use of psychostimulants among college students: a preliminary study. Psychology, Health & Medicine 2002;7:283–287.

No. 10
COMBINED TREATMENT OF VENLAFAXIN AND ECT IN TREATMENT-RESISTANT DEPRESSIVE PATIENTS

Nesrin Dilbaz, M.D., *Psychiatry, Ankara Numune Hastanesi, AN-EAH II Psikiyatri Klinigi Samanpazari, Ankara 06, Turkey;* Cem Sengul, M.D., Tuncer Okay, M.D., Goksel Bayam, M.D., Ali Turkoglu, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to have more information about combined use of ECT and an antidepressant in treatment ressitant depression.

SUMMARY:

We reviewed 21 depressive patients who were treated with a combination of electroconvulsive therapy (ECT) and venlafaxine. The indication of the ECT venlafaxine treatment was inadequate response to at least one antidepressant trial of adequate doses and duration. Propofol was used as an anesthetic agent during ECT treatments. Ninety percent of the patients benefited from the combined treatment. The responsivity to combination treatment was not associated with high dose of venlafaxine. In most of the patients, the combined treatment was safe and well tolerated. Adverse reactions occured in 57% of the patients and included concentration difficulties (4 patients), memory problems (7 patients) and headache (1 patient). Asystole was not observed in any patients. Treatment was safe with a low dose of venlafaxine equal to or lower than 225mg/day. It seems that treatment of ECT combined with low dose venlafaxine and propofol as anesthetic agent is effective and safe. This strategy may be a therapeutic option in treatment-resistant depressive patients.

REFERENCES:

1. Perrin GM: Cardiovascular aspect of electroshock therapy. Acta Psychiatr Neurol Scand 1961; 36:1–45.
2. Weiner RD, Coffey CE, Kreystel AD: The monitoring and managment of electrically induced sewizures. Psychiatr Clin North Am 1991; 14:845–869.

SCIENTIFIC AND CLINICAL REPORT SESSION 4—ADHD

No. 11
SLEEP HYGIENE AND MELATONIN TREATMENT FOR ADHD SLEEP-ONSET DELAY

Margaret D. Weiss, M.D., *Children's and Women's Mental Health, 4500 Oak Street, Box 178-B430, Vancouver V64 3H1, Canada;* Melissa Bomben, M.S., Michael Wasdell, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the efficacy of melatonin in the treatment of delayed sleep onset in children with ADHD. The participant should also come to understand the relative efficacy of sleep hygiene in the treatment of delayed sleep onset in children with ADHD.

SUMMARY:

Objective: This double-blind, placebo-controlled, randomized trial determined the efficacy of melatonin treatment in reducing delayed sleep onset in children with ADHD who continued to have sleep onset problems after behavioral intervention (sleep hygiene).

Methods: Children aged 6–14 with DSM-IV ADHD, stable on stimulant medication, with minimum sleep onset delay of 60 minutes were enrolled. Baseline evaluation of sleep was followed by a rigorous sleep hygiene intervention. Patients compliant with sleep hygiene who continued to show a minimum 60-minute sleep latency entered randomized crossover treatment of melatonin versus placebo. The primary outcome variable was sleep latency, as determined by parent-completed sleep log.

Results: 33 children enrolled in the trial; 22 completed crossover treatment. Sleep onset latency was significantly lower with melatonin treatment than with placebo ($p < .01$), when controlling for period effect. There was not a significant carry-over effect and no serious adverse events were reported.

Conclusion: Sleep hygiene and melatonin are safe and effective treatments for delayed sleep onset in children with ADHD. Findings suggest cumulative benefit of sleep hygiene paired with the chronobiotic effect of melatonin.

REFERENCES:

1. Corkum P: Sleep problems in attention deficit hyperactivity disorder, in Sleep Disturbances in Children and Adolescents with Disorders of Development: Its Significance and Management. Edited by Stores, Wiggs. London: Mac Keith Press, 2001, pp 174–181.
2. Ivanenko A. McLaughlin Crabtree V, Tauman R, Gozal D: Melatonin in children and adolescents with insomnia: a retrospective study. Clinical Pediatrics 2003; 42:51–58.

No. 12
COMORBIDITY DIFFERENCES IN ADHD THROUGHOUT THE LIFE CYCLE

Atilla Turgay, M.D., *Department of Psychiatry, Scarborough Hospital, 3030 Birchmount Road, Toronto, ON M5G 2C4, Canada;* Rubaba

Ansari, M.A., Michael Schwartz, Ph.D., David Ng, M.D., Llewelyn W. Joseph, M.D., Joanna Blanchard, M.A., Nadeem Chaudhry, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the differences of comorbidities in different age groups with ADHD and plan appropriate treatment decisions for different ADHD profiles.

SUMMARY:

Objective: Most ADHD comorbidity studies are based on small samples and do not provide information about age and comorbidity relationships. This study is based on a large clinical sample with 2,931 males and 628 females (N=3,559) with ADHD, age range two to 88 years to study comorbidity changes throughout the life cycle.

Methods: Gadow-Sprafkin, Offord/Boyle, and DuPaul ADHD rating scales—patient, parent, and school versions, supported the DSM-IV diagnosis given by a child and adolescent psychiatrist.

Results: In preschool children, oppositional defiant disorder (ODD), conduct disorder (CD), pervasive developmental disorder (PDD), and anxiety disorders (AD) were most common (60.67%, 21.91%, 20.79%, 4.21%, respectively). In adolescents, the rate of comorbid anxiety and mood disorders increased. For all age groups, males had more ODD, conduct disorder, and substance use disorder. Females were more prone to AD, major depression (MD), or dysthymic disorder (DD) (15.65% vs. 13.32%, 25.17% vs 10.29%; 17.01% vs. 12.53%, respectively). MD, AD, and DD were most common in adults with ADHD (41.08%, 18.52%, 13.80%, 4.71%, respectively). Adult females had more comorbid MD, AD, or DD than males (54.02% vs. 35.71%, 27.59% vs. 14.76%, 16.09% vs. 12.86%, respectively).

Conclusions: Clinicians should consider using structured interviews and general psychopathology rating scales to reliably diagnose the comorbid disorders since the treatment differs according to comorbidity profile.

REFERENCES:

1. Solokangas RK, Vaahtera K, Pacriew S, Sohlman B, Lehtinen V: Gender differences in depressive symptoms. J of Affective Disorders 2002; 3:215–220.
2. Biederman J, Newcorn PJ, Sprich S: Comorbidity of ADHD with conduct, depressive, anxiety, and other disorders. Am J Psychiatry 1991; 148:564–577.

No. 13
ADHD SYMPTOMS AND BEHAVIOR IMPROVED WITH MODAFINIL PEDIATRIC FORMULATION

Laurence L. Greenhill, M.D., *Child Psychiatry, New York Psychiatric Institute, 1051 Riverside Drive, New York, NY 10032;* Sharon B. Wigal, Ph.D., Christopher Kratochvil, M.D., Samuel Boellner, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the therapeutic effects of modafinil on core ADHD symptoms; describe the therapeutic effects of modafinil on functional outcomes such as behaviors and social skills; describe the adverse events the treating clinicians thought were probably related to modafinil.

SUMMARY:

Objective: Evaluate once-daily pediatric formulation of modafinil (MOD) in children, adolescents with ADHD.

Methods: Patients 6–17 yrs with ADHD were randomized to nine weeks of double-blind treatment with placebo or MOD, titrated to clinical effect from 85 mg (days 1–2) then 170 mg (days 3–7) in 85-mg increments weekly. Assessments included teacher- and parent-rated ADHD Rating Scale-IV (School and Home ADHD-RS-IV), clinician-rated Clinical Global Impression of Improvement (CGI-I), parent-rated Social Skills Rating Scale (SSRS), and Connors' Parent-Rating Scale: Revised Short Form (CPRS).

Results: Modafinil (n=163; mean stable dose, 369 mg/day) significantly improved ADHD symptoms (School and Home ADHD-RS-IV total scores) vs placebo (n=81; both $p<0.0001$). Effect size=0.69 for School ADHD-RS-IV total score. Similar results were seen on ADHD-RS-IV Inattention and Hyperactivity/Impulsivity subscales ($p<0.001$), CPRS Hyperactivity subscale, ADHD index, and cognitive problems and oppositional behavior domains ($p<0.01$), and SSRS Hyperactivity and Problem Behavior (elementary level, $p<0.01$) domains. Modafinil significantly improved overall clinical condition: 48% MOD vs 17% placebo patients were "much/very much" improved on the CGI-I ($p<0.0001$). Most common adverse events (AEs) were insomnia (MOD, 29%; placebo, 4%), headache (20% vs 15%), and decreased appetite (16% vs 4%), which were not treatment limiting; 3% of MOD- vs 4% of placebo-treated patients discontinued due to AEs.

Conclusion: Parents, teachers, and clinicians report robust improvements with the pediatric formulation of modafinil for ADHD symptoms and various negative behaviors, with few treatment-limiting side effects.

REFERENCES:

1. American Academy of Pediatrics. Clinical practice guidelines: diagnosis and evaluation of the child with attention-deficit/hyperactivity disorder. Pediatrics 2000; 105;1158–1170.
2. Rugino TA, Samsock TC: Modafinil in children with attention-deficit/hyperactivity disorder. Pediatr Neurol 2003; 29:136–142.

SCIENTIFIC AND CLINICAL REPORT SESSION 5—ISSUES IN BIPOLAR DISORDER

No. 14
EXCESS MORTALITY IN BIPOLAR AND UNIPOLAR DISORDER

Urban P. Osby, M.D., *Department of Molecular Medicine, Karolinska Institute, Centrummottagningen, Box 1527, Solaa SE-171 29, Sweden;* Lena Brandt, B.S.C., Nestor Correia, Ph.D., Anders Ekbom, M.D., Par Sparen, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to differentiate increased suicide risk from increased risk for death from natural causes among patients with mood disorder.

SUMMARY:

Objective: The aim of the study was to assess mortality outcome in bipolar and unipolar disorder in Sweden, with a population of 9 million.

Method: All patients with either bipolar (6,578 men and 8,808 women) or unipolar disorder (15,829 men and 23,353 women) during 1973–95 in Sweden, were followed up in the cause-of-death register from their first hospital diagnosis. Standardized mortality ratios (SMR:s) in five-year, age- and calendar-time classes were calculated, as well as the number of excess deaths and time trends for SMR:s.

Results: In bipolar disorder, SMR:s for all causes of death were 2.5 for men and 2.7 for women. For cardiovascular deaths, SMR:s were 1.9 and 2.6, respectively. SMR:s for suicide were 15.0 and 22.4. Most excess deaths were due to natural causes. In unipolar disorder, SMR:s for all causes of death were 2.0 for both men and women. For cardiovascular deaths, SMR:s were 1.5 and 1.7, respectively, and SMR:s for suicide were 20.9 and 27.0. Most excess

deaths were due to violent causes. There was an increasing time trend for suicide in women with unipolar disorder.

Conclusion: Bipolar patients had an increased mortality both from suicide and cardiovascular causes. Suicide was highly increased in unipolar patients while cardiovascular mortality was less increased.

Source of funding: Stockholm County Council

REFERENCES:

1. Ösby U, Brandt L. Correia N, Ekbom A, Sparén P: Excess mortality in bipolar and unipolar disorder in Sweden. Archives of General Psychiatry 2001; 58:844–850.
2. Hoyer EH, Mortensen P, Olesen AV: Mortality and causes of death in a total national sample of patients with affective disorders admitted for the first time between 1973 and 1993. British Journal of Psychiatry 2000; 176:76–82.

No. 15
DO ANTIDEPRESSANTS HELP OR HINDER RECOVERY FROM MIXED MANIA?

Joseph F. Goldberg, M.D., *Department of Psychiatry, Zucker Hillside Hospital, 79-59 263rd Street, Glen Oaks, NY 11004;* Christine J. Truman, M.D., Charles L. Bowden, M.D., John Fordis, B.A., Stephen R. Wisniewski, Ph.D., Michael E. Thase, M.D., Gary S. Sachs, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this presentation, participants will understand features that define mixed or dysphoric manias and the evidence base informing the risks and benefits of adding antidepressants to mood stabilizers during mixed states.

SUMMARY:

Objective: The treatment of bipolar mixed states remains controversial, since mood stabilizers alone often do not provide sufficient control of both manic and depressive symptoms. Risks versus benefits of antidepressant use with mood stabilizers during mixed states have received little study.

Method: From among the first 1,000 enrollees in the NIMH Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD), illness characteristics and naturalistic treatment outcomes were examined for those who entered in a DSM-IV mixed/cycling state. Comparisons were made of patients who took lithium, divalproex, or an atypical antipsychotic with versus without an antidepressant. Survival analyses compared times until achieving a "recovering" or "recovered" status for those taking versus not taking an antidepressant.

Results: Eighty-seven subjects (8.7%) entered the study in a mixed/cycling state. Upon entry, 47 (54%) were taking an antidepressant either with (25 [53%]) or without (22 [47%]) a standard mood stabilizer. No specific clinical factors differentiated patients who did versus did not receive an antidepressant. Log rank tests revealed that the time until reaching a "recovering" or "recovered" status was not significantly different when either lithium, divalproex, or an atypical antipsychotic was taken with versus without an antidepressant.

Conclusions: In this naturalistic dataset, use of antidepressants plus standard mood stabilizers or atypical antipsychotics did not appreciably either hasten or delay the time until achieving signs of recovery from a mixed/cycling manic episode. The findings do not support an advantage for the use of antidepressants when depression accompanies a manic or hypomanic syndrome.

REFERENCES:

1. Prien RF, Himmelhoch JM, Kupfer DJ: Treatment of mixed mania. J Affect Disord 1988; 15:9–15.
2. Bauer MS, Callahan AM, Jampala C, et al: Clinical practice guidelines for bipolar disorder from the Department of Veterans Affairs. J Clin Psychiatry 1999; 60:9–21.

No. 16
MIXED EPISODES: ILLNESS CHARACTERISTICS

Gary S. Sachs, M.D., *Department of Psychiatry, Harvard-Massachusetts General Hospital, 50 Staniford Street, Suite 580, Boston, MA 02114;* Megan F. Joseph, B.A., Cindy H. Hwang, B.A., Gianna Marzilli, B.A., Tanya B. Tran, B.A., David J. Borrelli, M.D., Andrew A. Nierenberg, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the significance of mixed episodes based on prospective assessment.

SUMMARY:

Objective: Bipolar subjects with mixed episodes (BPMx) and without mixed episodes (BPO) were compared to determine if their illness characteristics differed.

Method: BPMx subjects were identified by searching the MGH Bipolar clinic database between 1999 and 2004 for subjects who met DSM-IV criteria for at least one mixed episode based on prospective follow-up assessments made with a modified version of the SCID mood episode modules. The BPO group was created by age and gender matching the BPMx group with bipolar patients who never met criteria for a mixed episode. The standardized battery of scales routinely administered at intake was used to compare illness characteristics between groups.

Results: Among 470 bipolar patients, 11% (n=53) met criteria for at least one mixed episode. Of these BPMx subjects, 72% (n=38) were female. No significant differences were found between BPMx and BPO patients on age of onset, duration of illness, BMI, family history of bipolar disorder, or NEO subscales. BPMx subjects had significantly higher rates of panic disorder ($p<.01$), eating disorders ($p<.02$), and history of suicide attempt ($p<.03$) than BPO subjects.

Conclusion: This study confirmed previous reports associating mixed episodes with comorbidity and suicide risk. Additional research is needed to determine the psychobiology of bipolar patients with mixed episodes.

REFERENCES:

1. Dell'Osso L. et al: The manic-depressive mixed state: familial, temperamental, and psychopathologic characteristics in 108 female inpatients. Eur Arch Psychiatry Clin Neurosci 1991; 240(4–5): p. 234–9.
2. Sato T, et al: Cincinnati criteria for mixed mania and suicidality in patients with acute mania. Compr Psychiatry 2004; 45(1): p. 62–9.

SCIENTIFIC AND CLINICAL REPORT SESSION 6—PSYCHOTHERAPY

No. 17
AFFECT CHANGE IN DREAMS IN PSYCHOTHERAPY

Milton Kramer, M.D., *Department of Psychiatry, Maimonides Medical Center, 920 48th Street, Brooklyn, NY 11219;* Myron L. Glucksman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: understand that the affect in dreams in patients in psychotherapy becomes more positive across time and therapy and that the centrality of affect in the dream formation and interpretation process has been supported.

SUMMARY:

Objective: Affect is central to our understanding of many processes including dreams. Dream researchers have questioned the primary position of affect in dream generation and understanding. We examined the manifest dream reported in psychotherapy for the presence of affect and changes in valence between the first dream reported and the last.

Method: We selected the first and last dream reported by 24 patients who had been in long-term dynamic psychotherapy. Both authors scored each dream report for presence and valence of affect. The dream associations were scored for presence and valence of affect. The change in affect frequency and valence from the first to last dream was summarized and a similar summary was done by gender.

Results: The scoring reliability between authors for presence of affect and valence of affect in the 48 dream reports was 93.6% and 91.7%. Affect was present in 58.3% of the dreams and the valence was positive in 21.9%, negative in 38.5%, and absent in 39.6%. There was affect in the associations in 88.2% of the 17 dreams without manifest affect and the valence of affect was negative 93.3% of the time. Affect was present 95.8% of the time either in the dream report or the associations. The valence in the first dream report was positive in 8.3%, negative in 47.9%, and absent in 41.7%, and in the last dream report it was positive in 33.3%, negative in 29.2%, and absent in 37.5%. Men had affect in their dream reports more often than women, 65% and 53.6%, respectively. Both genders showed an increase in dream reports with positive valence from the first to last report.

Conclusions: Affect is almost always present either in the dream report or the associations and becomes more positive in both men and women either as the result of treatment or the passage of time. The centrality of dream affect in dream formation and interpretation is supported, if the view of the dream experience includes the associations.

REFERENCES:

1. Kramer M, Brik I: Affective processing by dreams across the night. Sleep [supplement] 2002; 25:A180–181.
2. Glucksman M Kramer M: Using dreams to assess clinical change during treatment. J American Academy of Psychoanalysis and Dynamic Psychiatry 2004; 32:345–358.

No. 18
THE EMPATHIC STANCE

Steven H. Lipsius, M.D., *Department of Psychiatry, George Washington University, 2141 K Street, N.W., Suite 404, Washington, DC 20037*

EDUCATIONAL OBJECTIVES:

Participants should be able to recognize the overall advantages of the empathic stance, and compare them to those of the neutral stance. Participants should learn techniques available through the empathic stance, applying those compatible with their own style relevant to the patients they treat.

SUMMARY:

Empathy has long been recognized for its importance concerning the working alliance. The thesis of this presentation, relevant to all clinicians, is that the "empathic stance" is also vital to helping patients access and work through the dynamic core of their disorders. With the "neutral stance," the therapists hold back genuine empathic responses in order to maintain objectivity; this often distorts the interaction and has the opposite result. Patients who feel they are being heard and understood by an empathically attuned therapist usually are less resistant and share more, increasing what is available for objective study.

The crux of the presentation, however, is the advantages of the empathic stance in allowing the therapist to be sufficiently internalized to help patients reach the subjective core of their illness. Patients who no longer feel alone are better able to tolerate previously unbearable affects. The empathically internalized therapist has a host of techniques to help patients rework unresolved conflicts, including those with images of family-of-origin members.

Recent neuroscience findings correlate well with the empathic approach, its greater access to the somatic component of affects, and more direct impact upon neural networks, of relevance to both psychiatry and psychosomatic medicine.

REFERENCES:

1. Lipsius S H: Working through in psychoanalytic psychotherapy; An alternative and complementary path. J Amer Academy of Psychoanal 2001; 29(4):585–600.
2. Fonagy P: The human genome and the representational world: the role of early mother-infant interaction in creating an interpersonal interpretive mechanism. Bulletin of the Menninger Clinic 2001; 65(3):427–448.

No. 19
CREATIVE THINKING: A DOOR TO THE INTERIOR LIFE THAT ENHANCES THE PSYCHOTHERAPEUTIC PROCESS

Rosa A. Chavez-Eakle, M.D., Emory *University, 1639 Pierce Drive, Suite 4000, Atlanta, GA 30322*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant will be able to recognize the basics of the creativity facilitation strategies and will be able to use them within the psychotherapeutic practice.

SUMMARY:

When facing creative patients in everyday practice, can we use their creative potential to enhance the psychotherapeutic process? Is creative production a door to their interior life? The aim of this study was to explore the creative process in the context of psychotherapeutic change while incorporating creative problem solving (CPS) and creativity facilitation techniques (CFT). Ten artists (six males and four females) referred to the Unit for the Study and Development of Creativity at the Ramon de la Fuente National Institute of Psychiatry in Mexico City were recruited because their creative production was impaired due to psychiatric disorders. All received specific pharmacological treatment and individual psychodynamic psychotherapy; a year later, they participated in group therapy incorporating CPS and CFT. All the sessions were recorded and transcribed and qualitative analysis was done using Atlas-ti. Their artistic production was analyzed. The psychotherapeutic process was speeded with CPS and CFT; individuals improved their association-making and creative fluency, their identity as artists, and made sense of their own life. They were able to identify and overcome creative blockages and developed strong links as a group. CPS and CFT can be useful tools during psychotherapeutic practice, especially in the treatment of highly creative individuals.

REFERENCES:

1. Chavez-Eakle RA, Lara MC, Cruz-Fuentes C: Personality: a possible bridge between creativity and psychopathology. Creativity Research Journal 2004, in press.
2. Safter HT, Torrance EP: Making the Creative Leap Beyond... Buffalo, N.Y., Creative Education Foundation, 1999.

SCIENTIFIC AND CLINICAL REPORT SESSION 7—SAFETY AND EFFICACY IN ANTIPSYCHOTIC THERAPIES

No. 20
EFFICACY AND SAFETY OF ZIPRASIDONE IN FIRST-EPISODE PSYCHOSIS

Tonmoy Sharma, M.D., *CNRC, Neuroscience Center, 7 Twistleton Center Priory Hill, Dartford DA1 2EN, United Kingdom;* Veena Kumari, Ph.D., Ravi Mehrotra, Ph.D., Anil Kumar

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to demonstrate knowledge of the effects of Ziprasidone on first-episode psychotic patients and their psychopathological symptoms.

SUMMARY:

There are little data on the efficacy and safety of Ziprasidone in patients with a first episode of psychosis who meet the criteria for schizophrenia or a related psychotic disorder. This study evaluated the effectiveness in acute first-episode, neuroleptic-naïve psychotic patients. Ten patients with first-episode psychosis participated in this six-week study. Domains measured included psychopathology, neurocognitive functioning, and changes in blood flow using fMRI. This report presents data from clinical measures of treatment response, and safety data from the study evaluating clinical efficacy.

Patients were assessed weekly using clinical scales to assess efficacy and safety in this open-label, dose-finding study. Ziprasidone was associated with baseline-to-endpoint reductions in symptom severity, measured by the Positive and Negative Syndrome Scale total score and positive subscale, and by the Clinical Global Impression severity rating. First-episode psychotic patients tolerated doses of Ziprasidone up to 80mg daily without any treatment-emergent parkinsonism or akathisia. There were no treatment-emergent cardiac abnormalities seen in this patient group. As expected on the basis of previous studies, Ziprasidone was effective in the acute reduction of psychopathological symptoms in this group of first-episode patients. Doses above 80mg daily might be tolerated less well by neuroleptic-naïve, first-episode psychotic patients.

REFERENCES:

1. Lieberman JA, Tollefson G, Tohen M, Green Al, Gur RE, Kahn R, McEvoy J, Perkins D, Sharma T, Zipursky R, Wei H, Hamer RM; HGDH Study Group: Comparative efficacy and safety of atypical and conventional antipsychotic drugs in first-episode psychosis: a randomized, double-blind trial of olanzapine versus haloperidol. Am J Psychiatry 2003; 160(8):1396–404.
2. Sharma T, Hughes C, Soni W, Kumari V: Cognitive effects of olanzapine and clozapine treatment in chronic schizophrenia. Psychopharmacology (Berl) 2003; 169(3–4):398–403.

No. 21
ATYPICAL ANTIPSYCHOTICS AND FALLS IN THE ELDERLY

Ira R. Katz, M.D., *Department of Geriatric Psychiatry, University of Pennsylvania, 3535 Market Street, Room 3001, Philadelphia, PA 19104*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should understand that historic concerns about the associations between psychotropic medications and falls may not apply to quetiapine and certain other atypical antipsychotic agents.

SUMMARY:

Objective: To evaluate the incidence of falls with atypical antipsychotics in elderly patients.

Method: Data from a 10-week, randomized, double-blind, placebo-controlled, fixed-dose study of quetiapine (100 and 200 mg/day) in elderly institutionalized patients (n=333) were evaluated.

Results: In the quetiapine group, 24.5% of patients (n=59) had 104 falls; placebo group, 22.8% (n=21) had 37 falls (p=0.752). There were no significant differences between quetiapine and placebo for the incidence of falls with visible injury (p=0.608), fracture (p=0.537), or head injury (p=0.653). For those who fell, mean time to the first fall (SE) was 49.5 (1.8), 56.5 (2.0), and 57.4 (2.1) days for quetiapine 200 mg/day, 100 mg/day, and placebo, respectively. Survival analysis did not demonstrate a significant difference between groups. Of the 104 falls in the quetiapine group, six (5.8%) were associated with somnolence/sedation, three (2.9%) with dizziness, three (2.9%) with abnormal gait, and one (1.0%) with extrapyramidal symptoms. None of the falls in the placebo group was associated with these symptoms.

Conclusions: Quetiapine did not statistically significantly increase the incidence of falls or fall-related injuries in elderly patients with dementia compared with placebo. Findings will be discussed in light of emerging data on other atypical antipsychotic agents and alternative medications.

REFERENCES:

1. Tariot PN, Profenno LA, Ismail MS: Efficacy of atypical antipsychotics in elderly patients with dementia. J Clin Psychiatry 2004; 65 (Suppl 11): 11–15.
2. Zhong K, Tariot P, Minkwitz MC, et al: Quetiapine for the treatment of agitation in elderly institutionalized patients with dementia: a randomized, double-blind trial. Poster presented at the 9th International Conference on Alzheimer's Disease and Related Disorders, Philadelphia, PA, USA, 2004.

No. 22
METABOLIC SYNDROME IN SCHIZOPHRENIA

Hannu J. Koponen, M.D., *Department of Psychiatry, University of Oulu, P.O. Box 5000, Oulu FIN-90014, Finland;* Kaisa Saari, M.D., Sari Lindeman, M.D., Markku Savolainen, M.D., Matti K. Isohanni, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should know about the prevalence of metabolic syndrome in schizophrenia.

SUMMARY:

Objective: Patients with schizophrenia have a shortened lifespan. Mortality from cardiovascular disease in schizophrenia is higher compared with general population. This might be due to higher prevalence of metabolic syndrome.

Aim: To explore the prevalence of metabolic syndrome in schizophrenia.

Method: Data were collected prospectively from the Northern Finland 1966 Birth Cohort population. Diagnoses were obtained from the national register. The presence of metabolic syndrome (according to criteria of the National Cholesterol Education Program) at the age of 31 yrs in patients of schizophrenia or other psychosis were compared with the other cohort poppulation.

Results: The prevalence of metabolic syndrome was high in subjects with schizophrenia compared with comparison group (19% vs 6%, p=0.010). The prevalence of metabolic syndrome in subjects with other psychoses was 5%.

Conclusion: The high prevalence of metabolic syndrome underscores the need to develop comprehensive efforts directed at controlling the weight, diet, and physical activity.

Funding source: This work was supported by grants from the Finnish Academy, Sigrid Juselius Foundation, and Stanley Medical Research Institute

REFERENCES:

1. Saari K, Koponen H, Laitinen J, Jokelainen J, Lauren L, Isohanni M, Lindeman S: Hyperlipidemia in persons using antipsychotic medication: a general population-based birth cohort study. J Clin Psychiatry 2004; 65:547–550.
2. Saari K, Lindeman S, Koponen H, Jokelainen J, Isohanni M: Higher serum triglyceride levels in early-onset schizophrenia. Am J Psychiatry 2004; 161:1:176.

SCIENTIFIC AND CLINICAL REPORT SESSION 8—CROSS-CULTURAL AND MINORITY

No. 23
ETHNICITY AND THE PREDICTION OF SUBSTANCE ABUSE IN HOSPITALIZED ADOLESCENTS

Daniel F. Becker, M.D., *Mills-Peninsula Medical Center, 1783 El Camino Real, Burlingame, CA 94010;* Carlos M. Grilo, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize some of the psychosocial predictors of drug and alcohol abuse in adolescent inpatients, and how these predictors differ according to ethnicity.

SUMMARY:

Objective: To examine psychosocial correlates of drug and alcohol abuse in hospitalized adolescents, and the extent to which these associations may be affected by ethnicity.

Method: 458 psychiatric inpatients, ages 12–19, completed a battery of psychometrically sound, self-report measures of psychological functioning, environmental stress, drug abuse, and alcohol abuse. Six multiple-regression analyses were conducted to determine the joint and independent predictors of both drug abuse and alcohol abuse—for European Americans (N=367), Latino Americans (N=44), and African Americans (N=47) separately.

Results: The regression analyses revealed that seven variables—age, depression, impulsivity, low self-esteem, delinquent predisposition, low peer insecurity, and history of child abuse—jointly predicted drug abuse for European Americans (R^2 = .26), Latino Americans (R^2 = .37), and African Americans (R^2 = .31), and predicted alcohol abuse for European Americans (R^2 = .23) and Latino Americans (R^2 = .42). Several differences were noted with respect to which variables made significant independent contributions to the predictive models. In predicting drug abuse, age, impulsivity, delinquency predisposition, and low peer insecurity made significant independent contributions for European Americans; delinquency predisposition and history of child abuse made independent contributions for Latino Americans; and age and depression made independent contributions for African Americans.

Conclusions: We found distinct patterns of psychosocial predictor variables by ethnic group, which may reflect differing risk factors for drug and alcohol abuse in these three groups. Such differences have potential implications for prevention and treatment programs.

REFERENCES:

1. Windle M: A longitudinal study of antisocial behaviors in early adolescence as predictors of late adolescent substance abuse. J Abnorm Psychol 1990; 99:86–91.
2. Robbins MS, Kumar S, Walker-Barnes C, Feaster DJ, Briones E, Szapocznik J: Ethnic differences in comorbidity among substance-abusing adolescents referred to outpatient therapy. J Am Acad Child Adolesc Psychiatry 2002; 41:394–401.

No. 24
STIGMATIZATION OF MENTAL ILLNESSES AMONG CHINESE PSYCHIATRIC PATIENTS IN CHINA AND THE U.S.

Albert Yeung, M.D., *Department of Psychiatry, Massachusetts General Hospital, 50 Standord Street, Suite 401, Boston, MA 02114;* Yong Xu, M.D., Wendy Guyker, B.S., Raymond Kam, M.D., Paul Yin, M.D., Maurizio Fava, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the extent of stigmatization among Chinese and Chinese-American psychiatric patients toward their illnesses, and how this affects treatment of psychiatric disorders.

SUMMARY:

Objective: To study the degree of understanding and stigmatization among Chinese and Chinese-American psychiatric outpatients toward their illnesses.

Method: Consecutive Chinese/Chinese-American patients who attended psychiatric outpatient clinics in Boston and Shanghai were asked the labels of their illnesses, and whether they agreed with the psychiatric diagnoses of their illnesses. Patients' degrees of stigma toward their psychiatric illnesses were assessed using a five-item questionnaire adopted from the "stigmatization scale" of the Explanatory Model of Interview Catalogue.

Results: One hundred and twenty Chinese and Chinese Americans were enrolled in the study (51% female, mean age 46±15). Only about half (52%) of the patients were able to give the correct labels of their illnesses. Sixty-five (54%) patients agreed with the diagnoses of the psychiatric disorders documented in their medical records. Forty (30%) patients reported that they had not heard of the psychiatric disorders they were diagnosed with. Patients' degrees of stigmatization (low 10%, medium 23%, and high 67%) toward their psychiatric illnesses were generally high. There was no significant difference in the findings between the two sites. Patients with psychotic disorders and patients with mood/anxiety disorders had similar levels of stigma toward their illnesses.

Conclusion: Many Chinese and Chinese-American psychiatric outpatients are either unfamiliar or not at ease with the psychiatric diagnoses of their illnesses. Stigmatization toward psychiatric illnesses is high. There is no difference in the degree of stigmatization toward mood/anxiety disorders and psychotic disorders. The significance of these results on treatment of Chinese patients will be discussed.

REFERENCES:

1. Roeloffs C, Sherbourne C, Unutzer J, et al: Stigma and depression among primary care patients. General Hospital Psychiatry 2003; 25:311–315.
2. Link BG, Phelan JC: Conceptualizing stigma. Annual Rev Sociol 2001; 27:363–385.

No. 25
USE OF THE PHQ9 FOR SCREENING AND TREATMENT OF MAJOR DEPRESSIVE DISORDERS IN CHINESE AMERICANS

Frederick Y. Huang, M.D., *Institute for Health, Rutgers University, 30 College Ave., New Brunswick, NJ 08901*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the use of the PHQ-9 to diagnose depression in Chinese-American populations as well as to measure follow-up outcomes in depressed Chinese-American populations.

SUMMARY:

Objective: The present analysis was conducted (1) to determine the effectiveness of the PHQ-9 in detecting major depressive disorder and (2) to determine the utility of the PHQ-9 in measuring treatment outcomes in Chinese Americans in a primary care setting.

Method: All adult primary care patients (3,474) at the Charles B. Wang Community Health Center, located in New York City, from January 1, 2003, to October 30, 2003, were screened for major depressive disorder using the PHQ-9 translated into Chinese. Those patients who screened positive for major depressive disorder participated in the collaborative care model of treatment at the clinic. Their follow-up PHQ-9 scores were measured at 2, 4, and 8 weeks using the PHQ-9.

Results: 4.1% (137) patients were found to have major depressive disorder using the cut-off score of > or = 10 on the PHQ-9 screening instrument. Of the depressed patients participating in the collaborative care model, the average PHQ-9 score had dropped by 43.2% (6.3) to a mean of 8.6 by 8 weeks of follow-up.

Conclusions: The PHQ-9 is an effective instrument to screen for major depressive disorder and measure treatment outcomes amongst Chinese-American patients in a primary care community clinic.

REFERENCES:

1. Chung H, Teresi J, Guarnaccia P, Meyers BS, Holmes D, Bobrowitz T, Eimicke JP, Ferran E Jr: Depressive symptoms and psychiatric distress in low-income Asian and Latino primary care patients: prevalence and recognition. Community Ment Health J 2003; 39(1):33–46.
2. Kroenke K, Spitzer RL, Williams JB: The PHQ-9: validity of a brief depression severity measure. J Gen Intern Med 2001; 16(9):606–13.

SCIENTIFIC AND CLINICAL REPORT SESSION 9—PERSONALITY DISORDERS

No. 26
EMOTION PROCESSING IN BPD: AN FMRI PERSPECTIVE

Harold W. Koenigsberg, M.D., *Department of Psychiatry, Mt. Sinai-Bronx VAMC, 130 West Kingsbridge Rd, #116A, Bronx, NY 10468;* Larry Siever, M.D., Xiaodong Guo, Ph.D., Antonia S. New, M.D., Marianne Goodman, M.D., Hu Cheng, Ph.D., Isak Prohovnik, Ph.D.

EDUCATIONAL OBJECTIVES:

The participant should recognize that patients with borderline personality disorder (BPD) utilize differently allocated brain networks when processing emotional stimuli than do healthy volunteers and that activation in specific regions correlates with the level of affective instability of the patient.

SUMMARY:

Objective: Emotional instability is a core feature of borderline personality disorder (BPD), yet its biological underpinnings are poorly understood. We employed functional MRI to compare patterns of regional brain activation in BPD patients and healthy volunteers as they process positive and negative emotional stimuli.

Method: BOLD fMRI images were acquired while 11 BPD patients and nine healthy volunteers viewed emotion-inducing pictures. Activation data were analyzed with SPM99 ANCOVA models.

Results: BPD patients demonstrated more extensive activation when viewing negative compared with positive pictures, and this difference was significantly greater than in controls. Greater activation to negative vs positive stimuli was observed in a network including the ventrolateral prefrontal cortex (BA47), the anterior and medial frontal cortex (BA9, BA10), and the cerebellum. Greater response to negative stimuli in BPD patients was significantly correlated with self-reported emotional instability, in the cingulate gyrus, fusiform gyrus, hippocampal and amygdala regions, and precuneus.

Conclusions: These findings suggest that BPD patients with affective instability process emotional stimuli via differently allocated brain networks than healthy control subjects. BPD patients appear to show greater activation of cerebellar structures and of brain regions involved in self-referential activity than do healthy volunteers when processing negative emotional pictures.

REFERENCES:

1. Koenigsberg HW, Harvey PD, Mitropoulou V, Schmeidler J, New AS, Goodman M, Silverman JM, Serby M, Schopick F, Siever LJ: Characterizing affective instability in borderline personality disorder. Am J Psychiatry 2002; 159(5):784–8.
2. Herpertz SC, Dietrich TM, Wenning B, Krings T, Erberich SG, Willmes K, Thron A, Sass H: Evidence of abnormal amygdala functioning in borderline personality disorder: a functional MRI study. Biol Psychiatry 2001; 50(4):292–8.

No. 27
PERSONALITY TRAITS IN PATIENTS WITH PANIC DISORDER

Mary Anne Pressman, M.D., *Department of Psychiatry, New York Medical College, 286 Soundview Avenue, White Plains, NY 10606-3822;* Eric D. Peselow, M.D., Caroline B. Williams, M.D.

EDUCATIONAL OBJECTIVES:

The participant should be able to evaluate frequency of DSM-IV personality disorders in patients with panic disorder during active illness and following clinical recovery.

SUMMARY:

Objective: The purpose of this report is to evaluate frequency of DSM-IV personality disorders in patients with panic disorder during active illness and following clinical recovery.

Method: To date we have evaluated 280 patients from an anxiety disorder clinic affiliated with Columbia University with panic disorder who were diagnosed using a modified symptom checklist adapted from the SCID during the acute stage of the illness and following clinical recovery (defined as being free from a full-blown panic attack for at least one month) 12–16 weeks later. To assess personality disorders the SIDP for DSM-IV was used both during the acute phase of the illness and upon clinical recovery. From the SIDP we were able to assess both dimensional personality traits and categorical diagnosis. All patients received a modified SCID to assess the probability of other anxiety or depressive disorders.

Results: At baseline, 179 of the 280 patients (64%) met criteria for at least one DSM-IV personality disorder with the two most frequent being avoidant (n=118 42.1%) and dependent (n=106 37.9%). However, upon clinical recovery, only 98 of the 280 patients (35.0%) met criteria for at least one DSM-IV personality disorder. The frequency of meeting criteria for a DSM-IV personality disorder as well as the dimensional trait score with respect to the Cluster A and Cluster C traits decreased to a significant level when the panic attacks ceased. Panic patients with a greater comorbidity of other anxiety disorders tended to retain the personality diagnosis.

Conclusion: Assessment of Axis II pathology is confounded by active psychopathology but even during symptom free periods, there

is high comorbidity between panic disorders and DSM-IV personality disorders. There was no funding source for this study.

REFERENCES:

1. Reich J: DSM-III personality disorders and the outcome of treated panic disorder. American Journal of Psychiatry 1988; 145 1149–1152.
2. Sanderson WC, Wetzler S, Beck AT, Betz F: Prevalence of personality disorders among patients with anxiety disorders. Psychiatry Research 1994; 51 167–174.

No. 28
IS PERIPARTUM DEPRESSION A BORDERLINE CONDITION?

Gisèle Apter-Danon, Ph.D., *Perinatal Psychiatry L'Aubier, Erasme Hospital University Paris 7, 121 bis Avenue du Général Leclerc, Bourg-La-Reine 92340, France;* Rozenn Graognic-Philippe, M.A., Marina Gianoli-Valente, Psy.D., Emmanuel Devouche, Ph.D., Annick Le Nestour, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should be able to recognize the importance of assessing personality disorder together with major depressive disorder during the peripartum, prepartum, and at three and six months postpartum.

SUMMARY:

The aim of this study is to assess association of personality disorder with depression during the prenatal and postnatal period, in order to diagnose at-risk situations both for mother and infant.

Method: Mothers were systematically recruited in a community setting both from maternity ward and parent-infant psychiatry clinic of suburban Paris, during third trimester of their pregnancy. 96 women gave informed consent to participate in a large on-going study on mother-infant relationship during the first year of infant life. 88 were assessed prenatally, and at 3 and 6 months postnatally with the Structured Interview for the Diagnosis of Personality Disorder for DSM4 (SIDP4) and for major depressive disorder (MDD) with the Montgomery and Asberg Depression Rating Scale (MADRS). All pregnancies were monitered at local hospital.

Results: 19 mothers out of 88 (21,59%) had a diagnosis of borderline personality disorder (BLPD). BLPD was highly correlated with MDD prenatally (Chi2 Pearson p=,00063; Exact Fischer p=,00216), at three months (Chi2 Pearson p=,00012; Exact Fischer p=,00042) and at six months (Chi2 Pearson p=,00346; Exact Fischer p=,00593).

Conclusion: BLPD is not uncommonly associated with MDD during the peripartum. Offering diagnosis and clinical treatment to these at high-risk women and their young infants becomes a priority. Women mental health professionals, and those concerned with maternal and infant well being and child development, working both in inner city and hospital setting, should be particularly concerned by this topic.

This research is supported by a grant from the French Ministry of Health AOM98/001

REFERENCES:

1. Rothschild L, Zimmerman M: Borderline personality disorder and age of onset in major depression. J Pers Dis 2002; 16 (2): 189–99.
2. Field T, Diego M, Hernandez-Reif M, Schanberg S, Kuhn C, Yando R, Bendell D: Pregnancy anxiety and comorbid depression and anger: effects on the fetus and neonate. Depress Anxiety 2003; 17(3):140–51.

TUESDAY, MAY 24, 2005

SCIENTIFIC AND CLINICAL REPORT SESSION 10—EPIDEMIOLOGY AND OTHER ISSUES IN PSYCHIATRY

No. 29
PARENTAL SEPARATION AT BIRTH AND SCHIZOPHRENIA AND DEPRESSION

Pirjo H. Maki, M.D., *Department of Psychiatry, University of Oulu, P O Box 5000, Peltolantie 5, Oulu 90014, Finland;* Juha M. Veijola, Ph.D., Matti Joukamaa, M.D., Helinä Hakko, Ph.D., Matti K. Isohanni, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should learn about the possible association between very early separation in the first year of life and mental disorders in adulthood.

SUMMARY:

Objective: We studied the association between very early separation and later development of schizophrenia and depression in adolescence and adulthood.

Method: The index cohort consisted of 3,020 subjects born from 1945 to 1965 in Finland who were temporarily isolated from their family immediately after birth to nursing homes due to tuberculosis in the family. The average separation time was seven months. For every index subject, two reference subjects were matched for sex, year of birth and place of birth. The data on schizophrenia and depression were obtained from the Finnish Hospital Discharge Register by December 31, 1998.

Results: The 28-year cumulative incidence of schizophrenia was 1.6% both in the index cohort and in the reference cohort (RR 1.0; 95%CI 0.8–1.4). 4.0% of the index subjects and 3.1% of the reference subjects had been treated in hospital due to a depression (1.3; 1.1–1.7).

Conclusion: Separation at birth was not found to be associated with schizophrenia. Temporary placement to adequate nursing homes in the first year of life is unlikely to increase the risk for schizophrenia. The index subjects had a somewhat elevated risk for hospital-treated depression. We found that separation from the parents at birth was not found to be strongly associated with severe depression.

REFERENCES:

1. Mäki P, Veijola J, Joukamaa M, Läärä E, Hakko H, Jones P B, Isohanni M: Maternal separation at birth and schizophrenia—a long-term follow-up of the Finnish Christmas Seal Home Children. Schizophr Research 2003; 60(1):13–19.
2. Veijola J, Mäki P, Joukamaa M, Läärä E, Hakko H, Jones P, Isohanni M: Parental separation at birth and depression in adulthood - a long-term follow-up of the Finnish Christmas Seal Home Children. Psychol Med 2004; 34:357–362.

No. 30
PARENTAL SEPARATION AT BIRTH AND SUBSTANCE-USE DISORDER

Juha M. Veijola, Ph.D., *Department of Psychiatry, University of Oulu, P O Box 5000, Peltolantie 5, Oulu 90014, Finland;* Pirjo H. Maki, M.D., Matti Joukamaa, M.D., Marianne Haapea, M.B., Matti K. Isohanni, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand that early separation may be important for later psychological development of an individual.

SUMMARY:

Objective: Problems in the early mother-infant relationship pose a hypothetical risk for substance abuse.

Methods: The index cohort consisted of 3,020 subjects born between 1945–1965 in Finland who were temporarily isolated from their family immediately after birth to adequate nursing homes due to tuberculosis in the family. The average separation time was seven months. For every index subject, two reference subjects were matched for sex, year of birth, and place of birth. The Finnish Hospital Discharge Register was used to identify subjects with substance use disorder arising from childhood to middle age, between January 1, 1971, and December 31, 1998.

Results: The 28-year cumulative incidence of alcohol dependence was 3.5% in the index cohort and 2.8% in the reference cohort (rate ratio 1.3, 95% CI 1.0–1.6). The incidences of hospital-treated drug abuse or dependence were 0.9% and 0.4% (RR 2.3, 95% CI 1.4–3.7), respectively.

Conclusions: The result may be explained by a variety of risks experienced during pregnancy, delivery, and childhood. One explanation may be that the very early separation from the parents at birth may have unfavorable effects on later psychological development.

REFERENCES:

1. Hope S, Power C, Rodgers B: The relationship between parental separation in childhood and problem drinking in adulthood. Addiction 1998; 93:505–515.
2. Mäki P, Veijola J, Joukamaa M, Läärä E, Hakko H, Jones P, Isohanni M: Maternal separation at birth and schizophrenia—a long-term follow-up of the Finnish Christmas Seal Home Children. Schizophrenia Research 2003; 60:13–19.

No. 31
PICA SYNDROME: REVIEW AND RELEVANCE

Jambur V. Ananth, M.D., *Department of Psychiatry, Harbor-UCLA Medical Center, 1000 West Carson Street, Building F-9 Box 495, Torrance, CA 90509-2910;* Virginia Corpuz, M.D., Belinda A. Hara, M.D., Sharat Parameswaran, B.S., Sarath Gunatilake, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant should (1) become aware of the pica syndrome and its manifestations, (2) appreciate the seriousness of the condition, and (3) understand the measures to be instituted in treating this condition.

SUMMARY:

Pica is a condition manifesting in the persistent ingestion of a number of nonnutritive substances. Despite speculations, a definitive explanation has never been formulated. Developmentally disabled persons, those with dementia, and cognitively impaired patients may not know what they are eating. Borderline personality or psychotic patients willingly swallow inedible objects. Pica in chronic psychotic patients is only a symptom of their primary disease. We consulted on 18 pica patients (aged 12 to 54 years with eight males and 10 females) admitted to a psychiatric facility. Eight of the 18 patients required surgical intervention. Three patients were on restraints at the time of the survey and another seven were on one-to-one observation. The majority of patients (17 of 18) had associated self-mutilating behaviors (hanging, cutting wrists, jumping off roofs). The common motives recorded for swallowing were suicidal ideation without command hallucinations (six out of 18), hallucinations (two out of 18), delusions (one patient), depression with desire to self-harm (five patients), and secondary gain (one patient). In spite of the fact that psychiatric pica patients endanger their lives and require constant supervision, resulting in a high cost of care, there is a paucity of information on pica in psychiatric patients.

REFERENCES:

1. McGee MD, Guthiel TD: Coprophagia and urodipsia in chronic mentally ill woman. Hosp Community Psychiatry 1989; 40:302.
2. Karp JG, Whitman L, Convit A: Intestinal ingestion of foreign body objects by male prison inmates. Hosp Community Psychiatry 1991; 42:533–535.

SCIENTIFIC AND CLINICAL REPORT SESSION 11—SOMATIC THERAPIES

No. 32
THE IMPACT OF ELECTROCONVULSIVE THERAPY ON QUALITY OF LIFE AND FUNCTION

W. Vaughn McCall, M.S., *Department of Psychiatry, Wake Forest University, Medical Center Boulevard, 8th Floor, Winston-Salem, NC 27157*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the impact of electroconvulsive therapy on function and quality of life in depressed patients.

SUMMARY:

Background: Some authorities have recommended limiting the use of ECT, partly because of inadequacy of literature regarding effects of ECT on quality of life (QOL) and function.

Aims: We examined the effects of ECT on QOL and function in a series of studies.

Methods/Results: In a preliminary study, we found that depressed inpatients were more likely to be referred for ECT instead of antidepressant medications if they reported greater difficulty at baseline with performing their primary role, and in completing their instrumental activities of daily living (IADLs). Subsequently, ECT was associated with greater improvement in the primary role and IADLs, and this was maintained for a year. In a second study, we followed changes in QOL, function, mood, and cognition in a prospective sample of 77 depressed ECT patients. All QOL and function outcomes were improved at the two and four week mark after ECT. Improvement in QOL was related to mood, while improvement in instrumental activities of daily living function was related to improvement in global cognition.

Conclusions: ECT is associated with early and sustained improvement in function and QOL. A restrictive attitude toward ECT is not warranted on the basis of its effects on QOL and function.

REFERENCES:

1. McCall WV, Reboussin BA, Cohen W, Lawton P: Electroconvulsive therapy is associated with superior symptomatic and functional change in depressed patients after psychiatric hospitalization. J Affective Disorders 2001;63:17–25.
2. McCall WV, Dunn A, Rosenquist PB: Quality of life and function after ECT. British J Psychiatry, in press.

No. 33
SEIZURES TARGETED TO CIRCUITRY: NEW FORMS OF CONVULSIVE THERAPY

Sarah H. Lisanby, M.D., *Department of Biological Psychiatry, Columbia University, 1051 Riverside Drive, NYSPI #126, New York, NY 10032-2695*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to identify new developments in the field of convulsive therapy.

SUMMARY:

Convulsive therapy has evolved significantly over the 70 years of its existence as a treatment in psychiatry. Major advances have been made in the safety of its delivery, and in our understanding of its mechanisms of action. At the same time, the field has progressed in its understanding of the neural circuitry underlying major depression. Technology now exists to tailor this treatment to that underlying circuitry through more focal means of seizure induction. More precise targeting of the involved circuitry should ultimately provide a means of enhancing the specificity of convulsive therapy, while at the same time reducing its side effects by avoiding involvement of brain regions involved in the amnesia that can result from conventional electroconvulsive therapy (ECT). New developments in the induction of focal seizures using magnetic fields (magnetic seizure therapy, MST), and electrical stimulation (using refined stimulus parameters and Focal Electrically Administered Seizure Therapy, FEAST) will be presented.

REFERENCES:

1. Lisanby SH (Volume Editor): Brain Stimulation in Psychiatric Treatment. Review of Psychiatry Series, Volume 23. Edited by Oldham JM. APPI, 2004.

No. 34
ETHICAL AND LEGAL IMPLICATIONS OF PSYCHIATRIC EVALUATION OF PEDIATRIC GASTRIC BYPASS

Gagan Dhaliwal, M.D., *Department of Psychiatry, 1500 Hillcrest Road, Apartment 922, Mobile, AL 36695*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should (1) demonstrate skills in performing psychiatric evaluations of obese children in context of possible gastric bypass surgery, (2) recognize ethical principles eg autonomy, beneficence, and nonmaleficence and medical decision-making for children, (3) demonstrate skills in managing malpractice liability on grounds of improper informed consent gastric bypass surgery.

SUMMARY:

Psychiatrists often evaluate adult obese patients to assess suitability for gastric bypass surgery and post surgery recovery. Recently with the obesity epidemic, psychiatrists are increasingly consulted to evaluate obese children in context of a possible gastric bypass surgery.

The presentation will focus on:

(1) Obesity poses serious lifelong risks to the child if left untreated and gastric bypass surgery also carries substantial morbidity and mortality risks.

(2) Psychiatric evaluation to adequately ensure that the child has the mental fortitude, motivation, and maturity and social environment to endure the procedure and post-operative regime.

(3) Available literature on obesity surgery in children, including the first major study of gastric bypass in children in 1975 at the University of Iowa.

(4) Psychiatrists often struggle with difficult ethical issues, including autonomy, beneficence, and non-malefience while performing these evaluations.

(5) Assessment of informed consent for surgery including issues of consent versus assent in children and mature minor doctrine in some states.

(6) Risk of malpractice liability to a psychiatrist including issues of improper informed consent. Sweet v. Sisters of Providence (895 P.2d 484 Alaska 1995) was a lawsuit based on failure of informed consent in children.

(7) Legal cases where parents of obese children were accused of medical neglect, including a Texas Case regarding termination of parental rights for failure to treat a child's obesity in 1995 (in re G.C., 66 S.W.3d at 517).

REFERENCES:

1. Weighing the consequences: bariatric surgery sometimes considered for obese children, but information lacking on long-Term Outcomes. Am Acad Pediatrics News 2003; 16:16.
2. Wilde ML: Bioethical and legal implications of pediatric gastric bypass. Willamette L Rev, Summer 2004.

SCIENTIFIC AND CLINICAL REPORT SESSION 12—COGNITIVE DISORDERS

No. 35
IS DEPRESSION A RISK FACTOR FOR COGNITIVE IMPAIRMENT: A META-ANALYSIS OF 20 COHORT STUDIES

Alex J. Mitchell, M.D., *Liaison Psychiatry, Leicester Partnership Trust, Leicester General Hospital, Leicester LE4 5PW, United Kingdom*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to critically appraise the evidence that links depression with cognitive impairment and dementia.

SUMMARY:

A previous meta-analysis of seven cross-sectional studies concluded that depression was associated with dementia, but this review did not consider a broad definition of cognitive impairment and could not separate cause and effect. Since then 22 cohort studies of varying quality have tried to answer this question more fully, but confusingly, six of these studies could find no significant association. Essentially, two pathways linking depression and dementia have been proposed. In the prodromal model, depression represents one of the first manifestations of early subjective symptoms of dementia. In the pathogenetic model, depression (or an associated factor) directly influences the onset of later cognitive decline. The key distinguishing feature is, therefore, whether depression exerts any putative effect many years before there is an indication of cognitive decline. We carried out an up-to-date meta-analysis concentrating on high quality cohort studies. Potential confounding variables include age of onset, gender, and importantly, time separating depression and later dementia. Evidence suggests that depression is strongly associated with concurrent dementia and prodromal dementia, but weakly correlated with distal risk of cognitive decline. Suggestions for future research are discussed.

REFERENCES:

1. Jorm AF: History of depression as a risk factor for dementia: an updated review. Australian and New Zealand Journal of Psychiatry 2001;35(6):776-81.
2. Vinkers DJ, Gussekloo J, et al: Temporal relation between depression and cognitive impairment in old age: prospective population based study. BMJ 2004; in press.

No. 36
TREATMENT OF AGITATION AND PSYCHOSIS IN ELDERLY PATIENTS WITH DEMENTIA

Pierre N. Tariot, M.D., *Department of Psychiatry, University of Rochester, Monroe Hospital, 435 East Henrietta Road, Rochester, NY 14620*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to identify the range of pharmacotherapeutic interventions available for agitation and psychosis associated with dementia, to understand the relative prominence of atypical antipsychotics among these treatment options, and appreciate the importance of achieving clinical effectiveness in patients with dementia.

SUMMARY:

Objective: To evaluate the clinical effectiveness of individual agents, including atypical antipsychotics, for treating agitation and psychosis in dementia.

Method: Placebo-controlled clinical studies on the use of psychotropic medications in elderly patients with Alzheimer's disease, vascular dementia, mixed dementia, or other dementias were identified from searches of Medline and recent presentations in Congress.

Results: A range of psychotropic medications may be considered for the treatment of agitation or psychoses associated with dementia in the elderly, including antipsychotics, antidepressants, anticonvulsants, anxiolytics/sedatives, and cholinesterase inhibitors. Antipsychotics are the only agents that have shown consistent benefit. Conventional antipsychotics are efficacious in about 20% to 30% of patients, the majority of whom experience side effects such as extrapyramidal symptoms, sedation, and cardiovascular effects. While single-agent, placebo-controlled studies have shown that atypical antipsychotics (risperidone, olanzapine, quetiapine, aripiprazole) are efficacious treatments of psychopathology in the elderly, safety and tolerability differences (including cerebrovascular adverse events) exist among agents. Available relevant data from the head-to-head comparative study of atypicals in the elderly (CATIE) will be presented.

Conclusions: Atypical antipsychotics appear to be efficacious for treatment of agitation and psychosis in dementia and are generally better tolerated than conventional agents. Individualized therapeutic decisions should consider the different side-effect profiles of these medications.

REFERENCES:

1. Tariot PN, Profenno LA, Ismail MS: Efficacy of atypical antipsychotics in elderly patients with dementia. J Clin Psychiatry 2004; 65 (Suppl 11):11–15.
2. Tariot PN, Ryan JM, Porsteinsson AP, Loy R, Schneider LS: Pharmacologic therapy for behavioral symptoms of Alzheimer's disease. Clin Geriatr Med 2001; 17:359–376.

No. 37
PREVALENCE OF DEMENTIA IN A SOUTHERN EUROPEAN POPULATION IN TWO DIFFERENT TIME PERIODS

Pedro Saz, M.D., *Departamento de Medicina y Psiquiatria, Universidad de Zaragosa, Domingo Miral, Zaragoza 50009, Spain;* Antonio Lobo, M.D., Guillermo Marcos, M.D., José-Luis Dia, M.D., Concepción De-la-Cámara, M.D., Tirso Ventura, M.D., José-Ángel Montañés, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) recognize that the global prevalence of dementia has not increased during the last decade in a Southern European city, and (2) recognize that environmental hypotheses of dementia are supported by the increased prevalence rate of dementia among men the last decade in the same city.

SUMMARY:

Objective: To compare the prevalence of dementia in representative samples of the elderly living in the same community in two different time periods and using the same methods.

Method: This report is part of the ZARADEMP Project, a large epidemiological study of dementia and depression in the elderly community. It includes a preliminary, prevalence investigation, the Zaragoza Study or ZARADEMP 0, completed the past decade; and a three-wave study completed now (baseline study or ZARADEMP I, and two follow-up waves, ZARADEMP II and III, to identify incident cases of disorder).

The results in representative samples of ZARADEMP 0 (n = 1,080) and ZARADEMP I (n=4,803) were compared for this report. Standardized researchers administered valid Spanish versions of case-finding instruments, the main one being the Geriatric Mental State (GMS), and the results were analysed using the AGECAT package to generate diagnoses.

Results: While total prevalence of dementia has not varied, adjusted prevalence among men was significantly higher in the Zaragoza Study (6.2%, CI 4.1–8.3) when compared with ZARADEMP I (3.4% CI 2.5–4.2). In support of the working hypothesis, the differences were more marked in the age group 80–84 years.

Conclusions: This is the first report about significant differences in the prevalence rate of dementia among men in two different time periods.

REFERENCES:

1. Lobo A, Launer LJ, Fratiglioni L, et al: Prevalence of dementia and major subtypes in Europe: a collaborative study of population-based cohorts. Neurology 2000; 54(Supl 5): 4–9.
2. Lobo A, Saz P, Marcos G, Dia JL, De-la-Cámara C: The prevalence of dementia and depression in the elderly community in a Southern European population: the Zaragoza study. Arch Gen Psychiatry 1995; 52:497–506.

SCIENTIFIC AND CLINICAL REPORT SESSION 13—PSYCHOSOMATIC MEDICINE

No. 38
SOMATIZATION INCREASES MEDICAL CARE UTILIZATION AND COSTS

Arthur J. Barsky, M.D., *Department of Psychiatry, Brigham and Women's Hospital, 75 Frances Street, Boston, MA 02115;* E. John Orav, Ph.D., David Bates, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: (1) describe the independent effects of somatization on medical care utilization and costs, and (2) know the prevalence of depressive and anxiety disorder in somatoform disorder patients.

SUMMARY:

Objective: We studied the medical care utilization of primary care patients with somatoform disorders, while taking into account the presence of other, comorbid psychiatric disorder.

Method: Consecutive medical outpatients completed self-report questionnaires assessing psychiatric disorder. Their medical care utilization and costs for the preceding year were obtained from a computerized encounter database.

Results: 2,668 questionnaires were distributed. 1,546 (80.8%) contained complete data and met eligibility criteria. 299 patients (20.5%) received a provisional diagnosis of somatoform disorder, of whom 42.3% had no comorbid depressive or anxiety disorder. Somatoform disorder patients had significantly more primary care visits, specialty visits, emergency visits, hospital admissions, and higher inpatient costs ($4389 [$755] vs. $1632 [$173]; $p < .001$) and outpatient costs ($4775 [$326] vs $2748 [$107]; $p < .001$). When adjusted for the presence of comorbid depressive and anxiety disorder, medical morbidity, and sociodemographic characteristics, somatoform disorder patients still had more primary care visits ($p = .002$), specialist visits ($p < .001$), emergency room visits ($p < .001$), hospital admissions ($p = .002$), ambulatory procedures ($p = .003$), and higher inpatient costs ($p < .001$) and outpatient costs ($p < .001$). When these findings are extrapolated to the national level, an estimated $230 billion a year in medical care costs are attributable to the incremental effect of somatization alone.

Conclusions: Somatoform disorder patients had twice the outpatient and inpatient medical care utilization and twice the annual medical care costs of non-somatoform disorder patients. Adjusting the findings for the presence of psychiatric and medical comorbidity had relatively little effect on this association. Approximately $250 billion per year in medical care costs are attributable to the incremental effort of effect of somatization alone.

Funding Source: Aetna Quality Care Research Fund

REFERENCES:

1. Smith GR: The course of somatization and its effects on utilization of health care resources. Psychosomatics 1994; 35:263–267.
2. Katon W, Von Korff M, Lin E, Lipscomb P, Russo J, Wagner E, et al: Distressed high utilizers of medical care. DSM-III-R diagnoses and treatment needs. Gen Hosp Psychiat 1990; 12:355–362.

No. 39
THE INTEGRATED MANAGEMENT OF MEDICALLY UNEXPLAINED SYMPTOMS

Donald Bakal, Ph.D., *Department of Senior Health, Rockview Hospital, 7007 14th Street, SW, Calgary, AB T2V 1P9, Canada;* Patrick Coll, M.D., Jeffrey Schaefer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should understand the psychobiological approach to medically unexplained symptoms and appreciate somatic awareness as a clinical practice heuristic for organizing dialogue and interdisciplinary treatment.

SUMMARY:

An integrated clinical model of medically unexplained symptom (MUS) management is presented that is based on collaboration between psychology, psychiatry, and internal medicine. The model represents a more sophisticated mind/body paradigm than is currently practiced in stepped-care approaches. The clinical framework utilizes somatic awareness as the guiding interventional strategy. Somatic awareness involves the direction of attention to bodily experience for the purpose of achieving health. Somatic awareness is a significant step beyond current therapy in terms of mind/body integration. The model is consistent with evidence-based medicine and relies on psychobiological processes that are common to patients with MUS. The theoretical framework emphasizes the psychobiological determinants of central sensitization. There has been a shift in emphasis away from the search for physical factors underlying MUS and more emphasis on nonspecific pathophysiological mechanisms associated with sensitization. Anxiolytic and opioid drugs are not encouraged for the control of MUS, largely because of their potential to exacerbate the sensitization processes behind the symptom(s). The psychobiological model, with its emphasis on symptom severity and somatic awareness, serves to help mental health and medical professionals integrate clinical services within a unified framework.

REFERENCES:

1. Bakal D: Minding the Body: Clinical Uses of Somatic Awareness. New York, Guilford Press, 1999.
2. Kroenke K: Patients presenting with somatic complaints: epidemiology, psychiatric comorbidity, and management. Int J Methods Psychiatr Res 2003; 12:34–43.

No. 40
MEDICAL AND PSYCHIATRIC COMORBIDITIES OF A SUBSTANCE ABUSING PUBLIC ASSISTANCE POPULATION

Bruce J. Schwartz, M.D., *39 Sheldon Street, Ardsley, NY 10502;* Scott Wetzler, Ph.D., Tami Videon, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize the importance of diagnosing and treating medical and psychiatric disorders in substance abusing patients given the prevalence and comorbidities of these disorders.

SUMMARY:

Objective: This study analyzes the prevalence of psychiatric and medical illnesses, as well as the rate of comorbidity in a population of substance abusing, public-assistance clients in NYC.

Methods: The NYC Human Resource Administration contracted with University Behavioral Associates (UBA) to comprehensively evaluate, and track the progress of public-assistance applicants who abuse substances. A multidisciplinary team performed a comprehensive assessment of each client. The present analyses are for clients who entered the program between January 1, 2001, and May 31, 2004 (n=2, 730).

Results: Five out of eight (63%) clients had at least one medical condition. The most common conditions were asthma (22%) and hepatitis C (21%), followed by tuberculosis (17%) and hypertension (14%). While every client had at least one substance-related DSM code, more than half (56%) had an additional non-substance-related psychiatric diagnosis. The most prevalent disorders were mood (37%), anxiety (20%), and adjustment (11%) disorders. Comorbidity of medical and psychiatric illnesses were common, nearly two out of every five (39%) clients had comorbid medical and psychiatric conditions.

Conclusions: Prevalence estimates indicate that public-assistance clients with substance abuse problems have a significant likelihood of comorbid medical and psychiatric illness. These findings underscore the need for diagnosing and treating comorbid conditions in this population.

REFERENCES:

1. Mertens JR, Lu YW, Parthasarathy S, et al: Medical and psychiatric conditions of alcohol and drug treatment—patients in a HMO. Arch Intern Med 2003; 163:2511–2517.
2. Grant BF, Stinson FS, Dawson DA, et al: Prevalence and co-occurrence of substance use disorders and independent mood and anxiety disorders: results from the National Epidemiologic Survey on Alcohol and Related Conditions. Arch Gen Psych 2004; 61:807–816.

SCIENTIFIC AND CLINICAL REPORT SESSION 14—BIOLOGICAL PSYCHIATRY AND NEUROSCIENCE

No. 41
BRAINSTEM CONTROL OF NEUROTIC AND PSYCHOTIC PROCESSES

Jacques St Laurent, M.d., *Department of Psychiatry, MCGill University, 495 Main Road, P.O. Box 153, Hudson PQ K1H 8J9, Canada*

EDUCATIONAL OBJECTIVE:

At the conclusion of this symposium, the participant should (1) recognize each pattern of behavior specific to area stimulated; (2) recognize the behavior typical of approach, flight, and ambivalence; (3) Evaluate the possible implications of behaviors electrically induced from brain areas related to alterness and dreaming, neurotic and psychotic phenomena.

SUMMARY:

Behavioral phenomena consisting of approach (self-stimulation, SS) flight and ambivalence (approach-flight) elicited by intracranial stimulation (ICS) or self-stimulation (SS) techniques along the neuroaxis from the forebrain to the hindbrain were filmed and analyzed. The main findings were: (1) approach, flight, and ambivalence could be obtained from all levels of the brain. (2) Contrary to Crow et al reports, no single, fixed behavioural pattern was common to approach. (3) There were insistead different patterns accompanying approach and ambivalence; these varied according to the area stimulated. When the SS electrode was moved from mediofrontal cortex, septum to posterior areas: ALH, PLH, VMT, and LC. A progressive change from motor imhibition to excitation appeared; the motor hyperactivity from the PLH retained some direction. The locomotor hyperactivity was at its highest form from the locus coeruleus (LC) and was considered as pure, nondirected, aimless. However, in the case of the sub-locus coeruleus (Sub-LC) transitory periods of adynamia followed eventually by progressive ambivalence after burst of SS. (4) Exploration with sniffing was found to be the most frequent behaviors accompanying approach and ambivalence. For SS, exploration was organized in the following topographical manner: non—systematic, non-organized, fragmented at the level of the LC, diffused at the median raphe (MR), non-existent at the dorsal raphe (DR), scattered at the level of the subst nigra (SN), and focalized at the ventromedial tegmentum (VMT), the posterior and anterior lateral hypothalamus (PLH, ALH). (5) The highest intensities of SS, flight and ambivalence were found in the more caudal areas, namely LC, VMT, PLH, for SS approach; the mesencephalic reticular formation (RMF) for neurotic-like ambivalence as described by Pavlov (1949) and Masserman (1969), the LC for psychotic-like ambivalence and the ventral region of the reticularis pontis caudalis (RPC) for flight. (6) Approach and ambivalence elicited in the alert rat from the LC. known or believed to be involved in the triggering of dream activity, was accompanied by disruptive and other complex cognitive behaviors which suggest that during alterness, this area may be involved in psychotic-like behaviours that are phylogenetically important for the development of motor and cognitive functions and psychotic processes.

REFERENCES:

1. St-Laurent J: Behavioral correlates of self-stimulation, flight, and ambivalence. Brain Res Bul 1988; 21(1) 61–77.
2. St-Laurent J, Adam-Carrière D, Belanger C: Brain stimulation and behavior in rats: psychiatric implications. First International Conference on Brain Stimulation Reward, Beerse, Belgium, 21–24, April 1992.

No. 42
BRAIN STIMULATION: WHY, WHERE, AND HOW?

Harold A. Sackeim, Ph.D., *Department of Psychiatry, New York Psychiatric Institute, 1051 Riverside Drive, Unit 126, New York, NY 10032*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should understand the rationale for the new focal brain stimulation treatments, and the mechanisms by which they stimulate neural activity.

SUMMARY:

Brain stimulation interventions represent a new era in therapeutics. Systemic administration of psychotropics leads to widespread effects on neural systems irrelevant to therapeutic action. Nonetheless, imaging research has identified spatially-distributed neural networks whose modulation is associated with clinical benefit. Thus, treatments that induce discrete physiological alterations in such networks may have superior therapeutic properties. The brain stimulation interventions achieve this goal in different ways with intrinsic differences in focality, depth of penetration, method of current induction, etc. This presentation will address (1) the rationale for this emerging field, including the fundamental principles underlying their use. This presentation will also review (2) the major conceptual issues in "how" these treatments are administered, describing both the practical differences among these interventions (convulsive vs. nonconvulsive, transcranial vs. direct stimulation, electrical vs. magnetic), and a blueprint for rational treatment development outlining how we can determine how best to administer these interventions. Finally, the remarkably fast introduction in recent years of a host of brain stimulation techniques, raises the issue of (3) how we can best match interventions to individual patients. Choice of intervention will depend heavily on the "where" in the brain we must intervene and the types of physiological alteration needed to achieve therapeutic benefit.

REFERENCES:

1. Sackeim HA: The convulsant and anticonvulsant properties of electronconvulsive therapy: toward a focal form of brain stimulation. Clinical Neuroscience Review, in press.
2. Sackeim HA: Vagus nerve stimulation, Brain Stimulation in Psychiatric Treatment, Review of Psychiatry, Volume 23 Edited by Lisanby SH. 2004.

No. 43
NEW FINDINGS ON DAILY PREFRONTAL REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION FOR DEPRESSION

Mark S. George, M.D., *Department of Psychiatry, Medical University of South Carolina, 67 President Street, Room 502 North, Charleston, SC 29425-0720*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should be able to discuss the recent and ongoing studies concerning daily left prefrontal rTMS for treating depression. They will be particularly acquainted with new information concerning response and remission and ongoing attempts to refine this technique.

SUMMARY:

Daily prefrontal rTMS for two weeks or more has shown an antidepressant effect in over 20 published small sample randomized, controlled comparisons, five separate meta-analyses of these studies, and in randomized trials with electroconvulsive therapy. However, the sample sizes of these studies have been small and the rTMS stimulus administered may not have been of an adequate dose in

terms of the intensity of stimulation or length of treatment in order to demonstrate an optimal antidepressant effect. Some psychiatrists are beginning to use rTMS in their clinical practices, despite continuing skepticism and questions concerning the ultimate clinical meaningfulness of these studies. A multi-center, industry-sponsored trial is under way, geared for potential FDA approval.

Recent scientific evidence suggests that the antidepressant response to rTMS is dose-dependent. This year we have launched an NIMH-sponsored, multisite study using rTMS parameters that maximize the stimulation duration and intensity within the published safety guidelines to treat 240 unipolar depressed adults with moderate levels of treatment resistance. We will investigate the safety and efficacy of repeated daily left prefrontal 5Hz rTMS @ 120% of motor threshold (MT) in a three week fixed dose trial. In subjects showing an antidepressant response after three weeks, rTMS will be administered for up to six weeks to achieve remission of clinical symptoms of depression. Patients who do not remit with the initial fixed dose trial will be administered 1Hz rTMS in an open trial over the right prefrontal cortex. Baseline magnetic resonance images will be used to determine the optimal stimulus intensity by adjusting for individual differences in cortical to skull distances. We are also determining the long-term antidepressant effect of TMS in remitters, using a standardized continuation medication protocol over six months. Finally, we will describe how we are evaluating whether neuroanatomic findings on magnetic resonance images, stimulus location, demographic, and/or clinical variables affect clinical response to TMS.

REFERENCES:

1. Fitzgerald PB, Brown TL, et al: Transcranial magnetic stimulation in the treatment depression: a double-blind, placebo controlled trial. Arch Gen Psychiatry 2003; 60:1002–1008.

SCIENTIFIC AND CLINICAL REPORT SESSION 15—ASPECTS OF BIPOLAR DISORDER

No. 44
NEGATIVE IMPACT OF MEDICAL COMORBIDITY ON THE COURSE OF BIPOLAR DISORDER

Dan V. Iosifescu, M.D., *Department of Psychiatry, Massachusetts General Hospital, 50 Staniford Street, Suite #401, Boston, MA 02114;* Polina Eidelman, B.A., Michael J. Ostacher, M.D., Stephanie V.M. Gironde, B.A., Andrew A. Nierenberg, M.D., Gary S. Sachs, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should understand the long-term impact of comorbid medical illness on the longitudinal course of illness in bipolar disorder.

SUMMARY:

Objective: Comorbid medical illness has been associated with poor outcome in major depressive disorder. We examined the impact of comorbid medical illness on the longitudinal course of bipolar disorder.

Method: We evaluated the number of lifetime episodes of mania and of depression in 83 outpatients meeting DSM-IV criteria for bipolar disorder at study entry. Longitudinal outcome was measured by number of days well (with no significant mood symptoms) in a 24-month interval. Baseline severity of medical comorbidity was assessed for each patient with the Cumulative Illness Rating Scale (CIRS).

Results: In a multiple linear regression, the severity of medical comorbidity (CIRS score, $P < 0.03$), the number of lifetime episodes of depression ($p < 0.01$), and the number of lifetime episodes of mania ($p < 0.02$) were independent predictors of the number of subjects' days well, when controlling for age, gender, and age of onset of bipolar disorder. The number of organ systems involved by medical illness was also correlated to the number of days well ($P < 0.04$). Subjects with medical comorbidity required a significantly higher number of psychotropic medications compared with subjects with no medical comorbidity ($P < 0.02$), after excluding medications prescribed for medical reasons.

Conclusion: Comorbid medical illness was negatively correlated with poor clinical outcome in bipolar disorder and with a larger number of psychotropic medications administered.

REFERENCES:

1. Iosifescu DV, Nierenberg AA, Alpert JE, Smith M, Bitran S, Dording C, Fava M: The impact of medical comorbidity on acute treatment in major depressive disorder. Am J Psychiatry 2003; 160: 2122–2127.
2. Iosifescu DV, Nierenberg AA, Alpert JE, Papakostas GI, Perlis RH, Sonawalla S, Fava M: Comorbid medical illness and relapse of major depressive disorder in the continuation phase of treatment. Psychosomatics 2004; 45: 419–425.

No. 45
LITHIUM CONTINUATION/DISCONTINUATION AFTER FOUR YEARS OF STABILITY

Eric D. Peselow, M.D., *Department of Psychiatry, New York University School of Medicine, 550 First Avenue, New York, NY 10016;* Matthew G. Biel, M.D., Caroline B. Williams, M.D., Ronald R. Fieve, M.D., Mary Anne Pressman, M.D.

EDUCATIONAL OBJECTIVES:

The participant should be able to assess the probability of remaining free of affective episodes in patients who were taken off lithium vs those who remained on lithium after four years stability in order to assess if bipolar patients could safely be discontinued from medication.

SUMMARY:

Objective: The utility of lithium in the prophylaxis of bipolar illness has been well established. However, lithium has many burdensome side effects and after remaining well patients are eager to discontinue treatment. It is not clear, however, how long one must remain on lithium before discontinuation is attempted and it is not clear whether there is a better chance for a favorable outcome with discontinuation after a first vs multiple manic episodes. The purpose of this study was to attempt to evaluate the long-term outcome of patients who had been stable on lithium for four years and then were either subsequently continued or discontinued from lithium.

Method: We have followed 156 patients with a history of bipolar disorder who had been stable on lithium for four years following resolution of acute symptoms. At that point, we discontinued 28 patients on lithium carbonate and continued 128. It was the patients' desire (along with the physicians' concurrence) that led to medication discontinuation. Of the patients discontinued, 15 had only one affective episode of mania and 23 had multiple episodes. Of those continued, 53 had only one episode of mania and 75 had multiple episode.

Results: Overall seven of 28 (46%) who were discontinued from lithium relapsed with a manic or depressive episode vs 59 of 128 (46%) of patients who continued on lithium. The probability of remaining well on discontinuation of lithium vs continuation was as follows: 67% vs 91% at one year, 47% vs 83% at two years, and 26% vs 77% at three years ($p<.0001$). First episode bipolar patients who were discontinued from lithium did slightly better than those with multiple episodes, but both groups did statistically worse than

first-episode bipolar patients and multiple bipolar patients who were continued on lithium.

Conclusion: Overall despite four year stability on lithium, subsequent discontinuation of medication was associated with a significantly higher relapse rate as opposed to continuation. Implications of these findings within the long-term context of treatment for bipolar disorder will be discussed.

There was no funding for this study.

REFERENCES:

1. Silverstone T, McPherson H, Hunt N, Romans S: How effective is lithium in the prevention of relapse in bipolar disorder? A prospective naturalistic follow-up study. Aust N Z J Psychiatry 1998; 32:61–6.
2. Suppes T, Baldessarini RJ, Faedda GL, Tohen M: Risk of recurrence following discontinuation of lithium treatment in bipolar disorder. Arch Gen Psychiatry 1991; 48:1082–8.

No. 46
MAGNITUDE OF THE EFFECTS OF QUETIAPINE TREATMENT IN BIPOLAR DISORDER

Wayne Macfadden, M.D., *CNS Therapeutics, Astrazeneca, 1800 Concord Pike, PO Box 15437, Wilmington, DE 19850-5437*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize the clinical profile of quetiapine in the treatment of bipolar depression.

SUMMARY:

Objective: To evaluate the efficacy of quetiapine in the treatment of depressive episodes in patients with bipolar disorder.

Methods: 542 outpatients with bipolar (n=360) or II (n=182) depression were randomized to eight weeks of quetiapine monotherapy (600 or 300 mg, once daily at bedtime) or placebo. The MADRS and HAM-A were used to assess improvements in depressive and anxiety symptoms.

Results: Quetiapine demonstrated significant improvement in MADRS total scores compared with placebo from Week 1 onward ($P<0.001$). Response rates ($\geq 50\%$ decrease in MADRS) were 58.2%, 57.6%, and 36.1% and remission rates (MADRS ≤ 12) 52.9, 52.9%, and 28.4% in the quetiapine 600 mg, 300 mg, and placebo groups, respectively, by Week 8 ($P<0.001$). Quetiapine 600 and 300 mg/day significantly improved the core symptoms of depression (apparent sadness, reported sadness, inability to feel, pessimistic thoughts, and suicidal thoughts). Both doses of quetiapine were approximately twice as effective as placebo in reducing suicidal ideation by Week 8 ($P\leq 0.001$). A significant improvement in anxiety symptoms occurred as early as Week 1 and was maintained to study end ($P<0.001$ for both doses). Quetiapine treatment was also associated with significant improvements in quality of sleep and overall quality of life.

Conclusions: Quetiapine monotherapy is efficacious for the treatment of bipolar depression.

REFERENCES:

1. Calabrese JR, Keck PE, Jr, Macfadden MM, Minkwitz M, Ketter TA, Weisler RH, Cutler AJ, McCoy R, Wilson E, Mullen J: A randomized, double-blind, placebo-controlled trial of quetiapine in the treatment of bipolar I or II depression. Am J Psychiatry, submitted.
2. Bowden CL, Davis J, Morris D, et al: Effect size of efficacy measures comparing divalproex, lithium, and placebo in acute mania. Depress Anxiety 1997;6:26–30.

SCIENTIFIC AND CLINICAL REPORT SESSION 16—CHILD AND ADOLESCENT PSYCHOPHARMACOLOGY

No. 47
PEDIATRIC FORMULATION OF MODAFINIL EFFECTIVE IN CHILDREN AND ADOLESCENTS WITH ADHD

James M. Swanson, M.D., *Pediatrics Department, University of California at Irvine, 19722 MacArthur Boulevard, Irvine, CA 92612;* Samuel Boellner, M.D., Thomas Rugino, M.D., R. Bart Sangal, M.D., Sharon B. Wigal, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the effect of the pediatric formulation of modafinil on different measures of ADHD in children and adolescents and side effects associated with modafinil.

SUMMARY:

Objective: To evaluate the new modafinil (MOD) pediatric formulation in children and adolescents with attention-deficit/hyperactivity disorder (ADHD).

Methods: A double-blind, flexible-dose, placebo-controlled study enrolled patients 6–17 yrs of age with ADHD. The starting dose of 85 mg/day MOD was titrated over 22 days to clinical effect (maximum, 425 mg/day) with once-daily dosing. Assessments included School (teacher-rated) and Home (parent-rated) ADHD Rating Scale-IV (ADHD-RS-IV), Clinical Global Impression of Improvement (CGI-I), and Test of Variables of Attention (TOVA).

Results: In MOD-treated patients (n=128; mean stable dose, 361 mg/day), improvement in School ADHD-RS-IV total score was significantly greater than in placebo-treated patients (n=66; −17.5 vs −9.7 mean change, respectively, $p<0.0001$). Effect size was 0.64 for the School ADHD-RS-IV total score. Similar mean changes, −17.6 for MOD vs −7.5 placebo ($p<0.0001$), were observed on the Home ADHD-RS-IV total score. Modafinil significantly improved inattention and hyperactivity/impulsivity ADHD-RS-IV subscales ($p<0.003$), overall clinical condition (CGI-I responders, 52% vs 18%; $p<0.0001$) and TOVA measurements of ADHD (all $p<0.03$ vs placebo). Insomnia (MOD, 28%; placebo, 7%), headache (22% vs 9%), and decreased appetite (18% vs 3%) were the most common adverse events. 5% on MOD and 6% on placebo discontinued due to adverse events.

Conclusion: The pediatric formulation of modafinil, once daily, is well tolerated and significantly improves ADHD symptoms, overall clinical condition, and attention in children and adolescents with ADHD.

REFERENCES:

1. American Academy of Pediatrics: Clinical practice guidelines: diagnosis and evaluation of the child with attention-deficit/hyperactivity disorder. Pediatrics 2000;105:1158–1170.
2. Rugino TA, Samsock TC: Modafinil in children with attention-deficit hyperactivity disorder. Pediatr Neurol 2003;29:136–142.

No. 48
MODAFINIL PEDIATRIC FORMULATION HAS EARLY AND SUSTAINED EFFECT IN ADHD

Joseph Biederman, M.D., *Department of Psychiatry, Massachusetts General Hospital, 55 Fruit Street, Warren Building 705, Boston, MA 02114; Timothy E. Wilens, M.D., Frank A. Lopez, M.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the effects and time course of treatment with the pediatric formulation of modafinil and the most common side effects in children and adolescents with ADHD.

SUMMARY:

Objective: To evaluate the pediatric formulation of modafinil using once-daily dosages in children and adolescents with ADHD.

Methods: Patients with ADHD aged 6–17 yrs were randomized to seven-wk double-blind, fixed-dose treatment with modafinil or placebo followed by two-week withdrawal period in which half of modafinil-treated patients were converted to placebo without tapering and half continued modafinil. Modafinil was administered once-daily, starting at 85 mg/day and increased over seven or nine days to dosages of 340 for patients <30 kg or 425 mg/day for patients ≥30 kg. Assessments included the School and Home ADHD Rating Scale-IV (ADHD-RS-IV) total score change from baseline to last on-treatment visit.

Results: After one week, modafinil-treated patients (n=120) had significantly greater improvements in School ADHD-RS-IV scores vs placebo-treated patients (n=63; p=0.009), with the effect maintained through week 7 (modafinil, −17.2 and placebo, −8.2 points; p<0.0001). Effect size was 0.75 for School ADHD-RS-IV total score. Modafinil significantly improved total scores on the Home ADHD-RS-IV compared with placebo; additionally, ADHD symptoms did not rebound upon abrupt discontinuation. The most common AEs were insomnia (modafinil, 24%; placebo, 0%), headache (17% vs 14%), and decreased appetite (14% vs 2%).

Conclusion: The pediatric formulation of modafinil, when titrated within one week, is effective and well-tolerated. ADHD symptom reduction is significant within one week and is sustained. Abrupt discontinuation was not associated with symptoms of withdrawal or rebound.

REFERENCES:

1. American Academy of Pediatrics: Clinical practice guidelines: diagnosis and evaluation of the child with attention-deficit/hyperactivity disorder. Pediatrics 2000;105:1158–1170.
2. Rugino TA, Samsock TC: Modafinil in children with attention-deficit hyperactivity disorder. Pediatr Neurol 2003;29:136–142.

No. 49
POLYPHARMACY AMONG YOUTHS: HOW PREVALENT IS IT?

Farifteh F. Duffy, *Department of Research, APIRE PRN, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209;* William E. Narrow, M.D., Donald S. Rae, M.A., Joyce C. West, Ph.D., Darrel A. Regier, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to demonstrate increased awareness of current trends in psychiatric practice related to psychopharmacological treatment of psychiatric disorders in children and adolescents.

SUMMARY:

Objectives: To assess rates and correlates of concomitant pharmacotherapy in children and adolescents treated by psychiatrists in a broad range of clinical settings.

Methods: Cross-sectional data on 392 child and adolescent patients from the 1997 and 1999 American Psychiatric Practice Research Network Study of Psychiatric Patients and Treatments were used; weighted estimates are provided. Concomitant pharmacotherapy is defined as the concurrent use of two or more psychopharmacologic medications for the treatment of psychiatric disorder(s).

Results: 84% of child and adolescent patients received one or more psychopharmacologic medications; patients on psychopharmacologic treatments received between one to six medications (mean= 1.8). Approximately 52% of patients on medications received concomitant pharmacotherapy (i.e., two or more medications). Highest rates of concomitant pharmacotherapy were among patients with bipolar disorder (87%). Correlates of concomitant pharmacotherapy included having a diagnosis of bipolar disorder, having co-occurring Axis I or II disorders or general medical conditions, and being inpatient.

Conclusions: Over 40% of child and adolescent patients were prescribed two or more psychopharmacologic medications. Patients with chronic and clinically complex conditions were more likely to receive concomitant pharmacotherapy. With high rates of concomitant pharmacotherapy among children and adolescents in psychiatric care, additional research on efficacy and safety of this treatment strategy is warranted.

REFERENCES:

1. Safer DJ, Zito JM, dosReis S: Concomitant psychotropic medication for youths. Am J Psychiatry 2003; 160:438–449.
2. Jensen PS, Bhatara VS, Vitiello B, et al: Psychoactive medication prescribing practices for U.S. children: gaps between research and clinical practice. J Am Acad Child Adolesc Psychiatry; 1999; 38(5):557–565.

SCIENTIFIC AND CLINICAL REPORT SESSION 17—PTSD AND ANXIETY

No. 50
PTSD DEPRESSION AND ANGER IN PATIENTS RECOVERED FROM SARS

Rima Styra, M.D., *Department of Psychiatry, University Health Network, 200 Elizabeth Street, 8EN-235, Toronto, ON M5G 2C4, Canada;* Allison McGeer, M.D., Sonja Kasapinovic, M.S.C., Marie Louie, M.D., Wayne L. Gold, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize the long-term psychological sequelae related to a life-threatening emerging infectious disease.

SUMMARY:

The stress of being diagnosed with an unknown life-threatening, infectious disease (SARS), may result in psychological sequelae. Ninety-five (89.6.%) health care workers, and 11 (10.4%) non-health care workers were assessed at three, six and 12 months post-recovery from SARS. Subjects were 69% female, mean age 41.0 ± 11.9. To determine the prevalence of PTSD, depression, and anger, all 106 patients were taken into consideration, while data from participants who only attended all subsequent visits were used to estimate the difference in severity of symptoms between the three time periods (ANOVA for repeated measures). At three, six, and 12 months post-recovery, the respective incidence of PTSD was 35.1%, 38.9% and 28.9% (IES-R, for n=56, F=2.93, p=0.06), and 46.6%, 46.3% and 45.7% for depression (CES-D, for n=56, F=3.72, p=0.028) indicating a high prevalence of PTSD and depression and a significant drop in symptoms of depression at the 12th month follow-up. Spielberger State Anger Scale scores indicated that at one-year post-recovery, subjects remained angry (STAXI State scores in the 80% to 85% of population norms (n=56, F=1.42 and p=0.25)), while STAXI Trait scores were equivalent to population norms. This study demonstrates long-term psychological adjustment to the effects of SARS, which

could be used as a model to study impacts of emerging infectious diseases.

REFERENCES:

1. Feinstein A, Owen J, Blair N: A hazardous profession: war journalists, and psychopathology. American Journal of Psychiatry 2002; 159:1570–1575.
2. Arena JG, Glenda MB, Gayle SR, Kimford JM: A comparison of tension headache sufferers and nonpain controls on the state-trait anger expression inventory: an exploratory study with implications for applied psychophysiologists. Applied Psychophysiology and Biofeedback 1997; 22(3):209–214.

No. 51
ARE ANXIETY DISORDERS UNDERDIAGNOSED AND UNDERTREATED IN PSYCHIATRY?

Joshua E. Wilk, Ph.D., *APIRE, Department of Research, American Psychiatric Association, 1000 Wilson Boulevard, Arlington, VA 22209;* Joyce C. West, Ph.D., William E. Narrow, M.D., Donald S. Rae, M.A., Darrel A. Regier, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize patterns of underdiagnosis and undertreatment of anxiety disorders in routine psychiatric practice.

SUMMARY:

Objectives: (1) To assess rates of detection and diagnosis of anxiety disorders in routine psychiatric practice; (2) To examine patterns of treatment of patients with anxiety symptoms or diagnoses.

Methods: 615 psychiatrists from a full range of clinical settings participated in the American Psychiatric Institute for Research and Education (APIRE) Practice Research Network's 1999 Study of Psychiatric Patients and Treatments (SPPT) generating nationally representative clinical data on 1,843 patients. Comparisons were also made with household respondents in the National Comorbidity Survey (NCS) who reported using specialty mental health services.

Results: The prevalence of anxiety disorders reported by psychiatrists in routine practice was much lower than the prevalence found in self-reported specialty mental health service users ascertained through a structured household interview. Phobias were 22 times more likely to be diagnosed in the NCS sample compared with the SPPT sample. Over 10% of SPPT patients with panic disorder were receiving neither psychotherapy nor anti-anxiety medication, while 14% of patients with no anxiety diagnosis, but moderate to severe anxiety symptoms were not receiving psychotherapy or anti-anxiety medication.

Conclusion: These findings suggest that anxiety disorders may be underdiagnosed and sometimes undertreated in routine psychiatric practice. Further research is needed to examine associated factors or clinical rationale for the findings such as clinical significance, comorbidity, and prevailing standards of diagnostic assessment.

REFERENCES:

1. Zimmerman M, Mattia JI: Psychatric diagnosis in clinical practice: Is comorbidity missed? Comp Psych 1999; 40:182–191.
2. Shear KM, Greeno C, Kang J, Ludewig D, Frank E, Swartz HA, Ganekamp M: Diagnosis of nonpsychotic patients in community clinics. Am J Psychiatry 2000; 157:581–587.

No. 52
BIOLOGICAL FINDINGS IN PTSD: CAN THEY BE CHANGED BY PSYCHOTHERAPY?

Friedhelm Lamprecht, M.D., *Department of Psychosomatic Medicine, Medical School Hannover, Carl-Neubergstr 1, Hannover 30625, Germany;* Martin Sack, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize biological processes in PTSD.

SUMMARY:

Among the numerous findings by neuroimaging and neuroendocrinological studies in PTSD patients, there is only anecdotal evidence how these findings can be changed by psychotherapy. We were interested how central and peripheral physiological measures would change after treatment of PTSD patients: Two samples of PTSD patients were assessed either by event related potentials (ERPs) before and after a treatment session with eye movement desensitization and reprocessing (EMDR) (n=10) in a modified oddball paradigm containing auditory standard, target, and novel tones, or by physiological assessment (HR = heartrate, RSA = respiratory sinus arrhythmia) during trauma script before and after EMDR treatment (n = 16). Moreover, psychometric evaluation with (PDS, IES, STAI) was applied before and after treatment and during follow up (six month).

Results: Compared with a sham-treated control group, ERPs showed a significant reduction of the 3a component, suggesting a reduced arousal and orienting to novel stimuli after treatment. Stress-related HR acceleration during trauma script decreased significantly compared with waitlist controls, while the increase of RSA (indicating parasympatic tone) demonstrated an improved physiological regulation. The psychometric measures showed significant improvements, which remained stable over six month follow up.

REFERENCES:

1. Lamprecht F, Sack M: Posttraumatic stress disorder revisited. Psychosomatic Medicine 2002; 64:222–237.
2. Sack M, Hopper JW, Lamprecht F: Low respiratory sinus arrthymia and prolonged psychophysiological arousal in posttraumatic stress disorder: heart rate dynamics and individual differences in arousal regulation. Biol Psychiatry 2004; 55:284–290.

SCIENTIFIC AND CLINICAL REPORT SESSION 18—ISSUES IN BIOLOGICAL PSYCHIATRY

No. 53
THE FAMILY GENETIC STUDY OF PATHOLOGICAL GAMBLING

Donald W. Black, M.D., *Department of Psychiatry, University of Iowa, Psychiatry Research MEB, Iowa City, IA 52442;* Patrick Monahan, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant should be able to understand the contribution of genetic factors to the development of pathological gambling.

SUMMARY:

Pathological gambling (PG) has become a significant health problem that is estimated to cost about $5 billion per year and an additional $40 billion in lifetime costs for reduced productivity, social services, and creditor losses. Despite its importance, relatively little is known about the role of heredity factors in its occurrence, though unsystematically collected family history data suggest that it runs in families. The authors present data from a systematic family interview study of PG in which 31 persons with DSM-IV PG and 31 community controls were recruited and interviewed regarding their first-degree relatives (FDRs). Available and willing FDRs were directly interviewed with structured instruments of known reliability and best-

estimate final diagnoses were blindly assigned for 240 case and 144 control relatives. The lifetime rates of PG and subclinical PG were substantially greater among case than control relatives; PG relatives also had significantly higher lifetime rates of mood disorders, substance use disorders, and antisocial personality disorder. The estimated lambda (λ), the ratio of definite PG in case and control relatives, respectively, is 4.7, which is similar to that for obsessive compulsive disorder, bipolar disorder, and panic disorder, and is strongly indicative of a genetic etiology.

REFERENCES:

1. Black DW, Moyer T, Schlosser S: Quality of life and family history in pathological gambling. J Nerv Ment Dis 2003; 191:124–126.
2. Eisen SA, Lin N, Lyons MJ, et al.: Familial influences on gambling behavior: an analysis of 3,359 twin pairs. Addiction 1998; 93:1375–1384.

No. 54
METABOLIC SYNDROME IN PSYCHIATRIC INPATIENTS RECEIVING ANTIPSYCHOTICS

John W. Goethe, M.D., *Department of Clinical Research, Institute of Living-Burlingame, 400 Washington Street, Hartford, CT 06106-3309;* Bonnie L. Szarek, R.N., Charles F. Caley, Pharm.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) describe metabolic syndrome, (2) discuss the association between atypical antipsychotics and the metabolic syndrome.

SUMMARY:

Objective: To determine the prevalence symptoms of metabolic syndrome (MtSn) and the demographic and clinical feature associated with this condition.

Method: BMI, triglycerides, cholesterol, FBS, and the presence of a diagnosis of hypertension (HTN) or diabetes (DM) were recorded for all inpatients treated with antipsychotics in 2003 (N=1,691). Patients meeting any of the ATPIII criteria for MtSn were compared with the remainder of the sample using chi square and logistic regression.

Results: Nearly half of the sample (45.3%) was positive for at least one symptom; 13.9% of patients had ≥ 3. BMI was >30 in 28.5% of patients, triglycerides > 150 mg/dl in 31.7%, HDL < 40/50 (male/females) in 34.8%. A diagnosis of HTN was recorded in 16.9% and DM in 11.1%. BMI > 30 was more frequent among females (39.3% vs 25.0% of males); triglyceride elevation was less frequent in patients with schizophrenia (27.6%) vs depression (39.4%, p=.01). Patients with either schizophrenia or depression were more likely than others to have DM (OR=3.65 and 1.5, respectively).

Conclusion: Risk factors for MtSn were common, supporting the need for routine screening and appropriate medical management of MtSn-related symptoms in patients receiving atypical antipsychotics.

Funding Source: Institute of Living research funds.

REFERENCES:

1. Melkersson K, Dahl M-L: Adverse metabolic effects associated with atypical antipsychotics: literature review and clinical implications. Drugs 2004; 64(7):701–723.
2. American Diabetes Association, American Psychiatric Association, American Association of Clinical Endocrinologists, North American Association for the Study of Obesity: Consensus development conference on antipsychotic drugs and obesity and diabetes. J Clin Psychiatry 2004; 65(2):267–272.

No. 55
ANOREXIA NERVOSA AND BULIMIA NERVOSA: FROM CULTURE TO GENES

Pamela K. Keel, Ph.D., *Department of Psychology, University of Iowa, E11 Seashore hall, Iowa City, IA 52242-1407*

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant should be able to understand the evidence suggesting the relative roles of culture and genes in the etiology of anorexia nervosa and bulimia nervosa and implications for treatment.

SUMMARY:

This presentation explores the extent to which eating disorders, specifically anorexia nervosa (AN) and bulimia nervosa (BN), represent culture-bound syndromes and discusses implications for conceptualizing the role genes play in their etiology. Three lines of evidence are presented to address this question: an evaluation of the presence of these disorders in non-Western cultures, a qualitative summary of historical evidence of eating disorders before their formal recognition, and a quantitative meta-analysis of changes in incidence rates since the formal recognition of AN and BN. Findings suggest that BN is a culture-bound syndrome and AN is not. Results suggest that heritability estimates for BN may show greater variability cross-culturally than heritability estimates for AN, and that the genetic bases of these disorders may be associated with differential pathoplasticity. These inferences indicate that AN and BN likely have distinct genetic bases. To examine this conclusion, results are presented from a latent class analysis to empirically define eating disorder phenotypes, and results from genome-wide linkage analyses of susceptibility loci for eating disorders are reviewed. Finally, implications for current treatment approaches for AN and BN will be examined in light of evidence for their distinct etiologies.

REFERENCES:

1. Keel PK, Klump KL: Are eating disorders culture-bound syndromes? Implications for conceptualizing their etiology. Psychological Bulletin 2003; 129:747–769.
2. Keel PK, Fichter M, Quadflieg N, et al: Application of a latent class analysis to empirically define eating disorder phenotypes. Archives of General Psychiatry 2004; 61:192–200.

WEDNESDAY, MAY 25, 2005

SCIENTIFIC AND CLINICAL REPORT SESSION 19—ADDICTION PSYCHIATRY

No. 56
VIRTUAL REALITY CUE EXPOSURE FOR CRACK COCAINE DEPENDENCE

Michael Saladin, Ph.D., *Department of Psychiatry, Medical University of South Carolina, Bee Street, Charleston, SC 29403;* Barbara Rothbaum, Ph.D., Ken Graap, M.A., Kathleen T. Brady, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to demonstrate an understanding of the use of virtual reality for substance use disorders.

SUMMARY:

Virtual reality (VR) integrates real-time computer graphics, body tracking devices, visual displays, and other sensory input devices to immerse a participant in a computer-generated virtual environment. VR exposure therapy has been successful for the treatment of anxiety

disorders. We have now applied VR to the treatment of substance use disorders in testing a new medium for providing cue exposure treatment for crack cocaine dependence. An open clinical trial was conducted to test the feasibility of this virtual crack house for inducing craving in crack cocaine dependent patients. Eleven patients were tested and exposed to the virtual crack scenes including sexual cues, dealer, using, buying, and selling crack. Results indicated that participants report a significant increase in craving from baseline in the virtual scenes. There is a significant heart rate increase for the buying, using, observing, and selling crack cocaine scenes. Skin conductance increases substantially during the scene in which subjects observe people who are using cocaine. It is concluded that virtual reality holds promise for use as an activation paradigm for use in the assessment and treatment of substance use disorders, including crack cocaine dependence.

REFERENCES:

1. Ressler KJ, Rothbaum BO, Tannenbaum L, Anderson P, Zimand E, Hodges L, Davis M: Facilitation of psychotherapy with D-Cycloserine, a putative cognitive enhancer. Archives of General Psychiatry, in press.
2. Gershon J, Anderson P, Graap K, Zimand E, Hodges L, Rothbaum BO: Virtual reality exposure therapy in the treatment of anxiety disorders. Scientific Review of Mental Health Practice 2002; 1: 78-83.

No. 57
LOW-DOSE NALTREXONE FOR OPIOID DEPENDENCE

Paolo Mannelli, M.D., *Department of Psychiatry, Duke University, 4323 Ben Franklin Blvd, Suite 700, Durham, NC 27704;* Charles Thornton, Ph.D., Heather Murray, Stephen H. Weinstein, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize different techniques of opiate antagonist administration in the treatment of opiod dependence.

SUMMARY:

Introduction: The return of interest in naltrexone for the treatment of heroin addiction cannot overshadow some limitations associated with its use. Low acceptance rates, high attrition, and incompatibility with opioid use may result in difficult compliance and questionable medium or long-term benefits of naltrexone treatment.

Objective: To investigate compliance, safety, and efficacy of low-dose naltrexone administration following opioid detoxification.

Methods: 429 inner-city opioid addicts were offered naltrexone (1-10 mg/day) and/or clonidine in a community-based outpatient treatment, 24 hours after administration of the last methadone dose and discharge from inpatient detoxification. Patients were also receiving counseling and case management before moving to long-term aftercare.

Results: 160 patients (37.3%) accepted naltrexone. They did not differ as to individual characteristics, drug abuse history, or motivation to treatment. Naltrexone administration did not induce more intense withdrawal than clonidine alone and was associated with lower attrition, longer stay in treatment, better outcome, and higher treatment attendance at follow up.

Conclusion: Controlled studies will confirm if low dose naltrexone can be succesfully administered in the transition to long-term care and serve a harm reduction function in the treatment of opioid addiction.

REFERENCES:

1. Tucker T, Ritter A: Naltrexone in the treatment of heroin dependence: a literature review. Drug Alcohol Rev 2000; 19: 73–82.
2. Rea F, Bell JR, Young MR, Mattick RP: A randomized, controlled trial of low dose naltrexone for the treatment of opioid dependence. Drug Alcohol Dependence 2004; 75: 79–88.

No. 58
BUPRENORPHINE VERSUS METHADONE TREATMENTS IN ADDICTED OPIOID PATIENTS: A TWO-YEAR OBSERVATIONAL STUDY

Paolo Marzorati, M.D., *Dependence Department ASL Milano, Drug addiction Unit, via boifava 25, milano 20148, Italy;* Livia Guglielmino, M.D., Pierluigi Vigezzi, M.D., Rosella Silenzio, M.D., Margherita de Chiara, M.D., Filomena Corrado, M.D., Edoardo Cozzolino, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be able to recognize effectiveness of buprenorphine and methadone treatment in our heroin addicted patients.

SUMMARY:

Aim: To show BPF and MMT effectiveness in incident heroin addict patients (pts.) in our center and to compare effectiveness one vs another from January 2001 to December 2003.

Methods: A protocol with inclusion and exclusion criteria for the two different drugs was established. Population: 121 pts (99 males)—with 135 treatments—were submitted to BPF therapy; 156 treatments in 136 pts (106 males) consisted in MMT. Pts showed similar socio-demographic and dependence characteristics except for occupational level (?2:p=0.004), educational level (degree) (?2:p=0.015) and average initial GAF; it was 64 ± 9.6 for BPF group and 59 ± 9 in MT group (?2:p=0.0011). Treatments: BPF treatments: average length was of 267 days (range 1-708): concerning only the first treatment they resulted 20.7% (25) short-term, 21.5% (26) medium-term and 57.8% (70) long term. MMT average length was 249 days (range:1-716): they were 15.5% (21) short-term, 30, 1% (41) medium-term and 54.4% (74) long term. The average maximum dosage was of 11 ± 6 mg/day (BPF) and 53.5 ± 29.3 mg/day (MMT). Psychosocial integrated treatments resulted about 40% in both therapies.

Results: BPF: GAF significantly increased in pts completing treatments (t:p=0.0004); retention rate for multiple treatments was 56% (54.9% in single treatments); negative urinary samples resulted 80 and 75.5%, respectively, for morphine and cocaine metabolites. MMT: GAF significantly increased in pts completing treatment: (t:p=0.008); retention rate for multiple treatments was 57.5% (58.6% in single treatments); negative urinary samples resulted 62.9% and 77.5%, respectively, for morphine and cocaine metabolites. BPF vs MMT: no significant difference as far as retention rate (?2:p=0.5; O.R.=0.8), initial and final GAF incremental values (t:p=0.97) and treatment outcomes (?2:p=0.4). On the contrary, a significant difference was noted in morphine negative urinary samples (?2:p<0.0001; O.R.=2.4). Subpopulations: Psychosocial treatments positively influenced both therapies as well as urinary analyses; no differences, on the contrary, as regard the outcomes of both treatments. MMT higher dosage group showed better outcome than lower one (?2:p=0.0006).

Conclusions: both substitutive therapies resulted effective. Similar effectiveness for retention rate, outcomes and GAF value increase; better effectiveness for BPF than MMT for reduction of morphine abuse during the treatment.

REFERENCES:

1. Mattick RP: Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. Cochrane Database System Rev 2003; (2) CD002207.
2. Ahamadi J: Methadone versus buprenorphine maintenance pfor the treatment of heroin dependent outpatients. J Subst Abuse Treat 2003; 24(3):217–20.

SCIENTIFIC AND CLINICAL REPORT SESSION 20—ADVERSE DRUG EFFECTS

No. 59
THINKING ABOUT ADVERSE DRUG EFFECTS: LESSONS FROM THE PSYCHOLOGY OF RISK AND DECISION MAKING FOR CLINICAL PSYCHOPHARMACOLOGY

Andrew A. Nierenberg, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street WACC 815, Boston, MA 02114-3117;* Yelena Wu, B.A., Polina Eidelman, B.A., Jordan W. Smoller, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the potential systematic biases in decision making that may affect psychopharmacological decisions. Participants should also be able to recognize the ways that these systematic biases may stem from how pharmaceutical companies frame risk.

SUMMARY:

Many factors influence clinicians' psychopharmacological decisions. While most of these prescribing decisions may be reasonable and evidence based, other decisions may be systematically biased. These systematic biases in decision making, informed by the field of the psychology of risk, have been well characterized in other medical and non-medical fields, but mostly ignored in clinical psychopharmacology. The purpose of this paper is to sensitize clinicians who prescribe psychiatric drugs to the issues of the psychology of risk, especially as they pertain to the risk of side effects. Specifically, the present analysis focuses on heuristic organization and framing effects that create cognitive biases in daily life as well as in medical practice. Furthermore, this presentation aims to increase awareness of how pharmaceutical companies may influence physicians by framing the risk of medication side effects to favor their products relative to competing products.

REFERENCES:

1. Smoller JW, Nierenberg AA: Small numbers, big impact. Harvard Rev of Psychiatry 1999; 7(2):109–13.
2. Tversky A, Kahneman D: The framing of decisions and the psychology of choice. Science 1981; 211(4481):453–8.

No. 60
SILDENAFIL TREATMENT OF SSRI-ASSOCIATED SEXUAL DYSFUNCTION IN NONRESPONDERS OF A DOUBLE-BLIND, PLACEBO-CONTROLLED STUDY: SINGLE-BLIND, OPEN-LABEL RESULTS

H. George Nurnberg, M.D., *Department of Psychiatry, University of New Mexico, 2400 Tucker NE, MSC 095030, Albuquerque, NM 87131;* Paula L. Hensley, M.D., Maurizio Fava, M.D., Alan J. Gelenberg, M.D., John Lauriello, M.D., Susan Paine, M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize that patient perceptions of receiving active drug may influence outcomes in the treatment of serotonergic reuptake inhibitor antidepressant-associated sexual dysfunction.

SUMMARY:

Objective: To determine, with blind maintained as to initial assignment, the additional clinical effectiveness of open-label sildenafil treatment for serotonergic reuptake inhibitor antidepressant-associated sexual dysfunction (SRI-AASD) in major depression in remission (MDD-R) patients who had a partial response or nonresponse to initial treatment in a double-blind, placebo-controlled (DBPC) study.

Methods: 76 men with SRI-AASD and MDD-R completed a DBPC with sildenafil treatment; 26 were full responders as assessed by the Clinical Global Impression-Sexual Function (CGI-SF) scale. With initial blind maintained, 50 (66%) partial or nonresponders (CGI-SF score >2) were eligible to continue open-label sildenafil (50–100 mg) treatment for another six weeks. 43 partial or nonresponders chose to enter: 16/17 initial-sildenafil and 27/33 initial-placebo recipients. Outcome measures included CGI-SF, International Index of Erectile Function, University of New Mexico-Sexual Function Inventory, and Hamilton Depression Rating Scale (HAM-D17). Changes from the open-label baseline were analyzed using paired *t*-tests, Chi-square, and ANOVA.

Results: Overall, 35/43 patients (81%; 95% CI: 67%–92%) achieved much/very much improved (CGI-SF<2) treatment response ($P<0.0001$); placebo/sildenafil 23/27 (85%; 95% CI: 66%–96%), sildenafil/sildenafil 12/16 (75%; 95% CI: 48%–93%), without between-groups difference ($P=0.41$). Erectile function, ejaculation/orgasm and overall satisfaction measures significantly improved in both groups ($P\leq0.002$). Mean depression scores remained consistent with remission in both groups for study duration (HAM-D≤7).

Conclusions: Open-label sildenafil treatment of SRI-AASD double-blind partial or nonresponders further improved outcomes. Combined with the DBPC full responders, sildenafil treatment provided effective antidote SRI-AASD treatment for 61/76 (88%) patients maintaining MDD-R with antidepressant adherence.

REFERENCES:

1. Seidman SN, Roose SP, Menza MA, Shabsigh R, Rosen RC: Treatment of erectile dysfunction in men with depressive symptoms: results of a placebo-controlled trial with sildenafil citrate. Am J Psychiatry 2001; 158:1623–1630.
2. Nurnberg HG, Hensley PL, Gelenberg AJ, Fava M, Lauriello J, Paine S: Treatment of antidepressant-associated sexual dysfunction with sildenafil: a randomized controlled trial. JAMA 2003; 289:56–64.

No. 61
ASSOCIATION BETWEEN SSRI SIDE EFFECTS AND ADHERENCE TO MODERN SSRIS

Stephen B. Woolley, M.P.H., *Burlingame, Institute of Living, 2200 Retreat Avenue, Hartford, CT 06106;* John W. Goethe, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) discuss the role of side effects in non-adherence to SSRI therapy, (2) list three variables, other than the presence of side effects, that are associated with non-adherence to SSRIs.

SUMMARY:

Objective: To investigate the association between discontinuation of SSRIs and patient-reported side effects (SEs).

Methods: 406 patients treated with SSRIs for major depressive disorder (MDD) were interviewed three months after index treatment. Variables included patterns of SSRI use, other medications, specific SEs reported and their severity, and clinical and demographic features. Bivariate and regression techniques were used for analysis.

Results: Approximately one in four subjects discontinued the SSRI. There were no differences among the SSRIs in either the presence/absence of SEs or discontinuation rates. However, experiencing "extremely bothersome" SEs was associated with a 50% increased risk of SSRI discontinuation. This association remained after controlling for other potential predictors of discontinuation. Discontinuation was *not* associated with having SEs (yes/no), with total number of SEs, or with severity ratings less than "extremely."

In a regression model, discontinuation was predicted by experiencing at least one "extremely bothersome" SEs, having anxiety or weight change that the patient associated with the SSRI, male gender, younger age, not having health insurance, and a reduction in GAF score.

Conclusions: The type and number of SEs did not explain discontinuation of SSRI therapy, and severity rating was relevant only when "extreme." The contribution of SEs to non-adherence to treatment should be re-examined.

Funding Source: Institute of Living Research Funds

REFERENCES:

1. Bull SA, Hunkeler EM, Lee JY, Rowland CR, Williamson TE, Hurt SW, Schwab JR: Discontinuing or switching selective serotonin reuptake inhibitors. Ann Pharmacother 2002; 36(4):578–584.
2. Demyttenaere K: Compliance during treatment with antidepressants. J Affect Disord 1997; 43(1):27–39.

SCIENTIFIC AND CLINICAL REPORT SESSION 21—DEPRESSION

No. 62
LAST OBSERVATION CARRIED FORWARD USE IN ANTIDEPRESSANT EFFICACY TRIALS: REVIEW OF 260 STUDIES

Alex A. Cardoni, M.S., *Burlingame Department, Institute of Living, 200 Retreat Avenue, Hartford, CT 06106;* Stephen B. Woolley, M.P.H., John W. Goethe, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) recognize and describe intent-to-treat samples and last observation carried forward (LOCF) data imputation in antidepressant clinical trials, (2) assess the analytic approach used for dealing with dropouts in antidepressant clinical trials.

SUMMARY:

Objective: To determine the extent to which efficacy trials utilize intent-to-treat analysis with last observation carried forward (LOCF), a method for analyzing data from research study dropouts, and publish the information needed to determine if there is a potential sample bias.

Methods: The authors reviewed published, randomized trials of antidepressants (n=260) to determine (1) designed vs actual methods employed (subject selection and retention, analytical approach), (2) the approach used to account for dropouts, and (3) whether the precise direction and magnitude of potential bias were discussed.

Results: Three-quarters of these studies were ≤6 weeks long. Approximately 85% had ≥2 treatment groups, and 44% had ≥1 control group. Mean dropout rate was 25% (range = 0-76%). A positive correlation between sample size and dropout rate (p=.03) was not explained by study duration. LOCF use during 1990–2003 was twice that in 1965–1989 (50% vs 24%) (p<.001). Among confirmed LOCF publications (n=97), only 31% mentioned potential bias, 24% its direction, and 2% its magnitude. Only one included the data needed to assess bias.

Conclusions: LOCF is frequently used in antidepressant trials, and the potential bias introduced is rarely addressed. The authors discuss alternative approaches for dealing with missing data and subject retention.

Funding Source: Institute of Living Research Funds

REFERENCES:

1. Lavori PW: Clinical trials in psychiatry: should protocol deviation censor patient data. Neuropsychopharmacol 1992; 6(1):39–48.
2. Wright CC, Sim J: Intention-to-treat approach to data from randomized, controlled trials: a sensitivity analysis. J Clin Epidemiol 2003; 56:833–842.

No. 63
THE EFFECT OF CHROMIUM PICOLINATE ON CARBOHYDRATE CRAVING IN ATYPICAL DEPRESSION

John P. Docherty, M.D., *Comprehensive NeuroScience, Inc., 21 Bloomingdale Road, 8N, White Plains, NY 10605;* James Komorowski, M.S., David A. Sack, M.D., Mark Roffman, Ph.D., Manley Finch

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to identify the effects of chromium picolinate in reducing carbohydrate craving, recognizing the syndrome of atypical depression and other symptoms of atypical depression.

SUMMARY:

Carbohydrate craving is common in atypical depression, and associated with adverse health outcomes. Prior small studies reported chromium picolinate (CrPic) reduced symptoms of atypical depression and carbohydrate craving, perhaps through its insulin-sensitizing action.

To more definitively examine the effects of CrPic on carbohydrate craving and other symptoms, an eight-week, placebo-controlled, randomized trial of CrPic was conducted in 113 patients with atypical depression (intent-to-treat group). 80% in both placebo and CrPic groups completed. 66% of patients received 80% or more of their medication (Evaluable group).

Results: Depression decreased significantly for both CrPic and placebo. However, specific symptoms improved significantly more with CrPic than placebo. No advantage was found for placebo.

(1) Carbohydrate craving decreased significantly more with CrPic than PBO (p<.05) in ITT and Evaluable groups.

(2) Baseline level of carbohydrate craving was a highly significant predictor of reduction in overall HAM-D (p = .0052) for CrPic, but not placebo.

(3) Work and activities; increased appetite, increased eating, psychomotor retardation, and morning worsening improved significantly more with CrPic than PBO both for ITT (p = .05) and Evaluable (p=.008) groups.

Conclusion: CrPic reduces carbohydrate craving in atypical depression and exerts beneficial effects on appetite, food intake and energy level.

REFERENCES:

1. Davidson JR, Abraham K, Connor KM, McLeod MN: Effectiveness of chromium in atypical depression: a placebo-controlled trial. Biological Psychiatry 2003; 53:261–264.
2. Wurtman RJ, Wurtman JJ: Brain serotinin, carbohydrate craving, obesity and depression. Obesity Research 1995; 3 (Suppl 4): 477S–480S.

No. 64
DOES REMISSION OF ACUTE DEPRESSION PREDICT LONG-TERM EFFICACY

Caroline B. Williams, M.D., *Department of Psychiatry, NYU School of Medicine, 126 East 36th Street, Apt. #3, New York, NY 10016;* Eric D. Peselow, M.D., Mary Anne Pressman, M.D., Gonzalo E. Laje, M.D.

EDUCATIONAL OBJECTIVES:

To evaluate whether remission (MADRS <8) or 50% response (MADRS 9–14 with 50% reduction of MADRS from baseline) of acute depression to one of four SSRIs continued efficacy over a five-year continuation period.

SUMMARY:

Objective: The long-term efficacy of selective serotonin reuptake inhibitors (SSRIs) in preventing recurrent episodes of depression after successful treatment of the acute episode has not been shown for >2 years in controlled trials or naturalistic studies. The quality of the response during acute treatment may be important in maintaining long-term efficacy. The purpose of this study is to evaluate patients who responded to one of four SSRIs: fluoxetine, citalopram, sertraline, and paroxetine acutely in a naturalistic clinical setting with either remission (MADRS 8 or less) or response (MADRS 9–14 with 50% reduction of MADRS) whether remission or response, predicted better long-term response.

Method: 281 patients who were acutely treated for depression with one of the four SSRIs and were continued on the medication to which they responded, were followed from their seventh month of euthymic mood until a well defined termination or a recurrence of depression (meeting DSM-IV criteria for major depression) causing a medical decision to reinstitute medication.

Results: Of the 154 patients who had remission of the acute depression, 107 maintained the response (70%) over a one to seven year course (average time followed 38 months) Of the 127 patients who had a 50% response of the acute depression, only 47 (37%) maintained the response. The five-year survival rate for the remitted group was 56% whereas the five-year rate for the group that had 50% response was 26%. (overall probability p<.0001)

Conclusion: In a naturalistic setting, long-term treatment with antidepressants yielded substantial relapse with acute response less than remission (MADRS<8)

There was no funding for this study.

REFERENCES:

1. Paykel ES, Ramana R, Cooper Z, et al: Residual symptoms after partial remission: an important outcome in depression. Psychological Medicine 1995; 25:1171–1180.
2. Keller MB, Kocsis JH, Thase ME: Maintenance phase efficacy of sertraline for chronic depression: a randomized control trial. Journal of the American Medical Association 1998; 280:1665–1672.

SCIENTIFIC AND CLINICAL REPORT SESSION 22—EATING DISORDERS

No. 65
ANGER DISCOMFORT PREDICTS DISORDERED EATING AMONG COLLEGE STUDENTS WITH OBESITY

Alayne Yates, M.D., *Department of Psychiatry, University of Hawaii, 1356 Lusitana St, 4th Fl, Honolulu, HI 96813;* Jeanne L. Edman, Ph.D., Mara S. Aruguete, Ph.D., Kurt A. Debord

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize sex differences in risk factors for obesity, recognize that body dissatisfaction affects motivation to lose weight, explore how anger discomfort influences eating pathology.

SUMMARY:

Objective: The present study examines disordered eating and exercise among obese college students.

Method: 88 males and 102 females with BMI scores above 30 are selected from a larger sample (N=1900). Survey includes: Anger Discomfort Scale; Self-Loathing Sub-Scale of the Exercise Orientation Questionnaire; Figure Drawings; and Eating Disorder Inventory-2.

Results: Females report higher drive for thinness (DT), body dissatisfaction, and more frequent dieting than males, and males report higher levels of exercise. Body dissatisfaction, anger discomfort, and self-dissatisfaction correlate with DT for both males and females. Regression analysis indicates that, among males, anger discomfort and dieting are significant predictor variables for DT, accounting for 46% of the variance. Among females, self-dissatisfaction and anger discomfort are significant predictors of DT, accounting for 47% of the variance. Neither body dissatisfaction or BMI are significant predictors of DT for males or females, suggesting that internal determinants are more important than external, appearance-based concerns.

Conclusion: Sex differences exist in the genesis/maintenance of eating pathology in obese college students. Self-dissatisfaction plays an important role for females but not males, while anger discomfort is important for both males and females.

Funding: UCERA, a non-profit foundation.

REFERENCES:

1. Yates A, Edman J, Crago M, & Crowell D: Using an exercise-based instrument to detect signs of an eating disorder. Psychiatry Research 2001; 105:231–241.
2. Yates A, Edman J, Aruguete M: Ethnic differences in BMI and body/self dissatisfaction among Caucasians, Asian subgroups, Pacific Islanders, and African Americans. J Adolesc Health 2004; 34(4).

No. 66
PSYCHOSOCIAL TREATMENT OF EATING DISORDERS

Cynthia M. Bulik, Ph.D., *Department of Psychiatry, University of North Carolina, 101 Manning Drive, First Floor, NSH CB7160, Chapel Hill, NC 27514-4220*

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, participants will be aware of scientific information regarding the utility of psychosocial treatments for anorexia nervosa and bulimia nervosa.

SUMMARY:

Psychosocial intervention is a critical component of treatment for both anorexia nervosa and bulimia nervosa. Eating disorders require a comprehensive multidisciplinary approach including medical management, psychotherapy, nutritional rehabilitation, and when appropriate, family intervention. As noted in the APA practice guidelines (2000), the goals of psychosocial treatments include helping patients: (1) understand and cooperate with their nutritional and physical rehabilitation; (2) change the behaviors and dysfunctional attitudes related to their eating disorder; (3) improve their interpersonal and social functioning; and (4) address comorbid psychopathology and issues that reinforce or maintain eating disorder behaviors.

Several clinical trials have been conducted for both bulimia nervosa and anorexia nervosa. Cognitive-behavioral, interpersonal, and family-based therapies have received the most attention in clinical trials of eating disorders. Evidence of their comparative efficacy will be presented for both disorders. Promising new psychotherapies will also be discussed together with critical issues related to the timing of psychotherapy relative to weight gain in anorexia nervosa, chal-

lenges in dissemination of evidence-based therapies, and barriers to implementation in the community.

REFERENCES:

1. Fairburn CG, Jones R, Peveler RC, Carr SJ, Solomon RA, O'Connor ME, Burton J, Hope RA: Three psychological treatments for bulimia nervosa. Archives of General Psychiatry 1991; 48:463–469.
2. McIntosh VVW, Jordan J, Carter FA, Luty SE, McKenzie JM, Bulik CM, Frampton C, Joyce PR: Three psychotherapies for anorexia nervosa: a randomized, controlled trial. American Journal of Psychiatry, in press.

No. 67
PSYCHOPHARMACOLOGY OF EATING DISORDERS

B. Timothy Walsh, M.D., *Department of Psychiatry, NY State Psychiatric Institute-Columbia Univ, 1051 Riverside Drive, Unit #98, New York, NY 10032-2603*

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, participants will be aware of scientific information regarding the utility of medication for anorexia nervosa, bulimia nervosa, and binge-eating disorder.

SUMMARY:

There has been substantial progress in the last 15 years in the development of psychopharmacological treatments for eating disorders. Progress in the treatment of bulimia nervosa has been most dramatic. Numerous double-blind, placebo-controlled studies have demonstrated that antidepressant medication is more effective than placebo in the treatment of this disorder. Surprisingly, the effectiveness of antidepressants does not seem closely tied to the pretreatment presence of significant mood disturbance. Important issues, however, remain incompletely resolved. These include the long-term outcome of pharmacological intervention, the potential advantages of combining medication and psychotherapy, and the best interventions for individuals who do not respond to standard treatments. The utility of other medication classes has not been extensively examined, but preliminary data suggest topiramate may be useful. Progress has also been made in the treatment of binge-eating disorder, which is described in an appendix of DSM-IV. Controlled studies suggest that antidepressant medications and medications associated with weight loss (e.g., topiramate, sibutramine) may be useful in the treatment of this illness. Anorexia nervosa remains relatively refractory to pharmacological intervention. However, preliminary data suggest that patients with this illness who gain to near-normal body weight may relapse less frequently when treated with fluoxetine.

REFERENCES:

1. Walsh BT: Pharmacological treatment of eating disorders: much progress, many problems, [Commentary] in Eating disorders. Edited by Maj M, Halmi K, Lopez-Ibor JJ, Sartorius N. Wiley, Chichester, 2003, pp 297–298.
2. Zhu AJ, Walsh BT: Pharmacological treatment of eating disorders. Canadian Journal of Psychiatry 2002; 47:227–234.

SCIENTIFIC AND CLINICAL REPORT SESSION 23—VIOLENCE AND TRAUMA

No. 68
EFFECTS OF TERRORISM ON PSYCHOPATHOLOGY: TWO YEARS AFTER 9/11

Judith A. Richman, Ph.D., *Department of Psychiatry, University of IL at Chicago, 1601 West Taylor Street, MC912, Chicago, IL 60612;* Kenneth W. Zlatoper, M.S., Joseph A. Flaherty, M.D., Kathleen Rospenda, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize the continuing influence of terrorism-related fears and consequences for elevated distress and drinking, and appreciate and design interventions related to the protective effects of social bonds.

SUMMARY:

The objective of this report from our NIAAA-funded longitudinal study of a Midwestern workplace cohort is to depict longer-term psychopathological and drinking effects of experiencing the events of 9/11/01 and threats of future terrorist events. Subjects in a five-wave workplace cohort study (initial n=2,492) were surveyed with mailed questionnaires in the fall of 1996, 1997, 2001, 2002, and 2003. At wave 5, in 2003, questionnaires (n=1,439) included a measure of terrorism-related stressors (adapted from the Psychosocial Resources Losses Instrument) and measures of psychological distress (depression, anxiety, hostility) and drinking behaviors, with outcomes additionally assessed at prior survey waves. Regression analyses demonstrate that terrorism-related stressors and experiences are significantly linked with distress and drinking, controlling for sociodemographic variables and baseline psychopathology. However, indicators of the strength of social bonds (measured by marriage, parenthood and perceived social support) manifested a protective effect on mental health in the face of terrorism-related stressors. Interventions aimed at strengthening social support systems may lead to psychological resilience in the wake of continuing threats of terrorism.

REFERENCES:

1. Richman JA, Wislar JS, Flaherty JA, Fendrich M, Rospenda KM: Effects of alcohol use and anxiety of the September 11, 2001 attacks and chronic work stressors: a longitudinal cohort study. American Journal of Public Health, in press.
2. Flaherty JA, Richman JA: Effects of childhood relationships on the adult's capacity to form social supports. American Journal of Psychiatry 1986; 143:851–855.

No. 69
9/11: TERRORISM, PSYCHIATRIC SYMPTOMS, SERVICE UTILIZATION, AND ALCOHOL INTAKE

Linda S. Grossman, Ph.D., *Department of Psychiatry, University of Illinois at Chicago, 912 South Wood Street, MC-913, Chicago, IL 60612;* Judith A. Richman, Ph.D., Kenneth W. Zlatoper, M.S., Cherise Rosen, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be familiar with data indicating that ongoing fear of terrorism is not only associated with increased drinking and psychiatric symptoms, but also with increased use of psychiatric services.

SUMMARY:

Objective: To provide data on the relationships among psychiatric services, psychopathology, alcohol intake, and trauma following terrorism, we surveyed a large sample (n=1439) following the 9/11/01 attack. We have surveyed this sample at total of four times during the past eight years as part of our ongoing NIAAA-funded longitudinal study.

Method: Subjects filled out questionnaires assessing frequency of mental health services usage, Terrorism-related Stressors (a trauma scale adapted from the Psychosocial Resources Losses Instrument), depression, anxiety, hostility, and alcohol intake.

Results: (1) There was a significant interaction effect between the severity of 9/11 trauma and the frequency of seeking psychiatric

services. (2) There was also a significant interaction between the severity of trauma and the use of mental health services in predicting alcohol consumption. Individuals reporting the most severe 9/11 trauma and those seeking mental health services reported the highest number of drinks per day. (3) Anxiety and hostility scores were greatest for those who reported severe trauma and who sought mental health services.

Conclusions: Since 9/11, trauma related to terrorism has become an especially prominent focus in psychiatric practice. This research demonstrates relationships among severe 9/11 trauma, psychiatric symptoms, alcohol consumption, and service utilization. Psychiatrists need to be informed about the profound impact fear of terrorism can have on patient outcomes, since it is likely that terrorism will be a continuing stressor in the future.

REFERENCES:

1. Silver RC, Holman EA, McIntosh DN, Poulin M, Gil-Rivas V: A nationwide longitudinal study of psychological responses to September 11. Journal of the American Medical Association 2002; 288:1235–1244.
2. Richman JA, Wislar JS, Flaherty JA, Fendrich M, Rospenda KM: Effects on alcohol use and anxiety of the September 11, 2001 attacks and chronic work stressors: A longitudinal cohort study. American Journal of Public Health, in press.

No. 70
CLOZAPINE, OLANZAPINE, AND HALOPERIDOL TREATMENT OF VIOLENT PATIENTS WITH SCHIZOPHRENIA

Menahem I. Krakowski, M.D., *Nathan Kline Institute, 140 Old Orangeburg Road, Orangeburg, NY 10962;* Pal Czobor, Ph.D., Leslie L. Citrome, M.D., Fabien Tremeau, M.D., Biman B. Roy, M.D., Linda Kline, R.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should understand the role of atypical antipsychotic agents in the treatment of violence in schizophrenia.

SUMMARY:

Objective: This NIMH-funded study is the first double-blind comparison of atypical antipsychotics (clozapine and olanzapine) with one another and with haloperidol in the treatment of violence in schizophrenic and schizoaffective patients selected on the basis of physical assaults.

Method: In a double-blind trial, 101 inpatients who had been physically assaultive within two weeks prior to study were randomly assigned to treatment with clozapine (N=33), olanzapine (N=34), or haloperidol (N=34) for 12 weeks. Incidents of physical assaults were recorded and their severity was scored on the Modified Overt Aggression Scale. The Positive and Negative Syndrome Scale (PANSS) was administered throughout the 12 weeks.

Results: There was an overall difference in frequency and severity of both physical ($F=4.2$, $df=3,98$; $p=.02$) and verbal assaults ($F=5.5$, $df=3,98$; $p<.01$) in the three treatment groups. Clozapine was superior to olanzapine, which was superior to haloperidol. Separate two-group comparisons corrected for multiple testing reached statistical significance for the clozapine-haloperidol comparisons only. There were no significant differences in PANSS scores among the three medication groups and differences in physical assaults were not related to differences in PANSS total score or PANSS factor scores.

Conclusions: Clozapine had superior antiaggressive effects. These were independent of its effect on psychotic symptoms.

REFERENCES:

1. Ratey J, Leveroni C, Kilmer D, Gutheil C, Swartz B: The effects of clozapine on severely aggressive psychiatric inpatients in a state hospital. J Clin Psychiatry 1993; 54:219–23.
2. Volavka J, Czobor P, Sheitman B, Lindenmayer JP, et al: Clozapine, olanzapine, risperidone, and haloperidol in the treatment of patients with chronic schizophrenia and schizoaffective disorder. Am J of Psychiatry 2002; 159:255–262.

SCIENTIFIC AND CLINICAL REPORT SESSION 24—SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS

No. 71
PREMORBID DEVELOPMENTAL ACHIEVEMENTS AND LATER RECOVERY IN SCHIZOPHRENIA

Martin Harrow, *Department of Psychiatry, University of Illinois, 1601 West Taylor Street, M/C 912, Chicago, IL 60612;* Thomas H. Jobe, M.D., Linda S. Grossman, Ph.D., Joseph F. Goldberg, M.D., Robert Faull, B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand whether premorbid developmental achievements identify major subtypes of schizophrenia that have different rates of recurring psychosis, different clinical courses over time, and different potentials for recovery.

SUMMARY:

Objective: This prospective 20-year multi-followup study assesses whether premorbid developmental achievements in patients with schizophrenia are linked to later outcome and potential recovery, and whether the relationship to subsequent outcome is diagnosis-specific or prognostic for all types of psychotic disorders.

Method: 216 patients (including 56 schizophrenia patients) from the Chicago Follow-Up Study were evaluated prospectively at index hospitalization and then followed up six times over the next 20 years. Employing standardized evaluations, patients were assessed at each follow-up for positive and negative symptoms, work and social functioning, rehospitalization, global outcome, and medication treatment.

Results: (1) Good premorbid developmental achievements in schizophrenia separate a subtype who show subsequent intervals of recovery ($p<.001$). (2) Schizophrenia patients show poorer premorbid developmental achievements than other psychotic and non-psychotic patients. (3) Schizophrenia patients with poor premorbid developmental achievements experience subsequent frequently recurring psychosis ($p<.001$). (4) This relationship was less robust for other psychotic and non-psychotic disorders.

Conclusions: In schizophrenia, poor premorbid developmental achievements are linked to both vulnerability-resiliency and neurodevelopmental impairments. Poor premorbid developmental achievements are important influences that identify major subtypes of schizophrenia, with different subsequent clinical courses, rates of recurring psychosis, and potentials for recovery. The data on schizophrenia vs. other psychotic disorders support diagnosis-specific models.

REFERENCES:

1. Bruder GE, Wexler BE, Sage MM, Gil RB, Gorman JM: Verbal memory in schizophrenia: additional evidence of subtypes having different cognitive deficits. Schizophrenia Research 2004; 68(2–3), 137–147.
2. Harrow M, Grossman LS, Herbener ES, Davies EW: Ten-year outcome: patients with schizoaffective disorders, schizophrenia,

affective disorders, and mood-incongruent psychotic symptoms. British Journal of Psychiatry 2000; 177, 421–426.

No. 72
PAIN INSENSITIVITY IN SCHIZOPHRENIA: STATE OR TRAIT MARKER?

Lisa Giles, M.D., *Department of Psychiatry, University of Cincinnati, 231 Albert Sabin Way, Cincinnati, OH 45267-0559;* Manpreet Singh, M.D., Henry A. Nasrallah, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize (1) the phenomenon of pain insensitivity in schizophrenia, (2) the increased risk of morbidity and mortality due to failure to respond to pain cues, (3) the limitations of the current literature and the need for controlled prospective studies.

SUMMARY:

Introduction: At the turn of the 20th century, Kraeplin noted that patients with schizophrenia "endure uncomfortable positions, pricks of needles, injuries without thinking about it." Bieuler also observed unusual self-mutilations like eye enucleation and auto castration. Many clinicians have observed patients with schizophrenia failing to respond to the pain of myocardial infarction, ruptured appendix, or perforated bowel. Although this pain insensitivity has been extensively described in the literature, this phenomenon is still poorly studied or understood. We reviewed the literature for clues of whether pain insensitivity in schizophrenia represents a state or trait marker.

Methods: We conducted a comprehensive Medline search to access the literature on pain insensitivity in subjects with schizophrenia and their first-degree family relatives.

Results: While the literature contains anecdotal observations, case reports and a few rigorous clinical studies citing patients with schizophrenia as being relatively indifferent to pain, there is a dearth of empirical, well-controlled studies. Early studies examining the response of subjects with schizophrenia to thermal or electrical pain were constrained by a variety of methodological confounders. Overall, the studies suggest that the higher threshold for pain observed in patients with schizophrenia is best explained by a complex, multifactorial model. Most intriguing is one recent study that found pain insensitivity in family members of persons with schizophrenia, suggesting that this phenomenon may be a trait or endophenotype rather than due to a psychotic state.

Conclusions: Pain insensitivity in schizophrenia is poorly understood and is associated with increased morbidity and mortality among affected individuals. This phenomenon may serve as an endophenotype and perhaps as a prodromal predictor of susceptibility. Future studies are needed to further clarify its neurobiology, pathophysiology, and practical clinical implications.

REFERENCES:

1. Devorkin RH: Pain insensitivity in schizophrenia: a neglected phenomenon and some implications. Schizophrenia Bulletin 1994; 20: 235–8.
2. Hooley J, Delgado M: Pain insensitivity in the relatives of schizophrenia patients. Schizophrenia Research 2001; 47: 265–273.

No. 73
EFFECTIVENESS OF AN EARLY PSYCHOSIS TREATMENT SERVICE

Donald E. Addington, M.D., *Department of Psychiatry, Foothills Medical Centre, 1403 29th Street, N.W., Calgary, AB T2N 2T9, Canada;* Jean M. Addington, Ph.D., Scott B. Patten, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants will be aware of the relapse rates that can be achieved in an early psychosis program that serves an entire population.

SUMMARY:

Background: Systematic reviews of randomized studies for complex treatment systems such as early psychosis treatment services yield inconclusive recommendations. Effectiveness studies offer alternatives for addressing policy and clinical decisions. Relapse is a key performance measure that can be used to assess the effectiveness of an early psychosis treatment service.

Methods: This was a two-year, longitudinal cohort study of consecutive admissions to an early psychosis treatment service that served the entire population in a catchment area. The primary outcome measure was relapse. The results were compared with the published literature.

Results: 120 consecutive consenting admissions were recruited, 92 (76%) of whom were followed to one year and 84 (70%) to two years. Relapse was assessed by clinicians using structured criteria, the reliability of which was assessed by independent chart review. The two-year relapse rate among subjects with complete two-year follow up was 33% (95% CI 23% to 44%). A Kaplan-Meier life table censoring subjects lost to follow up yielded a comparable estimate: 29% (95% CI 22% to 40%). These estimates compare favorably with a published range of 60% to 70% in the literature.

Conclusions: An early psychosis service that serves a geographic population and which is part of the routine mental health services of that population can achieve outcomes that compare favorably with the published literature.

Funding Source: Eli Lilly

REFERENCES:

1. Linszen DH, Dingemans PM, Lenior ME, Nugtor MA, et al: Relapse criteria in schizophrenic disorders: different perspectives. Psychiatry Res 1994; 54:273–281.
2. Ram R, Bromet EJ, Eaton WW, Pato C, Schwartz JE: The natural course of schizophrenia: a review of first-admission studies. Schiz Bull 1992; 18:185–207.

SCIENTIFIC AND CLINICAL REPORT SESSION 25—TREATMENT TECHNIQUES

No. 74
DOES EXERCISE HAVE A PLACE IN PSYCHIATRY?

James Annesi, Ph.D., *Wellness Advancement Department, YMCA of Metro Atlanta, 100 Edgewood Avenue, NE, Suite 1100, Atlanta, GA 30303;* Sheldon B. Cohen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should be knowledgeable about the evidence-based data supporting the use of physical activity/exercise in psychiatry and be able to develop techniques to incorporate physical activity/exercise into their lives and practices.

SUMMARY:

Objective: Exercise reportedly is helpful in the prevention and treatment of a variety of physical and mental diseases. This would make it an ideal psychosomatic intervention. Does data support such claims? What level of physical activity is required to be effective? Have psychiatrists found such techniques useful in their practices?

Method: We reviewed the vast literature concerning exercise as it applies to medicine, especially psychiatry. We share the authors' experiences, (JJA: behavioral psychologist/former professional tennis player), (SBC: psychiatrist/former amateur marathoner), their colleagues, clients, and patients. We examine the manifold obstacles to introducing physical activity into the lives of a largely sedentary American population. We include guides to venues/facilities that attendees can utilize when in Atlanta and a simple scale that meeting attendees and their patients can use to assess before and after exercise feelings (i.e., Exercise-Induced Feeling Inventory).

Results: The literature strongly supports preventive/therapeutic aspects of exercise. A seminal article notes that 30 minutes of regular, moderate physical activity is a practical way for most people to achieve their goals.

Conclusions: Physical activity can be an important therapeutic component. A moderate level of physical activity can be incorporated into psychiatric practice.

REFERENCES:

1. Pate RR, Pratt M, Blair SN, Haskell WL, Macera CA, Bouchard C, Buchner D, Ettinger W, Heath GW, King AC, Kriska A, Leon AS, Marcus BH, Morris J, Paffenbarger RS, Patrick K, Pollock ML, Rippe JM, Sallis J, Wilmore JH: Physical activity and public health: a recommendation from the Centers for Disease Control and Prevention and the American College of Sports Medicine. JAMA 1995; 273:402–406.
2. Morgan WP (editor): Physical Activity and Mental Health. Washington, DC, Taylor & Francis, 1997.

No. 75
RESTRAINT STRESS ELEVATES PLASMA ICYTOKINES LEVELS IN SUPEROXIDE DEPENDENT MANNER

Atsuo Sekiyama, M.D., *Institute for Advanced Medical Sciences, Hyogo College of Medicine, 1-1 Mukogawa, Nishinomiya, Hyogo 663-8501, Japan;* Haruyasu Ueda, Ph.D., Shinichiro Kashiwamura, Ph.D., Masatoshi Takeda, M.D., Haruki Okamura, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the molecular biological reaction to stress. It may help to objectively assess an important part of mental health. Objectifying a stress-induced body mechanism can lead to prevention of the initiation, promotion, and relapse of auto-immune diseases and inflammatory diseases.

SUMMARY:

Psychological/physical stresses have been known to cause relapse of auto-immune and inflammatory diseases. To reveal a mechanism by which non-inflammatory stresses affect host defenses, responses to immobilization stress in mice were investigated, focusing on the role of a multifunctional cytokine, interleukin-18 (IL-18). In the adrenal cortex, the stress-induced IL-18 precursor proteins (pro-IL-18) via ACTH and a superoxide-mediated conversion of pro-IL-18 to the mature form caused release of bioactive IL-18 into plasma. Inhibitors of reactive oxygen species suppressed stress-induced accumulation of plasma IL-18. The inhibitors also blocked stress-induced IL-6 expression. This, together with the observation that IL-6 was not induced by stress in IL-18 deficient mice, showed that IL-6 induction by stress is dependent on IL-18. Pathology in the mice with spontaneously developing SLE was exacerbated by the immobilization via IL-18. In stressed organisms, IL-18 may influence pathological and physiological processes. Controlling the pathway to suppress IL-18 levels may provide a preventative means against stress-related disruption of host defenses.

REFERENCES:

1. Conti B, Jahng JW, Tinti C, Son JH, Joh TH. Induction of interferon-gamma inducing factor in the adrenal cortex. J Biol Chem 1997; 272(4):2035-7.
2. Okamura H, Tsutsui H, Kashiwamura S, Ueda H, Yoshimoto T, Nakanishi Kenji: The Cytokine Handbook, Fourth Edition (2) 709–733, Review.

No. 76
TREATING DEPRESSION IN A VA PRIMARY CARE INTEGRATED BEHAVIORAL HEALTH MODEL

Cheryl A. Aquilino, Ph.D., *Behavior Health (A116), Stratton VA Medical Center, 113 Holland Avenue, Albany, NY 12208;* Anna G. Engel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to identify what patients can be effectively treated in an integrated behavioral health model as compared with those who require specialty psychiatric services.

SUMMARY:

Objective: To examine if improvement in mood symptoms of VA patients treated in an integrated behavioral health model was sustained over two years.

Method: Seventy-two patients, referred by primary care providers to a psychiatrist located in the same clinic, were given psychometric measures (e.g., Hamilton Depression Scale) as part of a clinical assessment. Two years post-intervention, 48 agreed to an interview including readministration of these measures. Data were analyzed using paired t-test and content analysis procedures.

Results: Patients treated and discharged back to primary care maintained remission as documented by a 50% reduction in HAM-D score ($p < .01$). Those dropping out or refusing treatment remained symptomatic maintaining their initial HAM-D score. Patients referred to specialty mental health when not achieving remission post-intervention improved relative to baseline but became more symptomatic over time according to follow-up HAM-D scores. Sixty-seven percent of patients pursuing referral to specialty care continued treatment. Identified benefits of an integrated model were therapeutic interaction, convenience, improved outlook, and less stigma.

Conclusion: An integrated behavioral health model is effective in sustaining improvement in depression in the veteran primary care population for at least two years.

In the absence of full remission, referral to specialty services is beneficial.

REFERENCES:

1. Foster M, Ragsdale K, Dunne B, Jones E, Ihnen G, Lentz C, Gilmore J: Detection and treatment of depression in a VA primary care clinic. Psychiatric Services 1999; 50: 1494–1495.
2. Gaynes B, Magruder K, Burns B, Wagner R, Yarnall K, Broadhead W: Does a coexisting anxiety disorder predict persistence of depressive illness in primary care patients with major depression? General Hospital Psychiatry 1999; 21: 158–167.

SCIENTIFIC AND CLINICAL REPORT SESSION 26—MEDICAL ILLNESS AND PSYCHIATRIC DISORDERS

No. 77
DEPRESSION CORRELATES WITH LEFT NIGROSTRIATOPALLIDAL CIRCUIT FOCAL LESIONS

Edward C. Lauterbach, M.D., *Department of Psychiatry, Mercer University School of Medicine, 655 First Street, Macon, GA 31201;*

Julia B. Tolley, M.Ed., William F. Bina, M.D., Thomas D. Hope, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize basal ganglia circuitry that is important in mood disorders

SUMMARY:

Objectives: The authors studied correlates of mood disorders after solitary focal basal ganglia (BG) stroke.

Methods: Forty subjects with BG lesions underwent DIS and SCID interviews to ascertain DSM-III and -IV psychiatric disorders. Subjects lacked cerebral atrophy. Stringent exclusion criteria were applied and confounding attributional factors were controlled for, including education, Hollingshead social class, alcohol consumption, recent losses, major life events, spousal support, cognitive status, Barthel disability index, medical conditions, medication status, cortical atrophy, ventriculomegaly, and other factors.

Results: Unipolar depressive disorders were associated with left nigrostriatopallidal (GPe) circuit lesions (OR=41.7, 95%CI 6—288, p<.00005), including the nigra, posterior pallidum, and posterior putamen (n=1 each). DSM-III and -IV major depression was associated with left posterior lenticular lesions (OR=26.0, 95%CI 4—169, p<.0005). Depressive disorder NOS (forme fruste subsyndromal major depression) occurred with left nigrotegmental midbrain lesions. Hypomania was observed after right rostral caudate lesions and left ventral lenticular (n=1 each). There were no significant differences in hyperintensity and ventriculomegaly ratings between subjects with BG lesions and age- and gender-matched radiological controls.

Conclusions: Left nigrostriatal (especially posterior pallidal) circuit dysfunction may eventuate depressive disorders and can produce left thalamocortical hypofunction. Limbic basal ganglia lesions may induce hypomania by disinhibiting thalamocortical circuits.

REFERENCES:

1. Lauterbach EC, Jackson JG, Price ST, et al: Clinical, motor, and biological correlates of depressive disorders after focal subcortical lesions. J Neuropsychiatry Clin Neurosci 1997; 9:259–266.
2. Lauterbach EC: Mood disorders and the globus pallidus, in Bédard MA, Agid Y, Chouinard S, et al (eds) Mental and Behavioral Dysfunction in Movement Disorders. Totowa, NJ: Humana Press, 2002, pp 305–320.

No. 78
DEPRESSION-RELATED IMPAIRMENT OF BARORREFLEX IN HEART FAILURE

Salvador M. Guinjoan, M.D., *Salud Mental, Hospital De Clinica, Ave Cordoba 2351 5 Piso, Buenos Aires 1121, Argentina;* Carlos Berbara, M.D., Maria Gabrielli, B.A., Daniel E. Vigo, M.D., Ricardo Perez-De-La-Hoz, M.D., Alfredo Ortiz-Fragola, Daniel P. Cardinali, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the impact of depression on autonomic modulation of heart rate in patients with heart failure.

SUMMARY:

Objective: To study the influence of depressive symptoms (21-item Hamilton scale) on cardiac autonomic input in a sample of 25 older adults (79 ± 6 years; ejection fraction, %, 45 ± 11) with decompensated heart failure of coronary origin, and to compare them with a sample of 19 age matched controls.

Method and Results: In the patient sample, heart rate variability (HRV) analysis of 10-min recordings detected decreased barorreflex influences on the heart rate signal (low-frequency HRV, 0.03-0.15 Hz) in relation to depressive symptomatology severity (r=0.42, p= 0.02, Spearman test). Depression did not seem to influence other measures of HRV in this sample. As expected, time- and frequency-domain HRV measures were lower in patients than in normal individuals.

Conclusion: The association of depression to decreased barorreflex modulation of the heart rate signal may contribute to explain depression-related increases in mortality in patients with heart failure of coronary origin.

Funding Source: University of Buenos Aires and CONICET.

REFERENCES:

1. Guinjoan SM, Ladrón de Guevara MS, Correa C, Schauffele SI, Nicola-Siri LC, Fahrer RD, Ortiz Frágola E, Martínez Martínez JA, Cardinali DP: Cardiac parasympathetic dysfunction related to depression in older adults with acute coronary syndromes. Journal of Psychosomatic Research 2004; 56(1):83–88.
2. Vigo DE, Nicola Siri L, Ladrón de Guevara MS, Martínez Martinez JA, Fahrer RD, Masoli O, Cardinali DP, Guinjoan SM: Relation of depression to heart rate nonlinear dynamics in patients ≥60 years of age with recent unstable angina pectoris or acute myocardial infarction. American Journal of Cardiology 2004; 93(6):756–760.

No. 79
RESPIRATORY PANIC DISORDER IN A LONG-TERM CLONAZEPAM FOLLOW-UP

Antonio E. Nardi, M.D., *Department of Psychiatry, Federal University Rio de Janeiro, R. Visconde de Piraja, 407/702, Rio de Janeiro 22410-003, Brazil;* Alexandre M. Valenca, M.D., Fabiana L. Lopes, M.D., Isabella Nascimento, M.D., Marco A. Mezzasalma, M.D., Rafael C. Freire, M.D., Walter A. Zin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the demographic, clinical, and therapeutic features of panic disorder subtypes.

SUMMARY:

Objective: to describe with prospective methodology the therapeutic response to clonazepam in the respiratory panic disorder (PD) subtype versus the non-respiratory subtype in a three-year follow up.

Method: 67 PD outpatients (DSM-IV) were previously divided into respiratory (n=35) and non-respiratory (n=32) subtypes and then openly treated with clonazepam for three years. The principal instruments used to evaluate response were the Clinical Global Impression, the Sheehan Panic and Anticipatory Scale, and Panic Disorder Severity Scale.

Results: In the first eight weeks the respiratory subtype had a significantly faster response. After the acute phase and at the end of the study (week 156), there was no difference in the scale scores and the reduction of panic attacks did not differ between the groups. The respiratory subtype had a later onset and a high familial history of anxiety disorders.

Conclusion: The respiratory PD subtype had a faster response to clonazepam at eight weeks and an equivalent response during the follow up.

Acknowledgements: Brazilian Council for Scientific and Technological Development (CNPq).

Grant: 304671/03-7.

REFERENCES:

1. Valença AM, Nardi AE, Mezzasalma MA, Nascimento I, Zin WA, Lopes FL, Versiani M: Therapeutic response to benzodiazepine in panic disorder subtypes. Sau Paulo Med J 2003; 121:77–80.

2. Rosenbaum JF, Moroz G, Bowden CL: Clonazepam in the treatment of panic disorder with and without agoraphobia: a dose-response study. J Clin Psychopharmacol 1997; 17:390–400.

SCIENTIFIC AND CLINICAL REPORT SESSION 27—PSYCHIATRIC ADMINISTRATION AND SERVICES

No. 80
CHANGING TRENDS IN PSYCHIATRIC EMERGENCY ROOM PATIENTS IN LARGE URBAN HOSPITALS

Christopher K. Chung, M.D., *Department of Psychiatry, Harbor UCLA Medical Center, 1000 West Carson Street, Box 498, Torrance, CA 90509;* Davin A. Agustines, M.D., Steve Brown, Ph.D., Jambur V. Ananth, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) describe the changing trends in the characteristics of patients who use psychiatric emergency services over a five-year period, and (2) discuss the relationship between changing community resources and changes in psychiatric emergency room use.

SUMMARY:

Objective: This study investigated the changing trends in the psychiatric and social characteristics of the patients who used a large urban community hospital psychiatric emergency room (PER).

Method: Records for all of the patients who visited the PER for the three-month period April 1 to June 30 of five different one-year cohorts (1998–2002) were reviewed. This resulted in a sample of 5916 patient incidents. Information on a variety of different variables was recorded. Statistical procedures were used to identify significant trends and changes that occurred in this group of people over the five-year period.

Results: The mean number of patients seen per day showed a statistically significant increasing linear trend. Trends and changes in sex ratio, racial makeup, diagnosis, length of stay, disposition, and several other variables were analyzed statistically. Several statistically significant trends were identified.

Conclusion: There is a general trend for an increased use of PER services by patients who tend to have more significant mental illnesses. These changing trends are discussed in terms of socio-economic changes in the community catchment area. Both linear and non-linear relationships appear to exist between the characteristics of patients who use the PER and the types of community resources available.

REFERENCES:

1. Lambert MT, LePage JP, Schmitt AL: Five-year outcomes following psychiatric consultation to a tertiary care emergency room. Am J Psychiatry 2003; 160(7):1350–3.
2. Clarke GN, Herinckx HA, Kinney RF, Paulson RI, Cutler DL, Oxman E: Establishing a new research agenda for studying psychiatric emergency room treatment decisions. Ment Health Serv Res 2001;3(1):25–34.

No. 81
DATA FROM A PSYCHIATRIC EMERGENCY SERVICE USING AN ELECTRONIC MEDICAL RECORD

Jennifer S. Brasch, M.D., *Department of Psychiatry, McMaster University, 50 Charlton Avenue E, Hamilton, ON L8N 4A6, Canada;* Rolf Sebalt, M.D., Christopher Webster, Ph.D., Marilyn Crayen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe the characteristics of a population seen in a psychiatric emergency service; list the advantages, disadvantages, and challenges of using an electronic medical record in a psychiatric emergency service.

SUMMARY:

Objective: To describe the population seen in a centralized psychiatric emergency service (PES) in Hamilton, Ontario, using PsychOnt, an electronic database developed to improve documentation and communication with other health care providers.

Method: PsychOnt comprises a server-side database with user-side data entry and chart printing as well as data reporting and other administrative components. The study sample is a continuous cohort of all assessments by the PES between April 22, 2002 and December 31, 2003.

Results: 4,577 consultations were performed for 3,322 separate patients. 6,696 services were documented (including consultations, and progress, follow-up, and discharge notes). 112 (3.3%) patients were responsible for 441 (14%) consultations. Demographic information (selected) includes 47.7% never married, and 30.0% receiving a disability pension. Patients described an average of 4.74 presenting problems. 79.5% had received prior psychiatric treatment. 50.6% were experiencing suicidal ideation at the time of the assessment, 8.3% threatened violence, and 11.1% were verbally aggressive. 37.5% were admitted to hospital.

Conclusions: An electronic medical record can be successfully used in a PES and provides a powerful research tool. The data demonstrate that the PES is serving a disadvantaged population, many of whom have a prior psychiatric listory and/or make repeated use of the PES.

No. 82
IMPLEMENTING A MIXED PSYCHIATRIC AND SOMATIC CARE UNIT IN A GENERAL HOSPITAL

Ariel Eytan, M.D., *Department of Psychiatry, Hug-Belle-Idee, 2 CH Petit-Bel-Air, Geneva 1225, Switzerland;* Christel Alberque, M.D., Marianne Gex-Fabry, M.S.C.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize possible time course evolutions of newly implemented psychiatric—somatic programs in general hospitals.

SUMMARY:

We describe the changes over the first three-year period of a newly implemented 18-bed unit located in an academic medical center in the French-speaking part of Switzerland. This facility is run by psychiatrists and cares for adult patients with both psychiatric and medical disorders, either acute or chronic. The unit started its activity in October 1999. The period October 12, 1999, to October 11, 2002, was retrospectively examined. The total number of admissions was 939, for 761 different patients. The population was majority female (64.1%), with a median age of 42 years, and a median length of stay of 15 days. The most prevalent psychiatric disorders were mood disorders (54.8%). Associated somatic disorders were very diverse. Over the three-year observation period, the following changes were observed over time: patients were increasingly referred from the district psychiatric hospital and from somatic units in the general hospital and less often from the hospital emergency department ($p<0.001$). Associated somatic disorders became more prevalent ($p<0.001$) and median length of stay increased from 14 to 18 days ($p<0.001$). Results support the hypothesis that the need for mixed inpatient programs is especially important for depressed patients with severe somatic disorders, both acute and chronic.

REFERENCES:

1. Brasch J, Sebaldt R, Webster C, Craven M: Implementation of PsychOnt, an electronic medical record, in a centralized psychiatric emergency service and characteristics of the population served over a 20-month period. Can J Psychiatry, submitted.
2. Currier GW, Allen M: Organization and function of academic psychiatric emergency services. Gen Hosp Psychiatry 2003;25: 124-129.

THURSDAY, MAY 26, 2005

SCIENTIFIC AND CLINICAL REPORT SESSION 28—EPIDEMIOLOGY AND COMMUNITY ISSUES IN PSYCHIATRY

No. 83
MORTALITY AMONG PSYCHOTIC PATIENTS WITHIN THE NORTHERN FINLAND 1966 BIRTH COHORT

Antti Alaräisänen, M.D., *Department of Psychiatry, University of Oulu, P.O.Box 5000, Oulu 90014, Finland;* Jouko Miettunen, Ph.D., Erika Lauronen, B.Med., Pirkko Räsänen, Ph.D., Matti K. Isohanni, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should know what we know about the prevalence and predictors of mortality of young individuals suffering from schizophrenic psychosis.

SUMMARY:

Objective: Schizophrenic persons have increased risk of mortality—about 1.5-fold, and in active phase even higher (8-10-fold). Suicide is the most common cause of premature death in schizophrenia: 28% of the excess mortality in schizophrenia, and 11% to 38% of all deaths in schizophrenia are attributable to suicide. The prevalence of schizophrenia among general population suicides is about 7%.

Aim: To analyze the prevalence and predictors of mortality among psychotic patients within the Northern Finland 1966 Birth Cohort.

Method: The cohort is based upon 12,068 pregnant women and their 12,058 live-born children in the provinces of Lapland and Oulu with an expected delivery date during 1966.

Results: A total of 14 persons have died for the following reasons: 10 suicide, two accident or trauma, one natural, and one cause is unknown. Predictors of mortality were violent criminality, male sex, and very good school performance.

Conclusion: We suggest that criminal activities, which are often consequences of alcohol abuse increase the mortality risk of rather young male schizophrenic persons, but also giftedness at school may be a risk factor.

Funding source: The Finnish Academy, Sigrid Juselius Foundation, The Stanley Medical Research Institute

REFERENCES:

1. Heilä H, Lönnqvist J: The clinical epidemiology of suicide in schizophrenia in Murray R, Jones P, Susser E, van Os J and Cannon M (eds): Epidemiology of Schizophrenia. Cambridge University Press, 2003.
2. Mortensen PB: Mortality and physical illness in schizophrenia, in Epidemiology of schizophrenia. Edited by Murray R, Jones P, Susser E, van Os J, Cannon M. Cambridge University Press, 2003.

No. 84
OUTCOME AND ITS PREDICTORS IN SCHIZOPHRENIA IN THE NORTHERN FINLAND 1966 BIRTH COHORT

Erika Lauronen, B.Med., *Department of Psychiatry, University of Oulu, P.O.BOX 5000, FIN-90014 University of Oulu, Oulu, Finland;* Juha M. Veijola, Ph.D., Jouko Miettunen, Ph.D., Peter B. Jones, Ph.D., Wayne S. Fenton, M.D., Johanna Koskinen

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should know the prognosis of schizophrenia and the possible background factors that may predict poor outcome in schizophrenia.

SUMMARY:

Objective: To examine recovery and related outcomes of schizophrenia before age 35 in a longitudinal, population-based birth cohort, and test the prognostic significance of selected historical, developmental, and illness-related variables.

Method: In the Northern Finland 1966 Birth Cohort, 146 living cases having known psychotic disorder were invited to the field study in 1999–2001. Among participating subjects there were 59 diagnosed as having DSM-III-R schizophrenia. Interviews and case registers were used to rate measures of outcome including clinical global impression, social and occupational functioning, positive and negative symptoms, occupational status, psychiatric hospitalizations, and antipsychotic medication. Outcome was categorized as good/moderate or poor, and complete recovery was studied. In addition, by studying all psychosis cases in this birth cohort, we explored the associations between early development and later course of illness.

Result: While approximately half of the schizophrenia cases had poor outcome, only one was considered as fully recovered. When compared with good outcome cases, cases having poor outcome had earlier age of illness onset and poorer achievement at school.

Conclusion: Only few subjects had favorable outcome of schizophrenia in this relatively early onset group. Only some variables were able to predict the course of illness in schizophrenia.

REFERENCES:

1. Lauronen E, Koskinen J, Veijola J, Miettunen J, Jones PB, Fenton WS, Isohanni M: Recovery from schizophreic psychoses within the Northern Finland 1966 Birth Cohort. The Journal of Clinical Psychiatry, in press, 2004.
2. Harrison G, Hopper K, Craig T et al: Recovery from psychotic illness: a 15- and 25-year international follow-up study. Br J Psychiatry 2001; 178:506–517.

No. 85
PSYCHIATRIC PRACTICES AND PATIENT OUTCOMES IN ASSERTIVE COMMUNITY TREATMENT

Paul R. Miller, M.D., *Department of Psychiatry, UCLA, 2406 Astral Drive, Los Angeles, CA 90046*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to describe how (1) Assertive Community Treatment (ACT) patients who have persistent severe mental disorders pose unique and difficult problems for psychiatrists, (2) many ACT patients have poor outcomes that correlate with deficient psychiatric practices, and (3) psychiatrists can remedy deficiencies by using evidence-based structured psychiatric practices, and likely improve outcomes as a result.

SUMMARY:

Objective: ACT patients, with their persistent serious mental disorders, often do not improve when managed with traditional psychiatric practices. The objective is to search for deficits in traditional psychiatric practices that correlate with and possibly contribute to poor outcomes.

Method: Evaluate psychiatric practices for 25 ACT patients by measuring diagnostic and treatment parameters in psychiatric write-ups, then correlating those measures versus independent diagnoses made with structured techniques (MINI, CADI), APA treatment guidelines, and patient's semi-annual measures of outcome-BPRS, Ham-D, GAF, number of ER/Hospital visits.

Results: Diagnostic deficits in write-ups: 48% had too few recorded symptomatic data to justify DSM-IV diagnosis; 40% had a different primary Axis I diagnosis from structured (MINI, CADI) techniques; 44% had additional diagnoses found by structured diagnoses. *Treatment deficits in write-ups:* 78% disagreed with APA's treatment guidelines. *Patient outcomes:* 52% had little/no significant improvement. *Results:* diagnostic deficits and treatment deficits correlated significantly with poor patient outcomes.

Conclusion: To improve patient outcome, psychiatrists can correct deficits by using (1) structured diagnostic interviews, (2) APA guidelines for treatment, (3) objective clinical tests to measure outcome.

Funding Source: none

REFERENCES:

1. Allness DJ, Knoedler WH: The PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illnesses: A Manual for PACT Start-Up. Arlington, Va, NAMI.
2. Miller PR et al: Inpatient diagnostic assessments: 1,2,3. Psychiatry Research 2001–2002; 105, 255–264; 105, 265–272; 111, 191–197.

SCIENTIFIC AND CLINICAL REPORT SESSION 29—TREATMENT OF SCHIZOPHRENIA

No. 86
EFFECTIVENESS AND TOLERABILITY OF ANTIPSYCHOTIC TREATMENTS FOR SCHIZOPHRENIA: TWO-YEAR RESULTS FROM THE INTERCONTINENTAL SCHIZOPHRENIA OUTPATIENT HEALTH OUTCOMES STUDY (IC-SOHO)

Martin Dossenbach, M.D., *Department of Neuroscience, Eli Lilly, Ges.m.b.H, Vienna, Austria, Barichgasse 40 – 42, Vienna 1030, Austria;* C.Y. Kim, M.D., S. Singh, M.D., Y. Dyachkova, M.S.C., M.E. McBride, Ph.D., P. Lee, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the clinical relevance of data obtained from real clinical practice settings across a large, culturally diverse sample of outpatients with schizophrenia. These results compliment existing conclusions based on randomized controlled clinical trials.

SUMMARY:

Objective: IC-SOHO is a three-year, prospective, observational study designed to evaluate treatment outcomes in a large and diverse population of outpatients with schizophrenia. The relative effectiveness and tolerability of antipsychotics assessed in naturalistic clinical practice settings will be reported.

Method: Outpatients who initiated or changed antipsychotic medication were enrolled, and post hoc treatment groups were created to facilitate individual antipsychotic comparisons. Only patients prescribed monotherapy treatment at baseline [olanzapine (n=3,222), risperidone (n=1,116), quetiapine (n=189) or haloperidol (n=256)] were compared, with one-year results reported and two-year findings to be presented. Detailed study and statistical methodology have been presented previously.

Results: After 12 months of treatment, all monotherapy treatments were effective. However, haloperidol-treated patients had three- to four-times lower odds of response (p=0.001), six-times higher odds of relapse (p=0.001), and significantly greater likelihood of developing EPS (p=0.001), when compared with patients receiving olanzapine or risperidone. Clinical effectiveness and tolerability profiles were found to vary between the new atypicals and will be discussed further.

Conclusion: These naturalistic data confirm many of the positive effects of atypical antipsychotics established in clinical trials.

REFERENCES:

1. Dossenbach M, Erol A, el Mahfoud Kessaci M, et al: Effectiveness of antipsychotic treatments for schizophrenia: Interim 6-month analysis from a prospective observational study (IC-SOHO) comparing olanzapine, quetiapine, risperidone, and haloperidol. Journal of Clinical Psychiatry 2004; 65:312–321.
2. Leucht S, Barnes TRE, Kissling W, et al: Relapse prevention in schizophrenia with new-generation antipsychotics: a systematic review and exploratory meta-analysis of randomized, controlled trials. Am J Psychiatry 2003; 160:1209–1222.

No. 87
AN INVESTIGATION OF COGNITIVE EFFECTS OF RIVASTIGMINE IN SCHIZOPHRENIA

Tonmoy Sharma, M.D., *CNRC, Neuroscience Center, 7 Twisleton Center Priory Hill, Dartford DA1 2EN, United Kingdom;* Catherine Hughes, Ph.D., Ingrid Aasen, Veena Kumari, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to demonstrate knowledge of acetylcholinesterase inhibitors, their effects on cognition in Alzheimer's disease, and the application to schizophrenia.

SUMMARY:

Cognitive impairment has the greatest impact on illness outcome in schizophrenia. The biggest challenge in schizophrenia therapeutics is to develop an efficacious treatment for cognitive impairments. The administration of acetylcholinesterase inhibitors such as rivastigmine, improves cognitive functions in Alzheimer's disease, where the loss of cholinergic neurons is thought to be responsible for cognitive deficits. There are reasons to believe that schizophrenic populations may benefit from procholinergic treatment to a greater extent than AD patients. The current study is part of a longitudinal project investigating the cognitive effects of rivastigmine, given as an add-on therapy to antipsychotic-treated patients in a placebo-controlled, double-blind design. The study initially involved 40 patients, of which 20 patients (11 assigned to rivastigmine and nine assigned to placebo) agreed to continued participation, remained on the study drug, and underwent assessment of neuropsychological functions at (1) baseline, and (2) after 12 weeks of treatment with placebo or rivastigmine. The results revealed a trend for improvement, with significant improvement seen in spatial working memory with rivastigmine treatment, compared with placebo. Results suggest that procholinergics can produce cognitive improvement in schizophrenia patients. Other procholinergic drugs, such as galantamine, also acting on the nicotine receptors, may produce stronger cognitive enhancement in schizophrenia.

REFERENCES:

1. Halstead WC: Brain and cognition. Chicago, University of Chicago Press, 1947.
2. Keefe RSE, Roitman SE, Harvey PD, Blum CS, DuPre RL, Prieto DM, Davidson M, Davis KL: A pen-and-paper human analogue of a monkey prefrontal cortex activation task: spatial working memory in patients with schizophrenia. Schizophr Res 1995; 17:25–33.

No. 88
RIVASTIGMINE OR GALANTAMINE FOR THE TREATMENT OF SCHIZOPHRENIC COGNITIVE IMPAIRMENT

Mohammad Z. Hussain, M.D., *Prince Albert Health District, Mental Health Centre, 2727 2nd Avenue West, Prince Albert S6V 5E5, Canada;* Zubaida Chaudhry, M.D., Waqar Waheed, M.D., Seema Hussain, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize neurocognitive deficits in schizophrenia, management with rivastigmine or galantamine, and its long-term impact on quality of life, social functioning, and functional recovery.

SUMMARY:

Objective: The majority of schizophrenic patients do not return to normative standards of cognitive functioning in spite of beneficial effects of novel neuroleptics on cognition. Changes in cholinergic functions in schizophrenia provide the rationale to test the effectiveness of cholinesterase inhibitors in treating cognitive impairment.

Method: A six-month, double-blind, placebo-controlled trial with rivastigmine 1.5 mg bid and galantamine 3 mg bid followed by open extension with rivastigmine 3 mg daily and galantamine 8 mg daily as adjunctive treatment in stable, compliant schizophrenics with cognitive impairment receiving clozapine, risperidone, or olanzapine was conducted in 26 males and 36 females, aged 20–58 (34.6), duration of illness 6–30 (14.92), years on clozapine 2–11 (6.12), olanzapine 2–5 (4.03), risperidone 2–7 (6.84). Trial completion: galantamine 18, rivastigmine 17, placebo 19. Five withdrew consent, three discontinued medication due to side effects. Following the blind trial, placebo patients were changed to either rivastigmine or galantamine and followed for 18 months.

Results: Patients on galantamine, rivastigmine, and one patient on placebo showed improvement in PANSS, cognition, and quality of life. During the first year, ten patients started working and four enrolled in educational upgrading. During the second year, another four started working. Majority reduced smoking.

Conclusion: Results suggest usefulness of rivastigmine and galantamine in enhancing cognitive performance and improving social and work functioning.

REFERENCES:

1. Rosler M, Anand R, Cicin A, et al: Efficacy and safety of rivastigmine in patients with Alzhelmer's disease: international randomized controlled trial. British Medical Journal 1999; 318:633–638.
2. Raskind MA, Peskind ER, Wessel T, et al: Galantamine in AD: a 6-month randomized, placebo-controlled trial with 6-month extension. Neurology 2000; 54:2261–2268.

SCIENTIFIC AND CLINICAL REPORT SESSION 30—ISSUES IN MOOD DISORDERS AND PSYCHIATRIC TRAINING

No. 89
THE USES OF READING POETRY FOR GENERAL PSYCHIATRIC EDUCATION

Neil E. Scheurich, M.D., *Department of Psychiatry, University of Kentucky, 3470 Blazer Parkway, Lexington, KY 40509*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should recognize the particular usefulness of poetry among literary forms for the exploration of creativity and illness, suffering and spirituality, and other humanistic themes relevant to general psychiatry.

SUMMARY:

While prose fiction, drama, and film have been extensively used for psychiatric education (presumably because of their realistic depiction of character and their general accessibility), poetry has been relatively neglected in this regard. But poetry has certain educational advantages as compared with other genres. Most significant is the form's concentrated power; poems lend themselves well to being read aloud and in entirety in group settings—thus obviating the need for extensive outside reading that is often not feasible for, or well-accepted by, residents and medical students—and facilitate detailed consideration of language and meaning, as well as shades and extremes of emotional experience. While aesthetic and clinical encounters differ in many ways, they do share a common hermeneutic ground.

As part of a didactic series for general psychiatry residents, four groups of poems were read aloud and discussed: Excerpts from the Book of Job and selected poems of Emily Dickinson, Sylvia Plath, and Wallace Stevens. In this report, the relevance of such poems to themes of suffering, spirituality, and resilience is explored. Compiled anonymous responses from participating residents indicated that most found the discussions to be enjoyable, stimulating, and relevant to their clinical work.

No outside funding was involved in this report, and no specialized knowledge of poetry or literature is assumed of the audience.

REFERENCES:

1. Terry JS, Gogel EL: Poems and patients: the balance of interpretation. Literature and Medicine 1987;6:43–53.
2. Scheurich N: Robert Pinsky and the poetry of psychiatry. Academic Psychiatry 2001;25:173–180.

No. 90
VARIATIONS IN DEPRESSION TREATMENT QUALITY: MEDICAID VERSUS COMMERCIAL CLAIMS

Stephen Able, Ph.D., *Eli Lilly and Company, Lilly Corporate Center, Indianapolis, IN 46285;* Rebecca Robinson, M.S., Stacey Long, M.S., Stella Chang, M.P.H., Onur Baser, Ph.D., Robert Obenchain, Ph.D., Ralph W. Swindle, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participant will learn variations across Medicaid and commercial data sources in antidepressant treatment patterns and associated care in terms of appropriate use according to NCQA guidelines and dose recommendations over time. Multivariate adjustments in demographic, clinical characteristics in-

cluding medical comorbidities, and antidepressant classes will be highlighted.

SUMMARY:

Objective: We compared antidepressant treatment patterns between Medicaid and private insurance claims to assess differences in treatment quality.

Methods: Adults with depression claims initiating antidepressant therapy were followed for 12 months using MarketScan Commercial Claims and Encounter (CCAE) and Medicaid data from the same three states. Claimants with prior antidepressant use or diagnoses of schizophrenia, bipolar, and psychoses were excluded. Treatment quality based on dose, duration, and "appropriate use" as defined by National Committee for Quality Assurance (NCQA) guidelines were assessed.

Results: Of the 10,383 CCAE and 20,170 Medicaid claimants, Medicaid patients were younger, sicker, and more likely to have capitated insurance (all p<.001). 13.6% of CCAE and 1.3% of Medicaid patients were complaint across all three NCQA measures. After controlling for demographics and antidepressant type, Medicaid patients were more likely than CCAE patients to initiate below recommended doses (OR 1.55) and less likely to have continuous therapy (OR 0.54), or switch/augment therapies (OR: 0.27–0.67) (all p<.001). Mental health specialty care was also associated with less early discontinuation (OR 0.76) and more continuous care (OR 1.18) (all p<.001).

Conclusions: Compliance with NCQA guidelines was significantly less, especially for Medicaid patients. Greater equity of care and patient follow up could result in less illness burden.

Funding: Eli Lilly and Company

REFERENCES:

1. Melfi CA, Croghan TW, et al: Access to treatment for depression in a Medicaid population. Journal of Health Care for the Poor & Underserved 1999; 10(2):201–215.
2. Petersen T, Dording C, et al: A survey of prescribing practices in the treatment of depression. Progress in Neuro-Psychopharmacology and Biological Psychiatry 2002; 26:177–187.

No. 91
ANTIDEPRESSANTS FOR DEPRESSION IN THE MEDICALLY ILL: ARE THEY EFFECTIVE?

Steven A. Cole, M.D., *Department of Psychiatry, SUNY at Stony Brook, Tower 10, Suite 20, Stony Brook, NY 11974-8101;* Evan Delucia-Deranja, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to discuss the evidence supporting the efficacy of antidepressant medication for treating depression in patients with comorbid medical illnesses.

SUMMARY:

Objective: This review evaluates efficacy of antidepressant medication for the treatment of depression with comorbid physical illness. A ten-year review in 1993 revealed only eight randomized, controlled trials in major depression, with evidence suggesting efficacy.

Method: A systematic review of Cochrane and PubMed (using terms including "depression" or "depressive" and multiple specific physical illnesses) revealed 458 clinical trials, including abstracts. After deleting studies that were not placebo controlled and were not published as full reports, only 46/458 remained.

Results: Forty-six studies included 5,592 patients with 12 specific diseases. In 40/46, antidepressants were significantly better than placebo. Positive and negative results and number of subjects for each illness studied were: Alzheimer's disease (5 positive; 0 negative, N=159); cancer (3, 1, 735); cardiac disease (4, 1, 3004); chronic pain (1, 0, 15); diabetes mellitus (3, 0, 143); HIV (8, 1, 437); Parkinson's disease (0, 1); peripheral arterial disease (1, 0, 120); CVA (13, 1, 837); rheumatoid arthritis (0, 1, 48); traumatic brain injury (1, 0, 10); vascular depression (1, 0, 84).

Conclusion: This review suggests positive efficacy of antidepressant medications in diverse medical illnesses, though the numbers of studies and patients for each illness are small. More controlled trials are needed.

REFERENCES:

1. Cohen-Cole SA, Kaufman K: Major depression in physical illness: diagnosis, prevalence, and antidepressant treatment (A ten year review: 1982–1992). Depression 1993; 1:181–204.
2. Katon W: Clinical and health services relationships between major depression, depressive symptoms, and general medical illness. Biological Psychiatry 2003; 54(3):216–226.

SCIENTIFIC AND CLINICAL REPORT SESSION 31—CONSULTATION-LIAISON PSYCHIATRY

No. 92
THE PREVALENCE OF MIGRAINE HEADACHES IN AN ANXIETY DISORDERS CLINIC SAMPLE

Catherine L. Mancini, M.D., *Department of Psychiatry, McMaster Medical Center, 1200 Main Street West, Hamilton, ON L8N 3Z5, Canada;* Michael A. Van Ameringen, M.D., Mark Bennett, B.A., Beth Pipe, B.S.N., Deirdre Dejean

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the relationship between migraine headaches and anxiety disorders, in an anxiety disorders clinic sample.

SUMMARY:

Objective: Migraine headaches are highly prevalent and in epidemiological studies have been found to affect 12% to 17% of North Americans in their lifetime. These studies have shown a significant relationship between migraine and psychiatric conditions including mood and anxiety disorders. Given this association, we examined the prevalence of migraine headache in an anxiety disorders clinic sample as well as examining the relationship between the two conditions.

Method: Two-hundred and thirteen consecutive admissions to an anxiety disorders clinic were evaluated for psychiatric diagnosis using a structured clinical interview and completed a self-report scale based on a headache diagnostic interview (Stewart et al. 1996), using International Headache Society criteria.

Results: Of the 213 patients, 67.1% (143/213) met migraine criteria. Of those 47.6% (68/143) met criteria for migraine without aura and 52.4% (75/143) for migraines with aura. Migraines predated the onset of the anxiety disorder in 44.8% (64/143), while 20.3% (29/143) reported the anxiety disorder predated the onset of migraine. Anxiety treatment improved migraines in 39.9% (57/143), while 5.6% (8/143) reported a worsening of headaches with anxiety treatment and 44.8% (64/143) reported no change. Significantly higher rates of migraine were found in those with comorbid lifetime major depression (MDD) than in anxiety disorders without MDD. (54.5% vs. 45.5%; ?2=6.673; p=0.01).

Conclusion: Migraine headaches are highly prevalent in an anxiety disorders sample, particularly in those with comorbid MDD. Treatment of the anxiety condition does not generally worsen the migraine headaches.

REFERENCES:

1. Breslau N, Rasmussen BK: The impact of migraine: epidemiology, risk factors, and comorbidities. Neurology 2001; 56(Suppl 1): S4–S12.
2. Lipton RB, Bigal ME, Steiner TJ, Silberstein SD, Olesen J: Classification of primary headaches. Neurology 2004; 63:427–435.

No. 93
ASSESSING ANXIETY WITH THE MEMORIAL ANXIETY SCALE FOR PROSTATE CANCER

Andrew J. Roth, M.D., *Department of Psychiatry, Memorial Sloan-Kett, 1242 2nd Avenue, New York, NY 10021;* Christian Nelson, Ph.D., Barry D. Rosenfeld, Ph.D., Adam Warshowski, M.A., Noelle O'Shea, R.N., Howard Scher, M.D., William Breitbart, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to identify anxiety in men with prostate cancer.

SUMMARY:

Objective: To assess reliability and validity of a revised version of the Memorial Anxiety Scale for Prostate Cancer (MAX-PC) to facilitate assessment of anxiety in a clinically varied population.

Methods: 367 ambulatory men with prostate cancer were recruited from Memorial Sloan-Kettering Cancer Center. Prior to routine Prostate Specific Antigen (PSA) tests, these men completed baseline anxiety, depression, and quality-of-life measures; follow-up evaluation was completed by mail, two weeks after receiving PSA results.

Results: The revised MAX-PC revealed a high degree of internal consistency and test-retest reliability for the total score and three subscales of general prostate cancer anxiety, anxiety related to PSA levels, and fear of recurrence. Concurrent validity was demonstrated by correlations with other measures of anxiety. Men with unstable or changing PSA scores (regardless of direction), had higher anxiety levels than those with steady PSA levels.

Conclusion: The revised MAX-PC appears to be a valid and reliable measure of anxiety in ambulatory prostate cancer patients that taps more specific aspects of anxiety than the general screening measures typically employed. This measure may help psychiatrists improve identification of patients in need of focused mental health interventions.

Funding: PepsiCo Foundation; T.J. Martell Foundation

REFERENCES:

1. Roth AJ, Kornblith AB, Batel-Copel L, Peabody E, Weingard K, Scher HI, Holland JC: Rapid screening for psychologic distress in men with prostate cancer: a pilot study. Cancer 1998; 82:1904–8.
2. Roth AJ, Rosenfeld B, Kornblith AB, et al: The Memorial Anxiety Scale for Prostate Cancer: validation of a new scale to measure anxiety in men with prostate cancer. Cancer 2003; 97:2910–2918.

No. 94
MODAFINIL AUGMENTATION OF SSRI THERAPY IN MDD

Maurizio Fava, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC-812, Boston, MA 02114;* Charles DeBattista, M.D., Michael E. Thase, M.D., Joseph G. Fanelli, M.D., Karl Doghramji, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to appreciate the emerging potential of modafinil to augment existing SSRI monotherapy in MDD patients.

SUMMARY:

Objective: To evaluate modafinil as augmentation of SSRI therapy in MDD patients with excessive sleepiness and fatigue utilizing a retrospective analysis of two placebo-controlled, double-blind studies.

Method: MDD patients (18–65 years) with partial response to SSRI monotherapy for a depressive episode participated in one of two randomized, double-blind studies. Modafinil 100–400 mg/day or matching placebo was taken in addition to existing SSRI therapy for six or eight weeks. Patients (N=348) selected for this retrospective pooled analysis met a common set of criteria from the two studies for symptoms (Epworth Sleepiness Scale [ESS] score ≥10, HAM-D-17 score between 4 and 25 [inclusive], Fatigue Severity Scale [FSS] score ≥4).

Results: At final visit, modafinil augmentation significantly improved overall clinical condition vs. placebo (Clinical Global Impression of Improvement responders [''very much improved'' or ''much improved''] were 42% vs. 31%; p=.035). Modafinil augmentation significantly improved wakefulness (ESS: p=.04 vs. placebo) and depressive symptoms (HAM-D-17: p≃.02 vs. placebo) at final visit. Modafinil augmentation reduced fatigue greater than placebo at final visit (FSS: −1.0 vs. −0.8; p=ns). 300 (86%) patients completed and 179 (>99%) modafinil-treated patients received a ≥200 mg dose.

Conclusion: This retrospective pooled analysis of two double-blind, placebo-controlled studies suggests that modafinil augmentation of SSRIs in MDD patients with partial response may significantly improve overall clinical condition, wakefulness, and depressive symptoms.

REFERENCES:

1. DeBattista C, Doghramji K, Menza MA, Rosenthal MH, Fieve RR: Adjunct modafinil for the short-term treatment of fatigue and sleepiness in patients with major depressive disorder: a preliminary double-blind, placebo-controlled study. J Clin Psychiatry 2003;64:1057–1064.
2. Fava M, Thase ME, DeBattista C: Modafinil as antidepressant augmentation therapy in major depressive disorder. Presented at the 157th annual meeting of the American Psychiatric Association, May 1–6, 2004; New York, NY.

SCIENTIFIC AND CLINICAL REPORT SESSION 32—BIPOLAR DISORDER THROUGH THE LIFE CYCLE

No. 95
BIPOLAR PRODROMAL PATTERNS AMONG AMISH YOUTH

Jon A. Shaw, M.D., *University of Miami Mental Health, 1695 NW 9th Avenue, Suite 1404A, Miami, FL 333136;* Janice A. Egelad, Ph.D., Jean Endicott, Ph.D., Cleona R. Allen, B.A., Abram M. Hostetter, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should (1) become familiar with the different pathways to juvenile bipolar disorder, and (2) become familiar with potential prodromal symptoms of Amish children of a BP1 parent.

SUMMARY:

Objective: Ten-year prospective study of well Amish children at risk for bipolarity to identify the frequency and pattern of prodromal symptoms/behaviors for BPI disorder.

Method: Follow 110 at-risk children with a BPI parent and 112 children with well parents in a matched sample. Ten-year data collec-

tion used annual structured and semi-structured interviews covering developmental, medical, and behavioral features. Randomized histories for 222 children were submitted blindly for risk rating on bipolarity by a panel of clinicians.

Results: Children in the bipolar sample had an overall risk rating of 41% compared with 16% for matched control children. Symptoms and behaviors noted more frequently among the at-risk group were: anxious/worried, attention poor/distractible in school, easily excited, hyper-alert, mood changes/labile, role impairment in school, somatic complaints, and stubborn/determined. Five additional manic-like behaviors became more evident among at-risk adolescents at the ten-year follow up: high energy, decreased sleep, problems of thinking/concentration, excessive and loud talking.

Conclusions: The children of a parent with a BPI disorder manifested, episodically, mini-clusters of prodromal characteristics more frequently than the children of normal controls. None of these children met diagnostic criteria for prepubertal bipolar disorder or pediatric mania.

REFERENCES:

1. Egeland JA, Shaw JA, Endicott J, Pauls DL, Allen CR, Hostetter AM, Sussex JN: Prospective study of prodromal features for bipolarity in well Amish children. J Am Acad Child Adolesc Psychiatry 2003;42; 786–796.
2. Bhangoo RK, Dell ML, Towbin K, Myers FS, Lowe CH, Pine DS, Leibenluft E: Clinical correlates of episodicity in juvenile mania. J Child and Adolesc Psychopharmacol 2003; 13:515–522.

No. 96
TYPICAL AND ATYPICAL ANTIPSYCHOTICS IN BIPOLAR DEPRESSION

Keming Gao, M.D., *Department of Psychiatry, Case Western Reserve University, 11400 Euclid Avenue, Cleveland, OH 44106;* Joseph R. Calabrese, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the role of antipsychotic agents in the treatment of bipolar depression.

SUMMARY:

Objective: Symptomatic bipolar patients experience more depressive symptoms than manic, but few studies have been designed for bipolar depression. Since antipsychotic agents have been shown to diminish depressive symptoms during the acute treatment of mania, atypical agents are now being developed for use in bipolar depression.

Methods: English-language literature published from 1980–2004 and cited in Medline was searched with terms generic/brand name of antipsychotics, and bipolar depression, bipolar disorders, or manic-depressive illness, and clinical trial. A depression rating scale was required for studies of the atypical antipsychotic agents. Peer-reviewed abstracts of placebo-controlled studies on bipolar depression were also included.

Results: Twenty-one randomized trials and 12 non-randomized prospective trials were identified with additional two abstracts. Both olanzapine and quetiapine have been shown to be superior to placebo in the acute treatment of bipolar depression, but quetiapine had a large acute effect. Olanzapine monotherapy is roughly twice as effective in the acute treatment of mania and prevention of relapse to mania as it is in acute bipolar I depression and prevention of relapse into depression. With the exception of perphenazine, there are no other randomized studies of typical antipsychotic agents that support the conclusion that this class of medication worsens bipolar depression.

Conclusion: Emerging data suggest that the atypical antipsychotic agents have a role in the acute and long-term treatment of bipolar depression. No convincing data support the impression that the typical antipsychotic agents worsen bipolar depression.

REFERENCES:

1. Tohen M, Vieta E, Calabrese JR et al: Efficacy of olanzapine and olanzapine-fluoxetine combination in the treatment of bipolar depression. Arch Gen Psychiatry 2003; 60:1079–1088.
2. Zarate CA, Tohen M: Double-blind comparison of the continued use of antipsychotic treatment versus its discontinuation in remitted mania patients. Am J Psychiatry 2004; 161:169–171.

No. 97
CHILDHOOD DISORDERS IN EARLY- VERSUS LATE-ONSET BIPOLAR DISORDER

Aude I. Henin, Ph.D., *Department of Psychiatry, Massachusetts General Hospital, 185 Alewife Brook Parkway, Cambridge, MA 02138;* Eric Mick, Sc.D., Joseph Biederman, M.D., Stephanie V.M. Gironde, B.A., Tanya B. Tran, B.A., Megan F. Joseph, B.A., Andrew A. Nierenberg, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the differences in childhood psychopathology of adults with early- vs. late-onset bipolar disorder.

SUMMARY:

Objective: To assess the childhood psychopathology of adults with early versus late-onset bipolar disorder.

Methods: Using structured diagnostic interviews (SCID and KSADS), childhood psychiatric diagnoses of 83 adults with bipolar disorder were assessed. Mean age of the subjects was 41.8 + 8.3 years with 67.5% female. Thirty-one adults with onset of bipolar disorder < age 18 (mean age of onset 13.5 + s.d. 3.2) were compared with 52 with onset > age 18 (mean age of onset 28.0 + s.d. 8.0).

Results: The early-onset group had higher rates of conduct disorder (24% vs. 2%; $p = .001$), ADHD (46% vs. 10%; $p < .0001$), oppositional defiant disorder (ODD) (38% vs. 2%; $p < .0001$), overanxious disorder (62% vs 35%; $p = .031$), but not separation disorder (8% vs 7%; $p = .877$). Age of onset for these comorbid disorders was earlier in the early-onset bipolar group for ADHD, ODD, overanxious disorder, and separation disorder.

Conclusion: Early-onset bipolar disorder is associated with more frequent specific comorbid childhood psychiatric disorders.

REFERENCES:

1. Sachs GS, Conklin A, Lafer B, et al: Psychopathology in children of late- versus early-onset bipolar probands. Paper presented at the annual meeting of the American Academy of Child and Adolescent Psychiatry, San Antonio, TX, 1993.
2. Perlis RH, Miyahara S., Marangell LB, Wisniewski SR, Ostacher M., DelBello MP, Bowden CL, Sachs GS, Nierenberg AA: Long-term implications of early onset in bipolar disorder: data from the first 1,000 participants in the systematic treatment enhancement program for bipolar disorder (STEP-BD). Biol Psychiatry 2004; 55(9):875–81.

SCIENTIFIC AND CLINICAL REPORT SESSION 33—MEASURING MOOD DISORDERS

No. 98
THE TARGETED TREATMENT OF DEPRESSION INVENTORY: NEW DEPRESSION INVENTORY DESIGNED TO GUIDE ANTIDEPRESSANT SELECTION

Richard J. Metzner, M.D., *Department of Psychiatry, UCLA, 916 North Foothill Road, Beverly Hills, CA 90210*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to identify treatment of depression according to both non-targeted and targeted prescribing models, and the potential benefits and drawbacks of a TTD-based depression test.

SUMMARY:

This report will summarize current research and thinking in the field about antidepressant selection. It will then focus on a new approach known as TTD: the targeted treatment of depression. TTD purportedly improves therapeutic efficacy by utilizing antidepressants (ADs) with different mechanisms of action for treating different depressive subtypes. SSRIs, for example, have been found to provide particular benefits in anxious/agitated/angry (demodulated) patients, while catecholaminergic ADs have proven more useful in apathetic/anergic (deactivated) states. Recent TTD-based algorithms have suggested potential improvements over traditional approaches. A new 17-item depression inventory, known as the TTDI, is a user-friendly implementation of the TTD model. The TTDI's M scale quantifies the potential need for modulation by serotonergic ADs; its A scale measures the possible need for activation with catecholaminergic agents. Unlike other depression tests with scores of zero or higher, these two bimodal scales can detect both positive and negative values, allowing for the identification of drug-induced blunted and manic states. Preliminary evidence suggests high scale reliability and user acceptance. Issues regarding the ability of models and tools such as these to improve antidepressant treatment will be discussed.

REFERENCES:

1. Heninger GR, Delgado PL, Charney DS: The revised monamine theory of depression. Pharmacopsychiat 1996; 29:2–11.
2. Filteau, MJ, et al: SSRIs in anxious-agitated depression: a post hoc analysis of 279 patients. Intl Clin Psychopharm 1995; 10:51–54.

No. 99
IS IT TIME TO REPLACE THE HAMILTON DEPRESSION RATING SCALE?

Mark Zimmerman, M.D., *Department of Psychiatry, Rhode Island Hospital, 235 Plain Street, Suite 501, Providence, RI 02905;* Michael Posternak, M.D., Iwona Chelminski, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the limitations of the Hamilton Rating Scale for Depression as an outcome measure in depression treatment studies, and to recognize the desirable features of an outcome measure.

SUMMARY:

Objective: The Hamilton Rating Scale for Depression (HRSD) is the most commonly used clinician-rated outcome scale in depression treatment studies despite the fact that multiple problems with the scale have been described. We review the advantages and problems with the HRSD, and discuss whether it is time to replace the HRSD as the primary outcome measure in treatment studies of depression.

Methods: The initial articles describing the HRSD were reviewed as well as critiques of the measure.

Results: We identified seven advantages of the HRSD, the most important being that its long-standing and widespread use enables a comparison of results across studies and conducting meta-analyses of treatment efficacy. Fifteen problems with the HRSD were identified such as the use of multiple versions of the scale, alternative guidelines in scoring the items, lack of a conceptual and psychometric framework for item inclusion and scoring, and the modest correspondence with the DSM-IV major depressive disorder diagnostic criteria.

Conclusions: A careful examination of the content of the HRSD indicates that it is a flawed measure. The psychometric, conceptual, and theoretical limitations of the HRSD are sufficiently great to warrant its replacement. Measures assessing the defining features of MDD are superior to the HRSD as an outcomes tool because they satisfy a basic requirement of an outcome measure—to thoroughly assess the disorder of interest. Moreover, these scales can be used for diagnostic purposes as well as determining remission of the defining features of MDD.

REFERENCES:

1. Hamilton M: A rating scale for depression. J Neurol Neurosurg Psychiatry 1960; 23:56–62.
2. Khan A, Khan SR, Shankles EB, Polissar NL: Relative sensitivity of the Montgomery-Asberg Depression Rating Scale, the Hamilton Depression Rating Scale, and the Clinical Global Impressions Rating Scale in antidepressant clinical trials. Int Clin Psychpharmacol 2002; 17:281–285.

No. 100
DAILY MEASUREMENTS ELUCIDATE EFFECTS OF INITIAL DOSING OF DULOXETINE

Madelaine M. Wohlreich, M.D., *Department of Neuroscience, Eli Lilly & Company, 5202 Potters Pike, Indianapolis, IN 46234;* Heidi Moore, Ph.D., James C. Mundt, Ph.D., Craig H. Mallinckrodt, Ph.D., John H. Greist, M.D., Lesley M. Arnold, M.D., Maurizio Fava, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to make more educated decisions about treatment of major depressive disorder with the new antidepressant duloxetine.

SUMMARY:

Objective: Compare tolerability and timing of onset of efficacy for duloxetine during the first week of treatment.

Method: Patients (N=112) exhibiting suboptimal response or poor tolerability to their current antidepressant were switched to open-label duloxetine 60mg QD. Comparators not currently receiving antidepressants (untreated) were randomized to duloxetine 60mg QD (N=70) or 30mg QD (N=67). Patients reported daily an adapted Visual Analog Scale for pain and Patient Global Impression of Improvement using Interactive Voice Response.

Results: Untreated patients started at 60mg reported significantly greater improvement vs. 30mg in shoulder and back pain on day one (D1), pain while awake (D3), global emotional improvement (D5), and global physical improvement (D7). Switch patients (started on 60mg) reported significantly greater improvement than untreated patients started on 30mg in pain while awake and back pain by days 3 and 4, respectively. Although 30mg untreated and 60mg switch patients reported significantly less nausea (16.4%, 15.2%) than 60mg untreated patients (32.9%), no significant differences occurred between groups in discontinuation due to nausea or other adverse events.

Conclusion: A 60mg QD dose demonstrated efficacy onset within 1 week, with improvement superior to 30mg QD as early as day one. Untreated patients on 30mg and patients switching directly from an SSRI reported less nausea, suggesting greater initial tolerability.

Funding: Eli Lilly and Company

REFERENCES:

1. Fredman SJ, Fava M, Kienke AS, White CN, Nierenberg AA, Rosenbaum JF: Partial response, nonresponse, and relapse with selective serotonin reuptake inhibitors in major depression: a survey of current "next-step" practices. J Clin Psychiatry 2000; 61:403–408.
2. Detke MJ, Lu Y, Goldstein DJ, Hayes JR, Demitrack MA: Duloxetine, 60 mg once daily, for major depressive disorder: a randomized, double-blind, placebo-controlled trial. J Clin Psychiatry 2002; 63(4):308–315.

SCIENTIFIC AND CLINICAL REPORT SESSION 34—OCD AND ANXIETY

No. 101
DEEP BRAIN STIMULATION IN INTRACTABLE OCD AND INTRACTABLE DEPRESSION

Benjamin D. Greenberg, M.D., *Department of Psychiatry, Butler Hospital, 345 Blackstone Boulevard, Providence, RI 02906*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the scientific rationale for deep brain stimulation in intractable OCD and intractable depression, its ethical and regulatory context, and evidence of efficacy and safety to date.

SUMMARY:

Deep brain stimulation (DBS), FDA-approved for movement disorders, is nonablative, reversible, and adjustable. Our collaborative investigations of DBS of the ventral anterior internal capsule and ventral striatum (VC/VS) in intractable obessive-compulsive disorder (OCD) began in 2001. The stimulation target was based on earlier lesion procedures including gamma knife capsulotomy for OCD and subcaudate tractotomy for depression, and was informed by the widespread use of DBS in movement disorders and initial experience with DBS for OCD in Belgium. After multi-disciplinary assessment and independent review of diagnosis, severity, treatment history, and consent capacity, OCD patients received bilateral implantation of custom DBS leads, and chronic stimulation. We noted acute and longer-term mood elevation in the OCD patients undergoing DBS, and subsequently began to study VC/VS DBS for intractable major depression. In severly depressed patients with very high levels of treatment resistance, DBS has had encouraging preliminary results. Initial and longer-term efficacy of DBS in both patient groups will be presented. Persistent adverse effects have been infrequent. Potential clinical roles of DBS will be discussed in light of available data. Another surgical approach, vagus nerve stimulation for treatment-resistant depression, will also be considered.

REFERENCES:

1. Greenberg BD, Rezai AR: Mechanisms and the current state of deep brain stimulation in neuropsychiatry. CNS Spectr 2003; 8(7): 522–6.

No. 102
CLINICAL CHARACTERISTICS OF OCD WITH AND WITHOUT COMORBID BDD

S. Evelyn Stewart, M.D., *Department of Psychiatry, Harvard University, 1558 Massachusetts Ave, Apt. 26, Cambridge, MA 02138;* Sabine Wilhelm, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) recognize BDD as a common comorbidity of OCD, and (2) identify and contrast clinical and treatment profiles of OCD-affected individuals, with and without comorbid BDD.

SUMMARY:

Objective: Body dysmorphic disorder (BDD) is considered an obsessive-compulsive spectrum disorder. Although the two disorders often co-occur, few studies have directly compared OCD with and without BDD. To identify similarities and differences in phenomenology and treatment response, data from these two groups were systematically examined.

Method: Forty-two individuals meeting DSM-IV criteria for OCD and BDD were characterized and compared with 233 individuals with OCD without BDD.

Results: Prevalence of BDD within the OCD sample was 15%. The group with OCD+BDD was younger, more predominantly female, with lower marriage rates and higher rates of comorbid major depression and substance abuse. OCD characteristics significantly differed with earlier onset and higher severity of hoarding and BDD-related symptoms in the OCD+BDD group. Changes in Y-BOCS scores from pre- to posttreatment were indistinguishable between groups

Conclusion: These findings confirm BDD as a common comorbidity of OCD and extend previous findings comparing OCD with and without BDD. The presence of comorbid BDD heralds an increased risk for depression, substance abuse, and poor psychosocial functioning. Further, the phenomenology of OCD is distinctive when occurring in the presence of BDD.

This work was supported by grants from the Obsessive-Compulsive Foundation and from a McLean Hospital Research Fellowship.

REFERENCES:

1. Phillips KA, Gunderson CG, Mallya G, McElroy SL, Carter W: A comparison study of body dysmorphic disorder and obsessive compulsive disorder. J Clin Psychiatry 1998; 59:568–575.
2. Wilhelm S, Otto MW, Zucker BG, Pollack MH: Prevalence of body dysmorphic disorder in patients with anxiety disorders. J Anx Disord 1997; 11:499–502.

No. 103
THE BURDEN EXPERIENCED BY FAMILIES OF INDIVIDUALS WITH ANXIETY DISORDERS

Michael A. Van Ameringen, M.D., *Department of Psychiatry, McMaster University, 1200 Main Street, West, Hamilton, ON L8N 3Z5, Canada;* Catherine L. Mancini, M.D., Mark Bennett, B.A., Beth Pipe, B.S.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to (1) understand the impact/burden of an anxiety disorder on family members. (2) examine the specific areas of family functioning that can be affected as a result of having an anxiety disordered individual in the family.

SUMMARY:

Objective: Anxiety disorders are associated with significant impairment in social and occupational functioning. Few studies have evaluated the impact/burden of anxiety disorders on family members. Investigations of families of posttraumatic stress disorder and obsessive-compulsive disorder individuals have found reduced social activity, increased psychological distress, and family dysfunction. This study further investigates the burden/impact of anxiety disorders on family members.

Method: Sixty-one consecutive admissions to an anxiety disorders clinic were evaluated for psychiatric diagnosis using a structured interview. A family member completed a questionnaire evaluating the burden/impact of having an ill family member in a variety of areas of family functioning.

Results: Overall, 50.8% of families reported significant, (moderate to severe) burden due to their family members illness. Forty-nine percent of families experienced significant burden due to the stoppage of recreational activities, 40% experienced burden due to the lack of contribution to household duties, and 30% due to the lack of income by the ill family member. A third of families reported seeking psychological help (treatment) to cope with their family members' illness. A greater number of family members of male versus female patients, experienced significant burden (70.6% vs. 43.2%; ?2=3.69;

p=0.055). There was no significant difference in the rates of family members experiencing significant burden when comparing primary anxiety disorder diagnoses.

Conclusion: This study suggests a significant burden to family members of individuals with anxiety disorders, in the areas of financial, social, and psychological well-being.

REFERENCES:

1. Steketee G: Disability and family burden in obsessive-compulsive disorder. Can J Psychiatry 1997; 42:419-928.
2. Jordan BK, Marmar CR, Fairbank JA, Schlenger WE, Kulka RA, Hough RL, Weiss DS: Problems in families of male Vietnam veterans with posttraumatic stress disorder. J Consult Clin Psychology 60(6): 916–926.

SCIENTIFIC AND CLINICAL REPORT SESSION 35—ALCOHOL AND DRUG RELATED DISORDERS

No. 104
A COMPARISON OF LORAZEPAM VERSUS DIAZEPAM TREATMENT OF ALCOHOL WITHDRAWAL

Jose R. Maldonado, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Room 2317, Stanford, CA 94305;* John O. Brooks, M.D., Long H. Nguyen, B.A., Merritt Schader, B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to understand the subtle differences in pharmacodynamic characteristics between the short acting benzodiazepine lorazepam and the long acting diazepam, and how they are equally efficacious in the management of alcohol withdrawal syndromes.

SUMMARY:

Objectives: Studies comparing the efficacy of long and short half-life benzodiazepines in the treatment of alcohol withdrawal have been conflicting. This study compared the effects of lorazepam (short half-life) with those of diazepam (long half life) on vital signs and the Revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-Ar).

Methods: Forty-eight male and female inpatients presenting with alcohol withdrawal symptoms at a university and a Veterans Affairs hospital were randomized to either lorazepam or diazepam treatment protocols at the time of admission. Measures consisted of the CIWA-Ar, administered three times per day, and corresponding vital signs were recorded throughout the length of stay.

Results: The average rates of change of CIWA-Ar scores and systolic blood pressure measurements were computed for each patient. There was no significant difference between the rates of change for either group on either measure (p>.05). Similarly, there was no significant difference on the total benzodiazepine usage between groups (p>.05).

Conclusions: This study did not reveal any evidence of a clinical advantage for choosing benzodiazepines according to their half lives. Our findings suggest that the choice of benzodiazepine in the management of alcohol withdrawal is not as critical as it is anecdotally assumed.

REFERENCES:

1. Liskow BI, Goodwin DW: Pharmacological treatment of alcohol intoxication, withdrawal, and dependence: a critical review. J Stud Alcohol 1987; 48:356.
2. Ritson B, Chick J: Comparison of two benzodiazepines in the treatment of alcohol withdrawal: effects on symptoms and cognitive recovery. Drug Alcohol Depend 1986;18:329.

No. 105
SUBOXONE IN PRIVATE PRACTICE

Ronald D. Abramson, M.D., *25 Main Street, Suite 7, Wayland, MA 01778*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should understand the feasibility of treating opiate addiction in a solo private practice setting with the use of Suboxone and psychotherapy.

SUMMARY:

Suboxone is a combination of buprenorphine and naloxone whose use has been approved for maintenance therapy for opiate addicts in general primary care and psychiatric practice. The intent of the introduction of this agent is to expand options for treatment of opiate addiction by allowing for maintenance treatment in the private sector.

Fifteen patients have so far been treated with this agent in this setting. All are Caucasian males, 19 through 47 years old, from middle-class settings. For 12 patients, oral and nasal consumption of Oxycontin was the main drug of abuse. The remainder used heroin intravenously. All had had at least two detoxifications and relapses. None had associated medical problems and none had comorbid abuse of other drugs. The lifestyle of all 15 patients was dominated by compulsive opiate-seeking behavior.

For 12 of the 15 patients, the use of Suboxone was very effective in abolishing cravings and promoting abstinence. All engaged in individual psychotherapy of varying frequencies of visits, and three were pharmacologically treated for comorbid psychiatric problems. However, for most, the use of Suboxone alone was a powerful assistance in promoting productive lives. Using Suboxone makes treatment of opiate addiction feasible in a private practice setting.

REFERENCES:

1. Sederer L, Kolodny A: Office-based buphrenorphine offers a second chance. Psychiatric Services 2004: 743.
2. Fiellin DA, O'Connor PG: Office-based treatment of opioid-dependent patients. New England Journal of Medicine 2002:817.

No. 106
NONMEDICAL USE AND DIVERSION OF STIMULANTS IN THE U.S.: 2002

Larry A. Kroutil, M.P.H., *HSER, RTI International, 3040 Cornwallis Road, Research Triangle, NC 27709-2194;* David L. Van Brunt, Ph.D., Robert M. Bray, Ph.D., Mindy Herman-Stahl, Ph.D., David C. Heller, B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the relative contributions of methamphetamine and other stimulants to the problem of non-medical stimulant use in the United States, and the demographic groups most likely to use methamphetamine or diverted medications.

SUMMARY:

Objective: To describe rates of prescription stimulant diversion (either non-medical use or non-prescribed use of a prescription drug) in the United States, and to compare the use of diverted prescriptions with methamphetamine across demo-graphic groups.

Method: Computed weighted frequencies from the National Survey on Drug Use and Health to obtain unbiased estimates of rates and correlates of non-medical stimulant use in the U.S. civilian

population age 12 or older (sample N=54,079). Logistic regressions provided adjusted odds ratios within demographic subgroups.

Results: In 2002, about 3.2 million persons (1.4% of U.S. population >= age 12) used any stimulant non-medically in the past year. Of these, 1.6 million (50.4%) principally used diverted medications (i.e., not methamphetamine). Persons under age 26 were more likely than older adults to abuse both methamphetamine (OR=2.46, 95% ci=1.78-3.39) and prescription stimulants (OR=3.84, 95% ci=3.05-4.83). Although males were more likely than females to report methamphetamine use (OR=1.40, 95% ci=1.07-1.82), non-medical use of prescription stimulants did not vary significantly by gender. There were no significant differences in methamphetamine or prescription stimulant estimates by population density.

Conclusions: The diversion of prescription stimulants is numerically substantial and comparable in rates to methamphetamine use. Stimulant diversion is not constrained by urban boundaries.

Data collection, survey design, and file preparation funded by the Substance Abuse and Mental Health Services Administation. Analysis supported by Eli Lilly and Company.

REFERENCES:

1. Substance Abuse and Mental Health Services Administration: Results from the 2002 National Survey on Drug Use and Health: National Findings (Office of Applied Studies, NHSDA Series H-22, DHHS Publication No. SMA 03-3836). Rockville, MD, Author, 2003.
2. Substance Abuse and Mental Health Services Administration: Amphetamine Treatment Admissions Increase: 1993–1999. The DASIS Report. Rockville, MD, Office of Applied Studies, 2001.

SYMPOSIUM 1—STEPPS TREATMENT MODEL FOR BPD
Collaborative Session With the National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the place of STEPPS in the treatment armamentarium for borderline personality disorder, and recognize its "value-added" nature

No. 1A
STEPPS: A NEW COGNITIVE SKILLS TREATMENT FOR BORDERLINE PERSONALITY

Nancee Blum, M.S.W., *Department of Psychiatry, University of Iowa, 1-189A MEB, Iowa City, IA 52242;* Donald W. Black, M.D., Bruce M. Pfohl, M.D., Don St. John, M.D.

SUMMARY:

This presentation gives an overview of the STEPPS program. The current program includes two phases, a 20-week (two hours/week) beginning outpatient group, and a one-year, twice monthly advanced group called STAIRWAYS. The combined program is identified by the acronym STEPPS, which stands for Systems Training for Emotional Predictability and Problem Solving (Blum, et al 2002). BPD is characterized as an emotional intensity disorder (EID) that clients can learn to manage. Key professionals, friends, and family members, who are identified as the client's reinforcement team, make up the client's system. These individuals learn a common language to communicate about the disorder and the skills to manage it, as well as ways to reinforce and support the newly learned skills. The program has three components: awareness of illness, emotion management skills training, and behavior management skills training. The program is fully manualized and utilizes a variety of materials (worksheets, poetry, artwork, and music) to illustrate and reinforce the skills and themes of each lesson. The Borderline Evaluation of Severity Over Time (BEST) scale allows clients to rate the intensity of their thoughts, feelings, and behaviors each week.

No. 1B
RANDOMIZED CLINICAL TRIAL OF STEPPS VERSUS TREATMENT AS USUAL

Donald W. Black, M.D., *Department of Psychiatry, University of Iowa, Psychiatry Research MEB, Iowa City, IA 52442;* Nancee Blum, M.S.W., Bruce M. Pfohl, M.D., Don St. John, M.D.

SUMMARY:

Borderline personality disorder (BPD) is a significant health problem associated with depression, substance abuse, domestic violence, excess health care utilization, and suicide. Yet, there is little consensus about the appropriate care of the person with BPD, and there are no standard treatments. The author describes a new cognitive-behavioral, systems-based group treatment developed for outpatients with BPD called STEPPS. The STEPPS program is fully manualized, and was developed to build on the cognitive-behavioral principals already shown to be effective in this patient population and to adapt this to diverse treatment settings integrating the social and professional support system available to patients and to train them to use their support systems more effectively. Data from a preliminary study involving 52 subjects are presented and the ongoing, randomized clinical trial is described and preliminary data regarding the efficacy of STEPPS are presented.

No. 1C
CAN STAFF ATTITUDES REGARDING BPD BE CHANGED?

Bruce M. Pfohl, M.D., *Department of Psychiatry, University of Iowa, 2229 Aber Avenue, Iowa City, IA 52246;* Connie Shanks, B.A., Nancee Blum, M.S.W.

SUMMARY:

Although there is evidence that psychotherapy and the judicious use of medications may result in significant functional improvement in patients with borderline personality disorder (BPD), many mental health providers tend to view individuals with BPD as unlikely or unwilling to benefit from treatment. We conducted a survey of 271 mental providers to assess attitudes toward individuals with BPD both before and after participating in a one-day workshop on BPD and the STEPPS group therapy model for treating BPD.

Comparing before and after scores, workshop participants demonstrated significant changes in attitude leading to a decrease in negative preconceptions regarding patients with BPD and an increase in positive attitudes regarding potential for change on seven of nine key variables. This included decreasing agreement with items such as "I would prefer to avoid treating patients with BPD," and "The prognosis for BPD is hopeless," and increasing agreement with items such as "I feel I can make a positive difference in the lives of patients with BPD," and "BPD is an illness that causes symptoms that are distressing to individuals with BPD." The results will be discussed in light of other studies examining the prevalence of negative attitudes toward patients with BPD among mental health professionals.

No. 1D
INTRODUCTION OF STEPPS IN THE NETHERLANDS

Roelof J.A. ten Doesschate, M.D., *Adhesie, P.O. Box 5003, Deventer 7400, Netherlands;* E. Bass Van Wel, M.D., W.M.J. Kockmann

SUMMARY:

STEPPS (in Dutch "Vaardigheidstraining Emotionele Regulatie Stoornis"- VERS) was introduced by Nancee Blum in the Netherlands in 1998 in two psychiatric institutes. Since 1998 about 300 trainers were trained in using the STEPPS/VERS program.

The VERS-program is now used in more than 50% of the mental health institutes in the Netherlands.

Research on the effectiveness of the program has been started.

REFERENCES:

1. Blum N, Pfohl B, St. John D, Monahan P, Black DW: STEPPS: a cognitive-behavioral, systems-based group treatment for outpatients with borderline personality disorder—a preliminary report. Compr Psychiatry 2002; 43:301–310.
2. Black DW, Blum N, Pfohl B, St. John D: The STEPPS group treatment program for outpatients with borderline personality disorder. J Contemp Psychother 2004, in press.
3. Cleary M, Siegfried N, Walter G: Experience, knowledge, and attitudes of mental health staff regarding clients with a borderline personality disorder. International Journal of Mental Health Nursing 2002; 11(3):186–91.

4. Freije H, Dietz B, Appelo M: Behandeling van de borderline persoonlijkheldsstoornis met de VERS: de Vaardigheidstraing. Emotionele Regulatie Stoornis, 2002.

SYMPOSIUM 2—9/11 IN NEW YORK CITY: LEARNING FROM THE PAST AND LOOKING TO THE FUTURE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to demonstrate knowledge of how the World Trade Center attack has informed clinicians about the practice of treating trauma syndromes, about responses and techniques for assisting children and schools, about the psychological burden of this work on therapists, and about the opportunities for preventive interventions.

No. 2A
LESSONS FROM 9/11: PSYCHIATRIC CARE OF VICTIMS

Scot G. McAfee, M.D., *Department of Psychiatry, St. Vincent's Hospital, 144 West 12th Street, New York, NY 10011*

SUMMARY:

The terrorist attack on the World Trade Center was a sentinel event for the mental health care system in New York City. In this presentation, Dr. McAfee will critically examine the psychiatric care for victims through the second anniversary of the diaster. The remarkable experience of mental health first responders to serve thousands of people in lower Manhattan will be analyzed, including the needs of the help seekers, the types of care provided, and the role of the local hospital. The second phase of diaster response called for the identification of particular subpopulations most susceptible to PTSD and other diaster-related conditions. Examples of specific risk groups, such as firefighters, will be used to illustrate the common principles of successful intervention. The indications for and benefits of psychotropic medications following catastrophic events will be highlighted, along with the value of nontraditional forms of healing, such as acupuncture, as a means of therapeutic engagement. The problem of vicarious traumatization and compassion fatigue arising in clinicians treating PTSD patients will be reviewed. The presentation will conclude by raising some unanswered questions that will frame the research agenda.

No. 2B
CHILDREN AND SCHOOLS IN THE YEARS AFTER A TERROR ATTACK

A. Reese Abright, M.D., *Department of Psychiatry, St Vincent's Hospital, 203 W 12th Street, New York, NY 10011-7762*

SUMMARY:

On September 11, 2001, there were over one million children and adolescents enrolled in the public, private, and parochial schools in the greater New York metropolitan area. Over 8,000 students attended schools in lower Manhattan in the zone of highest direct exposure to the attacks. They and their teachers were evacuated from their schools under conditions of life-threatening duress, were relocated to other schools for several months, and returned to their original schools amidst multiple traumatic reminders, including ongoing excavation and recovery efforts at the World Trade Center site. The focus of this presentation will be on efforts by staff at Saint Vincent Catholic Medical Center—Manhattan, the major hospital in closest proximity to the World Trade Center site, and other institutions in New York City to provide screening, assessment, and effective treatment for posttraumatic stress disorder and other emotional and behavioral problems experienced by these students and those in other areas of New York City in the days, weeks, months, and years since the attacks. The presentation will include a brief summary of pertinent literature and a description of challenges involved in the delivery of mental health services in schools following a catastrophic event.

No. 2C
VICARIOUS TRAUMATIZATION OF PSYCHOTHERAPISTS

Lea E. DeFrancisci, M.D., *30 E 21st Street, Apt. 30S, New York, NY 10010*

SUMMARY:

In the aftermath of the terrorist attacks on September 11, 2001, large numbers of New York City residents developed psychiatric symptoms and sought intervention by mental health professionals. A survey of psychotherapists was conducted in a Manhattan teaching hospital located near ground zero one year after the attack that collected data on the therapists' personal and professional backgrounds and on their psychological responses to treating posttraumatic syndromes in victims. This presentation will describe the results of this survey, which documented the development of "vicarious traumatization" among exposed therapists. Personal and professional risk factors and the symptomatic expression of compassion fatigue will be discussed, as well as strategies for identifying and protecting therapists from this distressing and potentially disabling condition.

No. 2D
PREVENTIVE INTERVENTIONS FOLLOWING ACUTE TRAUMA

Arieh Y. Shalev, M.D., *Hadassah University Hospital, P.O. Box 12000, Jerusalem 91120, Israel*

SUMMARY:

Among DSM-IV Axis I disorders, posttraumatic stress disorder (PTSD) is unique in that it follows a salient triggering event and is regularly preceded by recognizable and disturbing symptoms. Given recent findings of effective therapies for PTSD, PTSD should be amenable to prevention by early treatment strategies. In reality, however, systematic preventive interventions are rarely delivered or empirically assessed. This presentation will first outline the challenges and benefits of targeted prevention services for PTSD. These include allocation of resources, training of therapists, overcoming barriers to seeking help by victims, and the paucity of data-based evidence of efficacy. The presentation will then describe a comprehensive outreach and prevention project that was conducted in Jerusalem during a wave of terror attacks, and discuss the ways in which this large-scale program informs the debate on mental health preparedness spanning cultural and social diversity.

REFERENCES:

1. McAfee S: Ground one. Bull Menninger Clinic 2003; 67:48–51.
2. Fremont WP: Childhood reactions to terrorism-induced trauma: a review of the past 10 years. J Am Acad Child Adolesc Psychiatry 2004; 43:381–392.
3. Fullerton CS, Ursano RJ, Wang L: Acute stress disorder, posttraumatic stress disorder, and depression in disaster or rescue workers. Am J Psychiatry 2004; 161:1370–1376.

4. Hoge CW, Castro CA, Messer SC, et al: Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. N Eng J Med 2004; 351:13–22.

SYMPOSIUM 3—QUEER THINK FOR THE STRAIGHT SHRINK: EXPERT TIPS American Academy of Child and Adolescent Psychiatry

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand how clinicians with little or no understanding of gay and lesbian and transgender youth can better understand and work with these youth.

No. 3A
QUEER AS KIDS: ATTITUDE ENHANCEMENT

Richard R. Pleak, M.D., *Department of Child Psychiatry, North Shore Long Island Jewish Health System, 400 Lakeville Road, Second Floor, New Hyde Park, NY 11042*

SUMMARY:

Objective: Many experienced clinicians report feeling unprepared for dealing with gay and lesbian youth, particularly in validating sexual orientation and encouraging positive gay/lesbian identity formation. Comfort with this population includes not only didactic information, but also personal experiences, awareness of adolescent culture, and acceptance of the patient.

Methods: Studies on clinicians' attitudes working with gay and lesbian youth and surveys of training programs will be reviewed. Ways of addressing sexual orientation will be discussed, and topical resources, media and social examples will be given.

Results: In a survey of training directors, over 50% report that their programs did not view homosexuality as normal, 60% were not aware of gay or lesbian residents or faculty in their programs, and 97% report discouraging disclosure of sexual orientation. Based upon textbooks and journal articles, clinicians trained in earlier times had much more negative teaching about gay and lesbian people. Current materials are more positive about homosexuality, and many resources are now available to assist clinicians.

Conclusion: Clinicians can draw from personal experiences, up-to-date professional resources, gay and lesbian colleagues, and topical culture to better understand gay and lesbian youth, and to increase their comfort level in professional work with these youths.

No. 3B
HIGH HEELS AND SHOW TUNES: BOYS UNDER THE SPELL

Edgardo J. Menvielle, M.D., *Department of Psychiatry, Children's Hospital, 111 Michigan Ave NW, Washington, DC 20010-2916*

SUMMARY:

Objective: The lack of empirically-based developmental theories for children who might later identify as gay challenges psychiatrists' understanding and management of this population.

Methods: Some boys who will be gay have gender variance and exhibit interests such as dress up and doing impressions of glamorous female characters. The characterization of these aesthetic interests as "feminine" or "effeminate" is simplistic and incomplete, since these interests are not observed with such frequency and intensity among girls; and, female-typed behaviors like nurturing role-play are relatively rare among boys who will be gay. This type of play often has a distinct theatrical quality. Performance sports such as gymnastics and ice-skating are similarly favored over competitive team sports.

Results: Among adult gay males, interests with similar content are commonly associated with a gay culture. Examples include performing in over-the-top drag, and generally valuing highly stylized dramatic and musical expressions, such as opera and Broadway musicals.

Conclusion: Drawing from the literature on child gender variance and retrospective investigations of gay adults, the author proposes that some aspects of gay culture are also present in children, thus suggesting a developmental continuity. Clinical examples from child interviews and parent reports will illustrate the presentation.

No. 3C
THE L TEEN AND LESBIAN CHIC

Sarah E. Herbert, M.D., *Department of Psychiatry, Morehouse Medical School, 41-A Lenox Pointe Northeast, Atlanta, GA 30324*

SUMMARY:

Objective: Description of identity development in lesbian youth.

Methods: Recent research regarding how teenaged girls and young women define their sexual orientation and identity will be reviewed. This data will be compared with theories of gay or lesbian identity development.

Results: Girls and young women may come to identify themselves as lesbian or bisexual through different paths than have been described for boys or older cohorts of lesbian or gay adults. There is a suggestion from longitudinal research that sexual identity development in girls and young women may be less fixed and more fluid than previously recognized. Differences between male and female sexuality will be considered. Other issues discussed will be the impact of recent societal changes. Examples from recent popular culture will be used to illustrate how being lesbian is not only less threatening, but has actually become chic.

Conclusion: Clinicians who assess and treat teenaged girls and young women should be aware of the processes involved in lesbian identity development and how this identification may change over time. To better understand influences on lesbian or bisexual individuals in treatment, they should be familiar with the role models, resources, and images of lesbians in popular culture today.

No. 3D
STUDS, STEMS, AND JOTAS: QUEER LATINO YOUTH

Vernon A. Rosario, M.D., *Department of Psychiatry, UCLA Neuropsychiatry, 10850 Wilshire Boulevard, Suite 1210, Los Angeles, CA 90024*

SUMMARY:

Objective: Adolescence can be a period of intense exploration of sexuality and gender. This can be markedly different for diverse cultural and ethnic groups. These factors can make the assessment and treatment of gay and gender variant teenagers particularly challenging.

Methods: This presentation will review the prevalence of homosexuality and the widely divergent prevalence of gender atypicality reported in different countries, and will examine recent sociological and anthropological research on homosexuality and transgenderism in Latin America.

Results: Relying on cases of gender variant Latino teens, difficulties in teasing apart cultural constructs of gender and sexuality from gender atypicality in this population occur and can be examined.

Conclusion: Knowledgeable clinicians can help Latino teens in individual and group therapy to resolve issues of gender and sexuality.

REFERENCES:

1. Pleak RR: Ethical issues in the treatment of gender atypical children and adolescents, in Sissies and Tomboys. Edited by Rottnek M. New York, New York, University Press, 1999; pp. 34–51.
2. Menvielle E, Tuerk C: A support group for parents of gender nonconforming boys. Journal of the American Academy of Child & Adolescent Psychiatry 2002; 41(8):1010–13.
3. Herbert SE, Swann SK: Ethical issues in the clinical treatment of gender dysphoric adolescents. Journal of Gay and Lesbian Social Services 1999, 10(3/4):19–34.
4. Herdt G: Gay and Lesbian Youth. New York, Harrington Park Press, 1989.

SYMPOSIUM 4—COMORBID PSYCHOSIS AND SUBSTANCE USE: DIAGNOSIS, COURSE, AND OUTCOME

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the various factors differentiating patients with primary psychosis and substance use from patients with substance-induced psychosis in terms of diagnostic accuracy, diagnostic stability, illness course, and outcome, and also have an understanding of the neurobiological mechanisms of substance-induced psychosis.

No. 4A
DOES LONGITUDINAL FOLLOW-UP IMPROVE DIAGNOSTIC ACCURACY IN DUAL-DIAGNOSIS PATIENTS?

Michael B. First, M.D., *Department of Biometrics, NY State Psychiatric Institute, 1051 Riverside Drive, Unit 60, New York, NY 10032-2603*

SUMMARY:

Objective: DSM-IV differentiates substance-induced psychotic disorders from primary psychotic disorders with comorbid substance use based on the temporal relationship between symptoms and substance use. Although the use of longitudinal follow-up data has been proposed, its utility in improving diagnostic accuracy has not been systematically studied.

Method: A best estimate diagnostic procedure incorporating interview and other data at three time points (baseline, six and 12 months) was performed in 303 dual-diagnosis patients selected from admissions to emergency departments serving low-income New York City neighborhoods. We examined diagnostic agreement between baseline and best estimate diagnoses to determine how often longitudinal data resulted in a change in diagnosis.

Results: Overall diagnostic agreement between baseline diagnosis and best estimate was very good (kappa=.80) Of the 184 cases diagnosed at baseline as primary psychotic, only 10 were reclassified as substance-induced or indeterminate, and of the 114 baseline cases diagnosed as substance-induced only 19 were reclassified as primary or indeterminate.

Conclusion: Taking longitudinal information into account when making a diagnosis results in a change in only a small minority ((10%) of dual-diagnosis cases, suggesting that accurate diagnosis can be made for the majority of cases using baseline information alone.

No. 4B
THE STABILITY OF EARLY-PHASE PSYCHOTIC DISORDERS WITH SUBSTANCE USE

Deborah S. Hasin, Ph.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Box 123, New York, NY 10032*

SUMMARY:

Objective: The stability over time of the diagnostic distinction between a substance-induced psychosis and a primary psychotic disorder that co-occurs with the use of drugs or alcohol is critical for understanding illness course and planning appropriate treatment. Despite its importance, systematic study of this issue has been impaired by the lack of longitudinally based research diagnostic data.

Method: We compared DSM-IV psychosis diagnoses made at baseline with those made 12 months later in a cohort of 386 emergency department admissions employing a research diagnostic instrument for psychiatric and substance use comorbidity (PRISM). At intake participants had at least one psychotic symptom assessed during administration of the research protocol, had used alcohol and/or drugs within the past 30 days, and had no psychiatric inpatient history prior to the last six months. The nature of diagnostic changes are described as well as their correlates with demographic, family, and clinical characteristics.

Results: 89 percent of subjects retained the baseline diagnosis at follow up. Eleven percent changed from substance-induced psychosis to primary psychosis at follow up (PRISM/LEAD agreement 84.6%). "Change" cases most often bore non-affective psychosis diagnoses with concurrent substance dependence at follow up and had greater parental mental illness compared with those retaining a diagnosis of substance-induced psychosis.

Conclusions: Findings suggest that diagnostic change from substance-induced psychosis to primary psychotic disorder reflects the evolution of a psychotic illness that might have been precipitated by heavy and persistent substance use. Implications for future research are discussed.

REFERENCES:

1. First MB, Gladis MM: Diagnosis and differential diagnosis of psychiatric and substance use disorders, in Dual Diagnosis: Evaluation, Treatment, Training and Program Development. Edited by Solomon J., Zimberg S., Shollar E. New York, Plenum, 1993; 23–38.
2. CatonCLM, Drake RE, Hasin D, Dominguez B, Shrout PE, Samet S, Schanzer B: Differences between early-phase primary psychotic disorders with concurrent substance use and substance-induced psychoses. Archives of General Psychiatry, in press, 2004.

No. 4C
SUBSTANCE-INDUCED PSYCHOSIS PRESAGES PRIMARY PSYCHOSIS

Robert Drake, M.D., *Department of Psychiatry, NH-Dartmouth Psychiatric Research Center, 2 Whipple Place, Suite 202, Lebanon, NH 03766*

SUMMARY:

Background: Little is known about the long-term course of substance-induced psychosis.

Method: One-year follow-up of 133 patients presenting to upper Manhattan emergency services with first episode of substance-induced psychosis. Diagnoses at baseline and one-year follow up made using multiple sources of data, DSM-IV criteria, and the PRISM interview.

Results: One-fourth of the patients (n = 34, 25.6%) converted to a primary psychosis diagnosis by the one-year follow up. Several

baseline features predicted conversion to primary psychosis at one year: lack of competitive employment, parental mental illness, higher total symptom score, and lower awareness of illness.

Conclusions: The discussion will emphasize implications for diagnosis, treatment, and service development.

No. 4D
OUTCOME OF SUBSTANCE-INDUCED PSYCHOSIS AND PRIMARY PSYCHOTIC DISORDERS

Carol L.M. Caton, *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 56, New York, NY 10032*

SUMMARY:

Objective: Understanding illness course in substance-induced psychosis and primary psychotic disorder that co-occurs with the use of drugs or alcohol has implications for both treatment and prevention. Comparative outcome of these disorders has been limited by the absence of follow-up data on carefully diagnosed patient samples.

Method: We conducted a one-year follow-up of 386 patients experiencing psychosis in an early phase recruited from New York City psychiatric emergency departments. Based on DSM-IV research diagnostic assessments at one year, outcome was compared for substance-induced psychosis, primary psychotic disorder, and a group that changed from substance-induced psychosis at baseline with primary psychotic disorder on follow-up (change group).

Results: At follow-up, the remission rate was 90 percent in the substance-induced psychosis group, 50 percent in the primary psychosis group, and 38 percent in the change group. Across all diagnostic groups remission rates were significantly greater for those with better premorbid social functioning and earlier treatment in relation to psychosis onset. The change group had the highest rates of rehospitalization (53 percent), emergency service use (71 percent), and homelessness (29 percent) over the one-year follow-up period.

Conclusion: Findings reveal important differences in the outcome of early phase psychotic disorders that co-occur with the use of substances with implications for treatment and future research.

No. 4E
THE NEUROBIOLOGY OF SUBSTANCE-INDUCED PSYCHOSES

John H. Krystal, M.D., *Department of Psychiatry, Yale School of Medicine, VA Medical Center, 950 Campbell Avenue, West Haven, CT 06516*

SUMMARY:

This presentation will focus on unique and convergent aspects of four forms of substance-induced psychosis: (1) NMDA glutamate receptor antagonist (PCP-like), (2) psychostimulant (amphetamine-like or cocaine-like) (3) serotonergic hallucinogen (LSD-like), and (4) cannabinoid (marijuana-like). Human laboratory studies conducted by our group and others indicate that some features of psychosis is associated with the administration of sufficient doses of each of these drug classes. Of these drugs, the acute amphetamine psychosis is dominated by mood changes, thought disorder, and delusions, the acute serotonergic hallucinogen psychosis is dominated by perceptual changes, while the PCP and cannabinoid psychoses produce positive symptoms in the context of negative symptoms, thought disorder, and cognitive impairments. This symptom profile is generally consistent with the more severe and lasting consequences of drug ingestion associated with abuse of these drugs. This pattern raises questions about vulnerable individuals interacting with mechanisms uniquely associated with repeated drug administrations. There are some areas of mechanistic convergence among these agents. For example, all of them have the potential to stimulate abnormal or chaotic glutamate neurotransmission in some brain circuits. However, consistent with their distinct mechanisms of actions, each drug has specific mechanisms related to their receptor targets in the brain. The therapeutic implications of these mechanisms will be considered in this presentation.

REFERENCES:

1. Turner WM, Tsuong MT: Impact of substance abuse on the course and outcome of schizophrenia. Schizophrenia Bulletin 1990; 16(1):87–95
2. Addington I, Van Mastrigt S, Addington D: Duration of untreated psychosis: impact on two-year outcome. Psychol Med 2004; 34:277–84.
3. Pharmacologic model psychoses, in Neurobiology of Mental Illness. Edited by DS Charney, E Nestler, BS Bunney. New York, Oxford University Press, 1999; pp 214–224.

SYMPOSIUM 5—A SEX/GENDER RESEARCH AGENDA FOR DSM-V

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should become familiar with recent research findings on sex/gender and how such advances may influence future editions of DSM.

No. 5A
OPPORTUNITIES FOR ADVANCEMENT IN PSYCHIATRIC SCIENCE: SEX AND GENDER-SPECIFIC ANALYSES

Katherine L. Wisner, M.D., *Department of Psychiatry, University of Pittsburgh School of Medicine, WPIC 3811 O'Hara Street, Pittsburgh, PA 15213*

SUMMARY:

Objective: The question in the title of the Institute of Medicine (IOM) report, Exploring the Biological Contributions to Human Health: Does Sex Matter?, is answered with a resounding sex matters at the cellular level. The focus of this presentation is investigative opportunities through application of gender-focused analyses.

Method: The literature related to gender or sex and psychiatry was searched and synthesized to evaluate the extent to which we have incorporated the IOM recommendations for gender-focused analyses into our science.

Results: In epidemiological research, gender is the single strongest correlate of risk for many mental disorders: Compared with men, women are two to three times more likely to suffer from depressive and anxiety disorders and eight to ten times more likely to suffer from eating disorders. Males are more likely to develop developmental disorders and substance abuse. Why are these disorders partitioned by gender? A model and several examples of the application of gender analyses in clinical care and research will be discussed.

Conclusion: As we construct DSM-V, we must reap the scientific yield of the gender-focused analyses. The occurrence of two sexes is a great natural experiment that creates incredible opportunity for psychiatrists to explore hypotheses about differences in disease phenomenology and treatment response.

No. 5B
GENDER DIFFERENCES IN RATES OF PSYCHIATRIC DISORDERS: AN UPDATE

Myrna M. Weissman, Ph.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 24, New York, NY 10032-2603;* Bridget F. Grant, Ph.D.

SUMMARY:

Evidence for the differing gender distribution of rates by the different psychiatric disorders, based on epidemiologic community surveys, has been accumulating over the last 20 years. This paper will update the evidence including new data from the National Epidemiologic Survey on Alcohol and Related Conditions, a study of over 40,000 adults in the United States.

No. 5C
SEX DIFFERENCES IN NEUROBIOLOGY

Margaret Altemus, M.D., *Department of Psychiatry, Weill Medical College, 1300 York Ave, Box 244, New York, NY 10021*

SUMMARY:

As the knowledge base in neurobiology and relevant research technology continue to expand, we can expect that neurobiology will play an increasing role in the definition and validation of diagnostic categories as well as biobehavioral dimensions of psychopathology that may cut across diagnostic categories. A section of the recent APA monograph, A Research Agenda for DSM-V, outlined the importance of neurobiology and how it should be applied to the DSM-V process and more long-term efforts to refine our psychiatric diagnostic system. However, this section did not address sex differences in neurobiology, which are likely to contribute to known sex differences in the prevalence, symptom patterns, and treatment response of psychiatric disorders. Although there has been relatively little study of sex differences in neurobiology, there is emerging evidence that differences between the sexes include anatomy, neurochemistry, and functional activation and response patterns in the brain. Important gender differences in the physiology and pathophysiology of other bodily systems also have been identified, which are likely to impact on the etiology and course of psychiatric disorders.

No. 5D
GENDER ISSUES IN THE DSM

Kimberly A. Yonkers, M.D., *Department of Psychiatry, Yale University School of Medicine, 142 Temple Street, Suite 301, New Haven, CT 06451;* Katherine A. Halmi, M.D., William E. Narrow, M.D.

SUMMARY:

While we assume that the phenomenology of a psychiatric disorder as well as its clinical course is parallel in men and women, this is not always the case. There is considerable face validity for potential sex differences in the expression of various illnesses because sex differences in biological and societal factors can have a variety of influences in various developmental periods as well as stages of illness. The literature exploring sex differences in the expression of psychiatric illness as well as its treatment response includes results that are: (1) highly replicated and have consistent results or, (2) either not replicated or mixed. To illustrate, sex differences in rates of anxiety and unipolar mood disorders are documented through multiple large, community based studies. On the other hand, differences in the expression of various illnesses are less well studied and findings are often mixed. For example, the depressed pole of bipolar illness and mixed mania may be more common in women, while unipolar mania may be more common in men. In this presentation, a section of the work done for the DSM-V planning process that relates to sex differences in the presentation of and treatment for selected psychiatric disorders will be presented.

No. 5E
GENDER IN THE HISTORY AND FUTURE OF THE DSM

Thomas A. Widiger, Ph.D., *Department of Psychology, University of Kentucky, 115 Kastle Hall, Lexington, KY 40506-0044*

SUMMARY:

This paper will provide a summary of the history of the representation of gender within each edition of the Diagnostic and Statistical Manual of Mental Disorders. The presentation will also include a comprehensive summary of the gender ratios for each of the mental disorders included in the latest edition, DSM-IV-TR. A difficult issue for the authors of DSM-V is how much gender should have on the diagnosis of a respective disorder. Options include gender neutral diagnostic criteria, gender differences noted in the text, gender-related modifiers or specifiers, different diagnostic thresholds according to gender, gender-specific diagnostic criteria, and gender-specific disorders. All of these options have been used in prior editions of the diagnostic manual. Each alternative has a number of advantages and disadvantages, and each will be discussed in turn.

REFERENCES:

1. Leibenluft E: Women with bipolar illness: clinical and research issues. American Journal of Psychiatry 1996; 153(2):163–173.
2. Grant BF, Kaplan K, Shepard J, Moore T: Source and Accuracy Statement of Wave 1 of the 2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions. National Institute on Alcohol Abuse and Alcoholism. Bethesda, MD 2003.
3. Charney DS, Barlow DH, Botteron K, Cohen JD, Goldman D, Gur RE, Lin K-M, López JF, Meador-Woodruff JH, Moldin SO, Nestler EJ, Watson SJ, Zalcman SJ: Neuroscience research agenda to guide development of a pathophysiologically based classification system, in A Research Agenda for DSM-V. Edited by Kupfer DJ, First MB, Regier DA. pp. 31–83.
4. Leibenluft E: Women with bipolar illness: clinical and research issues. American Journal of Psychiatry 1996; 153(2):163–173.
5. Hartung CM, Widiger TA: Gender differences in the diagnosis of mental disorders: conclusions and controversies of DSM-IV. Psychological Bulletin 1998; 123:260–278.

SYMPOSIUM 6—RESEARCH ADVANCES IN LATE-LIFE MENTAL DISORDERS: TOWARD DSM-V
Collaborative Session With the National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) recognize diagnostic variations related to aging, (2) diagnose late-onset forms of common psychiatric disorders, and (3) understand psychosocial as well as neurobiological correlates of mental illnesses in late life.

No. 6A
AGE-RELATED DIAGNOSTIC VARIATIONS: PRESENTATIONS, COURSE, AND OUTCOME

Dilip V. Jeste, M.D., *Department of Psychiatry, University of California at San Diego, VA La Jolla Village Drive, 116A-13, San Diego, CA 92161;* Dan G. Blazer II, M.D.

SUMMARY:

This presentation focuses on most recent studies demonstrating age-related differences in clinical manifestations, course, and outcome of major mental illnesses such as depression, schizophrenia, and anxiety disorders. It is generally thought and taught that most psychiatric disorders other than dementia are less common in the elderly than among younger adults. Yet, there are several reasons to question such assertions. Many older adults who experience clinically significant psychopathology do not fit easily into the Procrusteen Bed of DSM. Physical and psychiatric comorbidity, common in older people, add to the diagnostic confusion. Elderly patients are also less likely to report psychiatric symptoms. Finally, some variants of disorders are more prevalent in late life, such as paranoid type of schizophrenia, and "vascular depression." Our data suggest that a classification of schizophrenia based on age of onset of illness may be more useful in terms of premorbid indicators, neurobiological underpinnings, prognostic considerations, and management issues than the current DSM classification based on symptom differences such as paranoid, catatonic, or disorganized types. Several Investigations report that a syndrome of "mixed anxiety-depressive disorder" may have both heuristic and clinical utility for older patients. There are data supporting the use of specific diagnostic criteria for elderly persons with psychiatric disorders.

No. 6B
THE USE OF BIOMARKERS IN THE ELDERLY: CURRENT AND FUTURE CHALLENGES

Raquel E. Gur, M.D., *Department of Psychiatry, University of Pennsylvania, 3400 Spruce Street, 10 Gates Building, Philadelphia, PA 19104;* Steven E. Arnold, M.D., Trey Sunderland, M.D.

SUMMARY:

Biomarkers have been developed in medicine to provide diagnosis, prognosis, and monitoring of disease progression. An ideal biomarker should detect a fundamental feature of the underlying pathophysiology of a disease and distinguish that illness from other conditions with an acceptable positive and negative predictive value. Furthermore, the biomarkers should be reliable, relatively non-invasive, simple to perform, and inexpensive.

Over the last decade, the geriatric illness that has seen the most significant growth of potential biomarkers is Alzheimer's disease (AD), where neuropsychological testing has long been the mainstay diagnostic and disease severity marker. Other emerging biomarkers across multiple domains are developing including blood tests, genetic markers, cerebrospinal fluid, and brain imaging.

With respect to more traditional psychiatric disorders of the elderly, there are interesting beginnings of such research. Geriatric depression has frequently been linked with cognitive impairment, cardiovascular disease, and neuroimaging abnormalities although much more work is needed to establish firm links with reliable and reproducible biologic markers.

This presentation will highlight progress in developing reliable measures for examining brain behavior relations in psychiatric disorders of the elderly. Gaps in knowledge and challenges will be discussed.

No. 6C
BIOLOGY AND PATHOPHYSIOLOGY: PSYCHOSOCIAL AND BEHAVIORAL CORRELATES

Charles F. Reynolds III, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh, PA 15213;* Patricia Arean, Ph.D.

SUMMARY:

Mental illnesses in later life occur in an interpersonal, psychosocial, and biological context. Taking depression as an example, loss, trauma, social isolation, coping style, socio-economic status, gender, and ethnicity are related to depression onset and treatment response variability in later life. An older person with a recent medical diagnosis may be more likely to become depressed and suicidal if he/she also has had a previous episode of depression, feelings of hopelessness regarding the illness, avoidant coping style, and poor social ties. Some research suggests that psychosocial risk factors may be modifiable, by teaching people resilience, by increasing coping skills, by provision of case management interventions, and by helping caregivers become more effective in caring for elderly family members with mental illness.

Our field is ready to move toward integrative models of depression (incorporating both psychosocial and biological factors), to address psychosocial factors important in minority mental health, to assess the efficacy of psychosocial treatments in specific mental illnesses such as traumatic grief, to assess the efficacy of psychosocial treatment for bringing about and maintaining complete recovery, to assess the value of psychotherapeutic approaches to suicidality, and to undertake prevention research in elderly who respond with sadness, loneliness, or insomnia to the vicissitudes of later life (e.g., bereavement, caregiving, and new medical illness with disability and loss of autonomy).

Supported by the Intervention Research Center for Late Life Mood Disorders (P30 MH52247), University of Pittsburgh School of Medicine

No. 6D
COMORBIDITY: MEDICAL AND CNS FACTORS IN LATE-LIFE DISORDERS

Susan K. Schultz, M.D., *Department of Psychiatry, University of Iowa College of Medicine, 500 Newton Road, Medical Education Bldg., Iowa City, IA 52242-1000;* George S. Alexopoulos, M.D., Linda K. Ganzini, M.D., Ira R. Katz, M.D., Barry D. Lebowitz, Ph.D.

SUMMARY:

Psychiatric syndromes arising in late life may lend themselves to a medical classification, which in turn may guide innovative studies of etiology, prognosis, and treatment. This concept grows from an appreciation of the medical and neurological comorbidity of late-life syndromes as well as the specific brain abnormalities observed in neuroimaging studies. However, it is unlikely that these disorders are the direct result of isolated neural lesions. Similarly, in non-CNS medical disorders, it is unlikely that one particular medical illness will directly cause a specific mental disorder, with the exception of such scenarios as a hyperthyroid-induced anxiety. We propose a model in which age-related medical and CNS disorders create a propensity for the development of psychiatric syndromes. The predisposing factors are distinct from the mechanisms mediating the expression of the syndromes, much like hypertension is distinct from stroke, but constitutes a morbid vulnerability. Research is needed to identify neurologic and medical abnormalities that may predispose to late-life psychiatric disorders as well as affect their outcome. This research may lead to a medical classification, forming a framework for treatments tailored to specific underlying pathways of illness. Furthermore, researchers must ask fundamental questions regarding issues such as frailty, pain, and the psychological distress associated with the end of life that add still more complexity to the care of the elderly patient.

REFERENCES:

1. Alexopoulos G. Meyers B, Young R, et al: "Vascular depression" hypothesis. Archives of General Psychiatry 1997; 54:915–922.

2. Snowdon DA: Healthy aging and dementia: findings from the Nun Study. Ann Intern Med 2003; 139:450–454.
3. Bruce ML: Psychosocial risk factors for depressive disorders in later life. Biological Psychiatry 2002; 52:175–184.
4. Alexopoulos GS, Buckwalter K, Olin J, Martinez R, Wainscott C, Krishnan KR; Comorbidity of late life depression: an opportunity for research on mechanisms and treatment. Biol Psychiatry 2002; 52(6):543–58.

SYMPOSIUM 7—HEALTH CARE MELTDOWN: WHAT CAN WE DO?

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe (1) the current health care financing problems in the United States, (2) national health insurance and financial consequences.

No. 7A
EVALUATING ONE STATE'S SINGLE-PAYER HEALTH CARE PROPOSAL: GEORGIA

Henry S. Kahn, M.D., *947 Blue Ridge Avenue, Atlanta, GA 303064416*

SUMMARY:

Few state legislatures have considered proposals to organize a universal health care plan. Despite conventional wisdom that Georgia has neither money nor popular support for such a program. Georgians for a Common Sense Health Plan (GCSHP) developed a comprehensive, generous, single-payer proposal—Secure Care—for all residents in our state. GCSHP sponsored (1) a data-driven analysis of SecureCare's impact on Georgia's economy, and (2) a statewide telephone survey of 800 households to solicit opinions on the proposal. Computer models showed that in 2003, against a total cost of $37.2 billion for health services, SecureCare would have reduced health expenditures by $716 million. Although the plan would provide full benefits—including mental health services, medications, and long-term care—the 2% global saving would come largely from reduced administrative costs (insurers, physicians, hospitals) and bulk purchasing (prescription drugs, durable medical equipment). Average household health expenditures would decrease by $122 annually, although households making >$75,000 would experience increased health spending. Georgians initially expressed ~72% support for SecureCare. After furnishing survey respondents with exhaustive lists of common objections, their support dropped to ~62%. GCSHP concludes that a universal, consolidated, state-sponsored plan would likely save money for Georgia, and it could easily win broad-based democratic support.

No. 7B
HOW WOULD A CANADIAN-STYLE SINGLE-PAYER HEALTH SYSTEM IMPACT THE PRACTICE OF COMMUNITY PSYCHIATRY IN AMERICA?

Karen M. Hochman, M.D., *Emory University, 206 Edgewood Avenue, S.E., Atlanta, GA 30303*

SUMMARY:

The final report of the President's New Freedom Commission on Mental Health has identified six fundamental goals for transforming mental health care in America. The current mental health system in America is complex, under-funded, and fragmented. The American Association of Community Psychiatrists has developed numerous position papers and guidelines to assist providers and treatment organizations in the development of state-of-the-art services. However, in the absence of adequate funding, it will not be possible to transform mental health care in America as recommended in the final report of the New Freedom Commission. This presentation will outline the history of the development of the Canadian health care system, describe the Canada Health Act, and discuss opportunities and challenges for the development of state of the art community mental health systems in Canada. The issue of mental health parity legislation is addressed. The presenter concludes by proposing that a single-payer, nationally funded health program where mental health parity is enshrined, can provide the funding basis for transforming mental health care in America without maintaining the disparities that currently exist.

No. 7C
WORKING UNDER A UNIVERSAL HEALTH CARE PLAN

Jonathan S. Davine, M.D., *East Region Mental Health Services, 2757 King Street East, Hamilton, ON L8G 5E4, Canada*

SUMMARY:

The Canadian health care system is a universal health care plan where the government is the single payor. Working under such a plan affords equal access to health care to all strata of the population. This is particularly important for mental health professionals, dealing with a population that is over-represented in the lower socioeconomic groups.

An important aspect of this plan is that in most situations, there are no limits on treatments. Treatment decisions are, therefore, based on need rather than on economics.

The presenter of this paper works in a general outpatient clinic affiliated with McMaster University in Hamilton, Ontario. OHIP is the Government of Ontario payor and stands for Ontario Health Insurance Plan. The fee structure for various psychiatric services in the province of Ontario will be described. We will also detail other innovative government supported systems, such as a capitation system that involves health service organizations, and a "shared care" model, which involves family medicine and psychiatry working together.

This single-payor system is very user friendly and significantly cuts down on time spent on paperwork during the course of one's week. There is also very little problem with accounts that are not paid. Although it is not a perfect system and some of the drawbacks will be outlined, overall there are a great number of advantages to working in a universal health care system.

No. 7D
FISCAL FEDERALISM AND MENTAL HEALTH CARE FOR HOMELESS PERSONS

Raymond J. Kotwicki, M.D., *Department of Psychiatry, Emory University, 1365 Clifton Road, N.E. Suite 6100B, Atlanta, GA 30322*

SUMMARY:

Researchers estimate that over half of all homeless individuals have a major mental illness or a substance abuse disorder. Compared with similar housed individuals, homeless persons with mental disorders who receive any care at all receive costly care that is often delayed and through inappropriate venues. States shoulder the expenses incurred for such care and fund payments through regressive taxes including sales taxes, "sin" taxes, and other means or through piecemeal federal health care programs. The presenter will propose that orchestrated, progressive federally funded mental health care is the ethical, efficient, and equitable means through which disenfran-

chised, severely mentally ill persons can receive appropriate mental health services. Participants in this symposium advocating for a single-payer national health care program need no previous training in mental health economics or homelessness. This symposium is directed toward clinicians who treat severely, persistently mentally ill individuals in publicly funded mental health centers, as well as participants who are engaged in the political processes of mental health care financing.

REFERENCES:

1. www.physicianspropsal.org
2. Final report of the President's New Freedom Commission on Health Care; Achieving the Promise: Transforming Mental Health Care in America. www.mentalhealthcommission.gov/reports/FinalReport/
3. Ministry of Health and Long-Term Care: Schedule of Benefits: Physician Services Under the Health Insurance Act, April 1, 2001.
4. Rosenheck R, Seibyl CL: Homelessness: health service use and related costs. Medical Care 1998; 36 (8): 1256–64.

SYMPOSIUM 8—CLINICAL ADVANCES IN EARLY DETECTION, PREVENTION, AND TREATMENT OF PSYCHOSIS
Collaborative Session With the National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant will be able to describe strategies for assessing psychosis risk, appreciate the role of family and/or pharmacological interventions in preventing the onset of psychotic disorders, and understand the impact of early detection and treatment on the initial course of schizophrenia.

No. 8A
ACCURATE PREDICTION OF AT-RISK PATIENTS

Diana O. Perkins, M.D., *Department of Psychiatry, Univ. of North Carolina, School of Medicine, Med School Wing D, Room 252, CB#7160, Chapel Hill, NC 27599-7160*

SUMMARY:

Most individuals who develop schizophrenia describe a prodrome prior to development of the first episode that may prove to be an opportunity for preventative intervention strategies. Current estimates are that 35% to 40% of individuals meeting clinically defined prodromal diagnostic systems (e.g. ultra-high risk criteria and Criteria of Prodromal Syndromes) develop psychosis after one year. While an impressive improvement over the general population annual risk of about 1/10,000 per year, this level of accuracy still results in more false positives than true positives. For individuals falsely identified as at-risk, the potential consequences include undue worry and concern, risk of stigma, and risk that preventative treatment attempts will expose individuals not truly prodromal to any risks associated with treatment. Improvements in psychosis risk prediction likely will rely on secondary screening of individuals meeting clinical at risk diagnostic criteria. The results of preliminary studies finding that the severity of cognitive deficits, olfactory function, level of functional impairment, and family history of psychosis improve specificity of risk prediction in clinically at-risk individuals will be discussed in this presentation.

No. 8B
FAMILY INTERVENTION IN THE PRODROME OF PSYCHOSIS

William R. McFarlane, M.D., *Department of Psychiatry, Maine Medical Center, 315 Park Avenue, Portland, ME 04102;* William L. Cook

SUMMARY:

Portland Identification and Early Referral (PIER) is a comprehensive, population-based system for early detection of prodromal psychosis in Greater Portland, Maine.

Objective: The goal is to reduce the incidence of initial psychotic episodes and schizophrenia in greater Portland, Maine (population 260,000).

Method: The principal strategy is to intervene prior to onset of psychotic disorders, arresting the development of functional disability. Health, education, and mental health professionals identify the at-risk population. Recent evidence demonstrates that family factors interact equally with genetic predisposition to provoke onset of schizophrenia. Therefore, preventive treatment is a prodrome-specific combination of intensive psychoeducational multifamily group, assertive community, and symptom-based pharmacological treatment. Methods will be described for intervening in different types of families and clinical sub-syndromes (schizophrenic and mood spectrum disorders) among prodromal patients.

Results: During the first year of treatment, PIER has led to low rates of conversion to psychosis (2.6% for criterion psychosis, 12.8% for any psychotic episode) among 44 prodromal young persons and high rates of engagement (90.7% of eligible cases) and retention in treatment (97.6% at three months). Functioning in cognitive, social, academic, and employment domains improved substantially.

Conclusions: Results suggest promise for prevention of psychotic disorders using family, individual, and pharmacological intervention.

No. 8C
PHARMACOLOGICAL INTERVENTION DURING THE PRODROMAL PHASE

Scott W. Woods, M.D., *Department of Psychiatry, Yale University, 34 Park Street, Room 38, New Haven, CT 06519*

SUMMARY:

The purpose of this paper is to review results from randomized and open-label prospective pharmacologic trials for patients believed to be in the prodromal phase of schizophrenia.

Methods: Published data from such studies identified by a comprehensive computerized database search were summarized.

Results: Three studies were identified. The first study randomized 59 prodromal patients to open-label risperidone plus CBT plus usual care vs usual care alone for six months. The transition rate to psychosis was significantly reduced in the group receiving open-label risperidone plus CBT (Arch Gen Psychiatr 2002; 59:921). The second study treated four prodromal patients with open-label risperidone for 12 weeks. Patients improved significantly on symptoms and one cognitive measure (Am J Psychiatr 2002; 59:1230). The third study randomized 60 prodromal patients to olanzapine vs placebo for 12 months. Patients improved significantly more with olanzapine than placebo on symptom measures over the first eight weeks (Biol Psychiatr 2003; 54:453).

Discussion: These small studies begin to suggest that prodromal patients may benefit on average from antipsychotic medications. Additional studies are needed before the database will be sufficient to suggest a standard of care. Trials of medications without antipsychotic properties may also be indicated, provided there is a strong theoretical rationale.

No. 8D
NONADHERENCE: A MAJOR RISK FACTOR FOR PSYCHOSIS IN PRODROMAL ADOLESCENTS

Barbara A. Cornblatt, Ph.D., *Department of Psychiatry, The RAP Program, Zucker Hillside Hospital, 444 Lakeville Road, Lake Success, NY 11042;* Christopher Smith, M.A., Andrea Auther, Ph.D., Todd Lencz, Ph.D., Christopher Currell, M.D., Ruth Olsen, B.S., Emilie Nakayana, Ph.D.

SUMMARY:

The New York Recognition and Prevention (RAP) program focuses on adolescents (ages 13 to 18) in the prodromal phases of schizophrenia. Primary goals are to identify development risk factors for psychosis and to use these to shape early interventions that impact the progression of illness. The RAP treatment strategy is naturalistic: all patients receive treatment by physician's choice based on best-practice standards for symptoms displayed. We are therefore able to track real-world treatment response patterns. Over 150 youngsters have thus far participated in the RAP program. In general, early intervention (psychosocial and pharmacological) appears quite effective, with close to 80% either clinically stabilized or improved. To date, 75 adolescents accepted into the program with attenuated (non-psychotic) symptoms have been followed for at least two years (range two to four years). Of these, 17 (23%) have developed a psychotic disorder, with (nine) 13% converting to full-blown schizophrenia. In all but one case, adolescents undergoing clinical decline had first stopped taking their prescribed medication for an extended time period (typically several weeks). We conclude that non-adherence to prescribed treatment is a major risk factor for psychosis. These findings also emphasize the critical importance of non-adherence in interpreting all treatment data.

No. 8E
REDUCING DURATION OF UNTREATED FIRST-EPISODE PSYCHOSIS

Thomas H. McGlashan, M.D., *Department of Psychiatry, Yale University, 301 Cedar Street, New Haven, CT 06519;* Ingrid Melle, M.D., Svein Friis, M.D., Tor K. Larsen, M.D., Jan O. Johannessen, M.D., Ulrik Haahr, M.D., Per Vaglum, M.D.

SUMMARY:

In first-episode psychosis (FEP), long duration of untreated psychosis (DUP) is correlated with poorer outcome, but the mechanism of this relationship is unclear. We aimed to reduce DUP in FEP in a defined health care sector with an early detection (ED) program compared with two parallel health care sectors without an ED program (No-ED). We consented 281 FEP patients in all sectors over four years. All sectors offered an equivalent standard treatment protocol. The ED area also carried out an intensive ED program.

Results: DUP in the ED sector was significantly shorter in the ED area (median five weeks) versus the no-ED areas (median 16 weeks). Clinical status measured by the Positive and Negative Syndrome Scale and the Global Assessment of Functioning Scale was significantly better for patients from the ED area at start of treatment and, with the exception of Positive and Negative Syndrome Scale positive subscale, at three months.

Conclusions: It is possible to reduce the DUP through an ED program. The reduction in DUP is associated with better clinical status at baseline that is maintained after three months. One-year follow-up results will be available by the time of the meeting. Discussion will include the possibilities for secondary and tertiary prevention through early detection/intervention in schizophrenia and how to demonstrate them.

REFERENCES:

1. Perkins DO: Evaluating and Treating the Prodromal Stage of Schizophrenia. Current Psychiatry Reports 2004; 6(4), in press.
2. McFarlane WR: Family-based treatment in prodromal and first-episode psychosis, in Early Intervention in Psychotic Disorders. Edited by Miller T. Amsterdam, Kluwer Academic Publishers 2001, pp. 197–230.
3. Woods SW, Breier A, Zipursky RB, Perkins DO, Addington J, Miller TJ, Hawkins KA, Marquez E, Lindborg SR, Tohen M, McGlashan TH: Randomized trial of olanzapine vs placebo in the symptomatic acute treatment of patients meeting criteria for the schizophrenia prodrome. Biological Psychiatry 2003; 54:453–464.
4. Cornblatt B, Lencz T, Kane JM: Treatment of the schizophrenia prodrome: is it presently ethical? Schizophrenia Research 2001; 51:31–38.
5. McGlashan TH: Duration of untreated psychosis in first-episode schizophrenia: marker or determinant of course (published correction appears in Biol Psychiatry 2000; 47:473) Biol Psychiatry 1999; 46:899–907.

SYMPOSIUM 9—CLINICAL EFFECTIVENESS TRIALS IN THE REAL WORLD: STATUS AND FINDINGS OF THE NIMH TREATMENT TRIALS
Collaborative Session With the National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of the symposium the participant should be able to describe the effectiveness of antipsychotic medications in schizophrenia, understand how to treat major depression resistant to initial treatment, describe the effectiveness of treatment interventions in adolescent depression, and understand the effectiveness of various treatments for bipolar disorder.

No. 9A
CURRENT STATUS AND CONTROVERSIES IN ANTIPSYCHOTIC DRUG EFFECTIVENESS: UPDATE FROM THE CATIE STUDY

Jeffrey A. Lieberman, M.D., *Department of Psychiatry, UNC School of Medicine, 7023 Neurosciences Hospital, CB# 7160, Chapel Hill, NC 27707*

SUMMARY:

The Clinical Antipsychotic Trials of Intervention Effectiveness project (CATIE) is an NIMH-sponsored project to evaluate the clinical effectiveness of antipsychotics in the treatment of schizophrenia and Alzheimer's disease. Although they were first developed for schizophrenia, antipsychotic drugs are now broadly used for other disorders, including behavioral signs and symptoms associated with Alzheimer's disease. Despite their widespread use in these conditions, the overall effectiveness and safety of these drugs remain unclear. Recently, psychopharmacology research has been dominated by the pharmaceutical industry. While industry-sponsored research is critical to new product development, its emphasis is on regulatory and marketing requirements rather than the effectiveness of the drugs at the general population level. Consequently, industry-sponsored research does not address broad public health or individual practitioner needs essential for good clinical decisions for individual patients. The CATIE trials are examples of practical clinical trials—they are meant to produce results that are generalizable to typical

treatment settings and to generate information that is useful to clinical and policy decision makers. The trials have been under way since 2001 and will be complete by the end of 2004. Information on the safety and effectiveness of the drugs that has become available since the trials began has only increased the importance of the two CATIE trials.

No. 9B
TREATMENT FOR ADOLESCENTS WITH DEPRESSION STUDY (TADS)

John S. March, M.D., *Department of Psychiatry, Duke University Medical Center, P.O. Box 3527, Durham, NC 27710*

SUMMARY:

The Treatment for Adolescents with Depression Study (TADS) is an NIMH-funded clinical trial that evaluates the effectiveness of four treatments for adolescents with major depressive disorder (MDD): fluoxetine (FLX), cognitive-behavior therapy (CBT), their combination (COMB), and clinical management with placebo (PBO). A total of 439 adolescents were randomized to receive one of these four treatment options for 12 weeks. Primary outcome measures were the Child Depression Rating Scale-Revised total score (CDRS-R) and the Clinical Global Impression-Improvement score (CGI-I). Compared with placebo, intent-to-treat random regression analyses indicated a statistically significant advantage for COMB (P = .001), but not for FLX (P = .10) or CBT (P = .40) on the CDRS-R. Combined treatment also proved superior to FLX (P = .02) and to CBT (P = .01) while FLX proved superior to CBT (P = 0.01). Responder rates were COMB = 71%, FLX = 61%, CBT = 43%, and placebo = 35%. Suicidal thinking improved significantly in all treatment arms, with COMB showing the greatest reduction (P = .02). Rates of harm-related adverse events were FLX = 11.9%, COMB = 8.4%, CBT = 4.5% and PBO = 5.4% (P = 0.15). In this study, the combination of fluoxetine and CBT offered the most favorable tradeoff between benefit and risk.

No. 9C
AN UPDATE ON THE STAR*D TRIAL

A. John Rush, M.D., *Department of Psychiatry, University of Texas, SW Medical Center, 5323 Harry Hines Boulevard, MC9086, Dallas, TX 75390-9086;* Madhukar Trivedi, M.D., Stephen R. Wisniewski, Ph.D., Maurizio Fava, M.D.

SUMMARY:

STAR*D (Sequenced Treatment Alternatives to Relieve Depression) is an ongoing multi-site trial of outpatients with nonpsychotic major depressive disorder recruited from primary and mental health practice settings. It aims to define the next best treatment step following the lack of symptom remission with the initial SSRI (citalopram), and to define the next best subsequent treatment steps should the second or third treatment fail, using a randomized design.

Findings to be presented include baseline comparisons of primary vs. specialty care depressed patients, comparisons of those with chronic vs. nonchronic depression, and comparison of those with early age at onset (i.e., <18 years of age) vs. later onset patients.

If data are available, the comparative symptomatic outcomes of three different medication switch options at Level 2 (sertraline, bupropion SR, or venlafaxin XR) and two different medication augmentation options at Level 2 (buspirone or bupropion SR) will be presented.

The psychometric performance of a brief clinician friendly inventory of depressive symptoms, available for routine use in practice, will be discussed.

No. 9D
TREATMENT OF BIPOLAR DEPRESSION: EFFECTIVENESS OF ANTIDEPRESSANTS' OBSERVATIONAL OUTCOMES IN STEP-BD

Gary S. Sachs, M.D., *Department of Psychiatry, Harvard-Massachusetts General Hospital, 50 Staniford Street, Suite 580, Boston, MA 02114*

SUMMARY:

The Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) has undertaken a range of bipolar research projects that will better illuminate the characteristics of the illness and provide essential data on the effectiveness of commonly used treatments. Clarifying the role of standard antidepressants for the treatment of bipolar depression is a high priority objective of the STEP-BD. The project includes both a double-blind, randomized trial and an observational component intended to assess outcomes among subjects seeking treatment for bipolar depression but unwilling to accept randomization. This presentation will examine the role of standard antidepressants using quasi-experimental methods to compare the outcomes of nonrandomized treatment. For these analyses intent-to-treat comparison groups were constructed based on use of any standard antidepressant within 21 days from the onset of a major depressive episode. Outcomes were based on standardized prospective ratings completed at clinical visits. This comparison of open treatment for bipolar depression found low recovery rates and no advantage for the adjunctive use of standard antidepressant medications.

REFERENCES:

1. Stroup TS, McEvoy JP, Swartz MS, Byerly MJ, Glick ID, Canive JM, McGee MF, Simpson GM, Stevens MC, Lieberman JA: The National Institute of Mental Health Clinical Antipsychotic Trials in Intervention Effectiveness (CATIE) Project: Schizophrenia trial design and protocol development. Schizophrenia Bulletin 2003; 29(1):15–31.
2. TADS Team: Fluoxetine, CBT, and their combination for adolescents with depression. JAMA 2004; 292(7):807–820.
3. Rush AJ, Fava M, Wisniewski SR, et al, for the STAR*D Investigators Group: Sequenced Treatment Alternatives to Relieve Depression (STAR*D): rationale and design. Controlled Clinical Trials 2004; 25:119–142.
4. Sachs GS, Thase ME, Otto MW, Bauer M, Miklowitz D, Wisniewski SR, Lavori P, Lebowitz B, Rudorfer M, Frank E, Nierenberg AA, Fava M, Bowden C, Ketter T, Marangell L, Calabrese J, Kupfer D, Rosenbaum JF: Rationale, design, and methods of the systematic treatment enhancement program for bipolar disorder (STEP-BD). Biological Psychiatry 2003; 53(11):1028–42.

SYMPOSIUM 10—NEW PHARMACOLOGIC APPROACHES TO ALCOHOLISM
American Academy of Addiction Psychiatry

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) recognize the nature and mechanism of new medications coming available for the treatment of alcoholism; (2) gain facility in opportunities for their use in clinical practice.

No. 10A
NEUROCHEMICAL BASIS FOR ALCOHOL PHARMACOTHERAPY

Raymond F. Anton, Jr., M.D., *Department of Psychiatry, Medical University of South Carolina, 67 President Street, P.O. Box 250861, Charleston, SC 29425*

SUMMARY:

Addiction neuroscience has been progressing at a rapid rate. Specific neuroanatomical and neurochemical pathways have been identified that are impacted by alcohol and which adapt over time to form the basis of alcohol dependence. This talk will present the current thinking on which neurochemical systems and pathways underlie craving and dependence. Possible pharmacological targets to reduce craving, drinking, and/or relapse will be highlighted. Data will be presented from animal and human studies, particularly in the area of neuroimaging of craving as it may relate to neurochemical pathways and receptors.

For instance, it is now well recognized that elevated dopamine in the nucleus accumbens is central to all drugs of abuse. However, more recent evidence suggests that opiate, glutamate, GABA, serotonin, cannabinoid, and CRF systems may all play a significant role in maintaining drinking and promoting dependence. Accumulating evidence suggests that connections between the pre-frontal cortex, anterior cingulate, and ventral striate (nucleus accumbens) may form the basis of reward circuit in the brain and that the amygdala may be important for environmental cue recognition or stress-induced drinking.

Medications that modify these systems such as naltrexone, acamprosate, topiramate, ondansetron, and SSRIs will be mentioned for potential use in alcohol dependence.

No. 10B
MATCHING SEROTONERGIC MEDICATIONS TO ALCOHOLISM SUBTYPES

Henry R. Kranzler, M.D., *Department of Psychiatry, University of Connecticut Health Center, 263 Farmington Avenue, Farmington, CT 06030-2103*

SUMMARY:

Reports that serotonin reuptake inhibitors (SRIs) reduce alcohol consumption in heavy drinkers generated considerable interest in the potential utility of these medications for alcoholism treatment. This approach was based on a preclinical literature showing a role for serotonin in the regulation of drinking behavior and on evidence of serotonergic dysregulation in alcoholism. A number of studies have now been conducted of SRIs and other serotonergic medications as adjuncts to the psychosocial treatment of alcoholism. With time, a growing recognition has emerged that alcoholism subtypes, derived using either cluster analytic or univariate age-of-onset measures, interact with serotonergic medications to predict treatment response. This presentation will review these developments, focusing on approaches to subtyping that are of clinical utility. The presentation will conclude with a discussion of genetic approaches that may serve to elucidate the relationship between alcoholism subtypes and the response to serotonergic medications.

No. 10C
COMBINATION MEDICATION STRATEGIES FOR ALCOHOLISM

Bankole A. Johnson, M.D., *Department of Psychiatry, University of Texas Health Science Center, 3939 Medical Drive, Suite 100, San Antonio, TX 78229-3900*

SUMMARY:

In recent years, several medications have been developed for the treatment of alcohol dependence. Basically, these medications have been developed with the view of neuromodulating cortico-mesolimbic dopamine function via another neurotransmitter system. Since cortico-mesolimbic dopamine can be modulated by a variety of central neurotransmitters [e.g., gamma-aminobutyric acid (GABA), glutamate, serotonin, and opioids] within the cortico-mesolimbic system, medication combinations offer the potential for additive effects on neuromodulation and, as a consequence, therapeutic efficacy for treating alcohol dependence. Dr. Johnson will provide a pharmacological approach to the mechanistic examination of potential sites for combinative neuromodulation. Next, as examples, Dr. Johnson will present clinical data on the combination of the mu-opioid antagonist, naltrexone, with the glutamate antagonist, acamprosate, and with the serotonin-3 antagonist, ondansetron. Additionally, new clinical data will be presented on the combination of ondansetron with the mixed GABA agonist/glutamate antagonist, topiramate. Finally, Dr. Johnson will discuss the potential challenges of medication combinations including the potential for higher rates of adverse events and, perhaps, reduced medication compliance. Taken together, Dr. Johnson will provide, with examples, a critical appraisal of the current data on medication combinations, and the strengths and potential weaknesses of this approach.

No. 10D
RELATIONSHIP BETWEEN 5HT TRANSPORTER FUNCTION AND CRAVING AMONG HISPANIC PATIENTS WITH ALCOHOLISM

Nassima Ait-Daoud, M.D., *Department of Psychiatry, University of Texas Health Science Center, 3939 Medical Drive, Suite 100, San Antonio, TX 78229*

SUMMARY:

Polymorphic variation in serotonin transporter function has been shown to interact with alcohol-drinking history in ways that might produce functional differences that could explain, at least in part, differential response to specific serotonergic agents among particular subtypes of alcoholics. To understand more fully the neuropharmacological impact of these serotonin transporter differences, it would be important to characterize response to behavioral measures of craving and abuse liability assessment among non-treatment-seeking alcoholics who differ in serotonin transporter polymorphism. Dr. Ait-Daoud will present new data from such a human laboratory study and include additional information on how these behavioral measures of craving and abuse liability assessment can be affected by the pharmacological stressor of central serotonin level depletion through the provision of a tryptophan-deficient diet. The experimental cohort was limited to Hispanic alcoholics in order to avoid the potential for ethnic differences in serotonergic transporter polymorphism frequency to complicate the interpretation of the results. In all, Dr. Ait-Daoud's presentation will enhance our understanding of how pharmacogenomic approaches using particular serotonergic medications might be usefully targeted toward specific subtypes of alcoholics.

REFERENCES:

1. Anton RF, Swift RM: Current pharmacotherapies of alcoholism: a U.S. perspective. American Journal on Addictions 2003; 12:S53–S68.
2. Pettinati HM, Kranzler HR, Madaras J: The status of sertonin-selective medications in the treatment of alcohol dependence, in Recent Developments in Alcoholism. Edited by Galanter M. New York, Plenum Press, 2003, pp 247–62.

3. Johnson BA, Ait-Daoud N: Neuropharmacological treatments for alcoholism: scientific basis and clinical findings. Psychopharmacology 2000; 149(4):327–344.
4. Johnson BA: Recent advances in the development of topiramate and other anticonvulsants for the treatment of addictive disorders: focus on alcohol and cocaine. CNS Drugs (in press).
5. Javors MA, Seneviratne C, Roache JD, Ait-Daoud N, Bergeson SE, Walss-Bass MC, Akhtar FZ, Johnson BA: Platelet serotonin uptake and paroxetine binding among allelic genotypes of the serotonin transporter in alcoholics. Progress in Neuro-Psychopharmacology and Biological Psychiatry, in press.

SYMPOSIUM 11—CARBOHYDRATE CRAVING AND MOOD DISORDERS: NEW AND COMPLEMENTARY TREATMENTS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand new research about the connection between eating preferences and behavior, insulin response, carbohydrate craving, and depressive syndromes.

No. 11A
MEDIATORS OF CARBOHYDRATE CRAVING IN DEPRESSION MAY ALSO SHORTEN LIFESPAN

Philip W. Gold, M.D., *Department of Neuroendocrinology, National Institutes of Mental Health, 10 Center Drive, Bethesda, MD 20892*

SUMMARY:

We now know that major depression is associated with a doubling of coronary artery disease and mortality at any age, independent of smoking or other risk factors for poor health. Furthermore, patients with major depression often experience increased carbohydrate craving, either as a concomitant of their depression or as a consequence of antidepressant treatment. Hypersecretion of insulin could contribute to both premature coronary artery disease and death, as well as to increased carbohydrate craving.

Depressed patients have several risk factors for insulin resistance and hyperinuslinism (e.g. hypecortisolism, catecholamine hypersecretion, increased cytokine production). Preliminary data have shown loss of insulin sensitivity in patients with major depression associated with hyperinsulinemia, and are sufficiently sound to warrant further investigation. This hyperinsulinism seems to be both a concomitant of depression per se, as well as, in some instances, a result of psychotropic drug treatment. In particular, atypical psychotic agents lead to insulin resistance and hyperinsulinism, at times of a severity to cross a threshold into type II diabetes insipidus.

It is not well known that insulin is a stress hormone and increased secretion during stress leads to insulin resistance, hyperinsulinism, and increased glucose for the brain. Insulin also activates the sympathetic nervous system and induces a proinflammatory state. Thus, the stress system activation in depression that remains pathologically unrestrained for long periods is likely to be associated with hyperinsulinism and its sequella, carbohydrate craving, premature heart disease, and death.

No. 11B
AN ANIMAL MODEL OF ADDICTION TO SUGAR

Bartley G. Hoebel, Ph.D., *Department of Psychology, Princeton University, Green Hall, Princeton, NJ 08544*

SUMMARY:

Rats show signs of addiction when placed on food restriction with daily 12-hr access to chow and 25% glucose or 10% sucrose starting 4 hrs into the dark cycle when they are awake. The cyclic fasting and bingeing results in overeating the sugar, which increases progressively during the first week. After a month on this diet, there is an increase in mu-opioid receptor and D1 dopamine receptor binding and an increase in D3 receptor mRNA in the nucleus accumbens. Microdialysis shows that taste alone is sufficient to release dopamine (DA) repeatedly in these animals, and they show behavioral cross-sensitization to amphetamine. Following these signs of sensitization, naloxone (20 or 10 mg/kg i.p. or 3 mg/kg s.c.) produces signs of withdrawal with teeth chattering, anxiety in an elevated plus maze and a decrease in extracellular DA in the NAc, while acetylcholine (ACh) increases, similar to morphine or nicotine withdrawal. This loss of DA and rise in ACh is indicative of an aversive withdrawal state and is also seen in an animal model of behavioral depression. As evidence of a lasting sugar dependency, after two weeks of sugar abstinence, they consume more sugar than ever before. Thus, intermittent bingeing on sweet food can act like a drug of abuse, causing DA sensitization and opioid dependency that appears to be like a mild addiction with depression-like withdrawal symptoms and may play a role in binge eating disorder or bulimia nervosa.

No. 11C
IMPLICATIONS OF CARBOHYDRATE CRAVING IN SAD

Norman E. Rosenthal, M.D., *Department of Psychiatry, Georgetown University, 11110 Stephalee Lane, Rockville, MD 20852-3656*

SUMMARY:

Since the earliest description of seasonal affective disorder (SAD), carbohydrate craving has been recognized as a cardinal symptom of the condition, affecting at least two-thirds of patients and predisposing to weight gain. Although carbohydrate-rich meals typically sedate healthy controls, they activate patients with SAD. Such meals are thought to boost brain serotonin synthesis by altering the ratio of branch-chain amino acids in the plasma in such a way as to facilitate the passage of tryptophan into the brain. Several lines of research suggest that deficient brain serotonin transmission (BST) may predispose to SAD. Light therapy, which is thought to enhance BST, reduces carbohydrate craving, along with the other symptoms of SAD. Carbohydrate craving is one of the best predictors of successful response to light therapy. SAD patients are less sensitive to sweet tastes than controls, which may be related to their carbohydrate craving. Deficient BST may also predispose to other conditions in which carbohydrate craving occurs, for example, premenstrual dysphoric disorder, depression in women, and alcohol dependency.

No. 11D
ATYPICAL DEPRESSION, CARBOHYDRATE CRAVING, AND CLINICAL RESPONSE

David A. Sack, M.D., *Comprehensive Neuroscience, Inc., 11080 Artesia Blvd., Suite A, Cerritos, CA 90703*

SUMMARY:

Carbohydrate craving, hyperphagia, and weight gain occur frequently in patients with depressive disorders and are especially prevalent in certain subtypes including atypical depression. The neurophysiology of carbohydrate craving and its relationship to treatment is only now beginning to be understood. Trivalent Chromium is a necessary cofactor for insulin, and a deficiency in chromium is associated with insulin resistance. Additionally, chronic administration of chromium in animal models increases serum free tryptophan

and brain serotonin and thereby may enhance brain serotonin transmission (BST). In case reports and a small pilot study patients with atypical depression showed significantly greater response to chromium, in the form of chromium picolinate (CrPic), than placebo. We conducted a Phase II type replication study examining the efficacy of CrPic in atypical depression. While there were no overall differences in response rates between the two conditions, the CrPic group showed significantly greater improvement in carbohydrate craving, weight change perception and rejection sensitivity. The level of carbohydrate craving significantly correlated with HAM-D (29 item) reduction in CrPic but not PBO patients. Improvement in the following cluster of six items on the 29 item HAM-D significantly differentiated CrPic from placebo: work and activity, increased appetite, increased eating, carbohydrate craving, retardation, and diurnal variation.

REFERENCES:

1. Glassman AH, Shapiro PA: Depression and the course of coronary artery disease. Am J Psychiatry, 1998; 155:4–11.
2. Colantuoni C, Rada P, McCarthy J, Patten C, Avena NM, Chadeayne A, Hoebel BG: Evidence that intermittent, excessive sugar intake causes endogenous opioid dependence. Obesity Research 2002; 10(6):478–88.
3. Rosenthal NE, Sack DA, Gillin JC, Lewy AJ, Goodwin FK, Davenport Y, Mueller PS, Newsome DA, Wehr TA: Seasonal affective disorder: a description of the syndrome and preliminary findings with light therapy. Archives of General Psychiatry 1984; 41: 72–80.
4. Wurtman RJ, Wurtman JJ: Brain serotonin, carbohydrate-craving, obesity, and depression. Obesity Research 3 1995; (Suppl 4): 477S–480S.

SYMPOSIUM 12—BEREAVEMENT, DEPRESSION, AND PTSD: BOUNDARY AND TREATMENT ISSUES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participants should be able to discuss the differential diagnosis and empirically based treatment strategies: (1) for bereavement-related major depression, (2) for bereavement-related post traumatic stress disorder, and traumatic grief.

No. 12A
GRIEF: MYTHS, EVIDENCE, AND UNRESOLVED QUESTIONS

George A. Bonanno, Ph.D., *Teachers College, Columbia University, 525 West 120th Street, Box 1218, New York, NY 10027*

SUMMARY:

Chronic or complicated grief reactions are a serious public health concern. Although most people recover from the disruptive impact of the death of a spouse within one to two years, as many as 20% of conjugally bereaved individuals will tend to suffer from chronic emotional difficulties that pervade many areas of their lives (performance at work and in caring for others). Unfortunately, despite the prevalence of chronic grief reactions, there is growing consensus among bereavement theorists that traditional models of coping with loss are not consistent with the empirical data. What's more, recent empirical evaluations have suggested that many existing clinical interventions for bereavement are inefficacious. I argue here that a necessary first step in developing more effective interventions for chronic grief is to highlight the ways that chronic grief may differ from other responses to loss. One way to achieve this goal is to clearly map the range of grief reactions shown in normal populations. It is also crucial to distinguish chronic responses to loss from pre-existing emotional difficulties that may be unrelated to grief. I briefly review evidence from several recent prospective studies highlighting these distinctions and their implications for intervention with chronically grieved individuals.

No. 12B
BEREAVEMENT-RELATED DEPRESSION: DIAGNOSTIC AND TREATMENT GUIDELINES

Sidney Zisook, M.D., *Department of Psychiatry, University of California, San Diego, 9500 Gilman Drive, # 0603R, La Jolla, CA 92093-0603;* Katherine Shear, M.D.

SUMMARY:

Each year more than 8 million Americans experience the death of a close family member. Two months after the death, about 20% of these grieving individuals (1.6 million people) meet DSM-IV criteria for major depressive episode (MDE). Depression following bereavement is as chronic and damaging as MDEs in any other context. Yet, many clinicians are uncertain about whether and how to treat bereavement-related depression. In large part, this uncertainty is a result of diagnostic ambiguities and symptomatic overlap between grief and MDE. Additionally, there is a prevalent but unsubstantiated concern that antidepressant medication could blunt emotions and impede necessary grief work. When clinicians fail to recognize, diagnose, and treat bereavement-related depressions, vulnerable grieving individuals are exposed to all of the burdens of untreated depressions for protracted periods. Thus, it is important to develop better diagnostic and treatment guidelines for this large and important group of depressed individuals. In this presentation, empirically based data on risk factors, course, and consequences of bereavement-related depressions will be presented. Next, several open and one controlled treatment studies will be reviewed. Based on the above, diagnostic guidelines (to help the clinician differentiate uncomplicated grief from bereavement-related MDE) and treatment recommendations regarding when (in relation to the loss) and how (education, psychotherapeutic nuances, and pharmacologic interventions) to treat will be described.

No. 12C
DISTINGUISHING TRAUMA AND TRAUMATIC LOSS: PTSD VERSUS TRAUMATIC GRIEF

Randall D. Marshall, M.D., *Department of Psychiatry, NY State Psychiatric Institute-Columbia Univ. 1051 Riverside Drive, Unit 69, New York, NY 10032*

SUMMARY:

Experiencing the death of a loved one is both a severe stressor and a trauma, and as such is associated with a number of serious mental health consequences, including, most commonly, MDD, PTSD, and traumatic grief. Because research to date suggests that treatment will vary in important ways between these three disorders, diagnosis is a critical first step. Yet traumatic grief (TG), by definition, involves aspects of traumatic reactions as well as grief reactions (separation). Both clinical conditions manifest highly distressing ruminations on past experiences; avoidance of reminders of the event as a strategy for managing thoughts and emotions; profound interpersonal withdrawal; and high comorbidity with depression. These similarities may lead to misdiagnosis of TG as PTSD. There are a number of important distinctions between TG and PTSD when the trauma is the death of a loved one. In PTSD, the person witnesses or is confronted with the death, and the focus of symptoms is on the event

per se, rather than the loss of the relationship. Fear is a dominant affect in PTSD, whereas anguished sadness is dominant in TG. Psychological schema related to danger are operative in PTSD; to loss, in TG. Finally, resolution of TG leads to a distancing from the horrific event itself and a narrowing of its meaningful implications for the self, for others, and the environment. In contrast, resolution of TG leads to a transformation of the internal relationship to the loved one that has a mostly positive emotional valence. Recent findings and case vignettes will be used throughout to illustrate these concepts.

No. 12D
DEPRESSION FOLLOWING BEREAVEMENT AND THE OCCURRENCE OF COMORBID PTSD

Paula L. Hensley, M.D., *Department of Psychiatry, University of New Mexico, 2400 Tucker Place NE, 4th Floor, Albuquerque, NM 87131;* Paula Clayton, M.D.

SUMMARY:

Research suggests that bereavement may precipitate not only depression, but also posttraumatic stress disorder (PTSD). For example, in the 1996 Detroit Area Survey of Trauma, sudden unexpected death of a loved one was the most frequently reported precipitating event among people with PTSD. When PTSD occurs in the bereaved, it is often comorbid with depression.

A study of bereavement-related depression was undertaken to test the efficacy of open-label antidepressant treatment and better understand the occurrence of comorbid PTSD. The study will treat 30 adult subjects who experience bereavement-related depression with the selective serotonin reuptake inhibitor (SSRI) escitalopram. The subjects are being recruited through advertisements in the media. They must be diagnosed with major depressive disorder (MDD) using DSM-IV-TR criteria; must have lost a spouse/significant other, child, parent, or sibling to death; and must have had the onset of MDD within a window of one month prior to the death and 11 months following the death. The screening interview must take place prior to the first anniversary of the death.

This report will focus on the occurrence of comorbid PTSD in this sample of depressed bereaved people. Results will be presented at the symposium.

No. 12E
TRAUMATIC GRIEF AND ITS TREATMENT

M. Katherine Shear, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara St, Pittsburgh, PA 15213*

SUMMARY:

Grief is the natural response to bereavement. Initially, grief comprises pangs of painful emotions, sense of disbelief, preoccupation with the deceased, and loss of interest in usual daily life. Later, grief becomes integrated. The loss is accepted, thoughts and feelings about the deceased are no longer intensely painful and preoccupying, though they remain bittersweet and accessible. The bereaved person re-engages with life goals. The trajectory toward integration occurs in fits and starts, but is usually well underway by six months. Sometimes this process is stalled and results in the syndrome called traumatic grief. Characterized by symptoms of traumatic distress (intrusive thoughts, avoidance, bitterness, and anger), separation distress (intense yearning and longing for the deceased, feeling that life has no meaning without the deceased, desire for proximity to possessions of the deceased), guilt, and failure to adapt, traumatic grief occurs in an estimated 10% to 15% of bereaved individuals. Antidepressant medication and interpersonal psychotherapy show limited effects on symptoms. We developed a novel psychotherapy that integrates interpersonal psychotherapy for depression and cognitive-behavioral treatment for PTSD. This presentation will review the syndrome of traumatic grief and present an overview of traumatic grief treatment, including outcome results and a brief video example.

REFERENCES:

1. Bonnano GA: Loss, trauma, and human resilience: have we underestimated the human capacity to thrive after extremely aversive events? Am Psychol 2004; 59(1):20–28.
2. Clayton PJ: Bereavement and depression. J Clin Psychiatry 1990; 51 Suppl: 34–38.
3. Marshall RD, Suh EJ: Contextualizing trauma: using evidence-based treatments in a multicultural community after 9/11. Psychiatr Q 2003; 74(4):401–420.
4. Zisook S, Chentsova-Dutton Y, Shuchter SR: PTSD following bereavement. Annals of Clinical Psychiatry 1998; 10(4):157–163.
5. Prigerson HG, Shear MK, Jacobs SC, Reynolds CF 3rd, Maciejewski PK, Davidson JR, Rosenheck R, Pilkonis PA, Wortman CB, Williams JB, Widiger TA, Frank E, Kupfer DJ, Zisook S: Consensus criteria for traumatic grief. A preliminary empirical test. Br J Psychiatry 1999; 174:67–73.

SYMPOSIUM 13—UNDERSTANDING COMPLEX MOOD DISORDERS: THE ROLE OF PERSONALITY VARIABLES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should appreciate the role of personality variables as risk factors and influences on treatment outcome in major depression.

No. 13A
PERSONALITY DIMENSIONS AND DISORDERS: A PSYCHOBIOLOGY UPDATE

Emil F. Coccaro, M.D., *Department of Psychiatry, University of Chicago, 5841 South Maryland Avenue, MC#3077, Chicago, IL 60637*

SUMMARY:

Objective: Data over the past two decades clearly point to a significant dimensional relationship between neurotransmitter-based function and personality traits in personality disorders. This presentation will review existing and new data regarding the neurobiology of personality traits.

Methods: Studies reviewed come from data related to pharmacologic challenge, and CSF neurochemical and imaging studies of personality disorder.

Results: Measures of various personality traits in personality disordered patients correlate with various measures of serotonin, norepinephrine, dopamine, GABA, and vasopressin Preliminary data also point to selected locations in the brain where potential abnormalities exist in subjects with prominent histories of selected personality traits. These data suggest treatment strategies that have been shown to be effective in selected patients with personality disorders.

Conclusions: The biology and clinical psychopharmacology of personality disorder is complex, but critical to understanding the nature of disordered personality traits in these types of patients. Insights from this continuing work will likely lead to new views in the classification of personality traits and personality disorders.

No. 13B
OPTIMIZING OUTCOME IN PATIENTS WITH BIPOLAR DISORDER AND PERSONALITY PSYCHOPATHOLOGY

Glenda M. MacQueen, M.D., *Department of Psychiatry, McMaster University, 1200 Main Street, West, 4N774 MUMC, Hamilton, ON L8N 3Z5, Canada*

SUMMARY:

Several models may be applied to understand the relation between bipolar disorder (BD) and personality disorders, particularly borderline personality disorder. This presentation reviews the evidence for the spectrum hypotheses and explanations for the high comorbidity between BD and axis II disorders. We will also review the impact of DSM-IV personality disorder symptoms on long-term clinical outcome in BD. Although few studies have examined the question of how personality features impact outcome in BD results from extant work and studies in major depressive disorder suggest that personality features are important in predicting outcome. In our own previous work, we used a life charting approach in which 87 patients with BD were followed for several years. Outcome was determined by examining symptoms over the most recent year of follow up and personality symptoms were assessed with the Structured Clinical Interview for DSM-IV (SCID II). Not surprisingly, patients with better outcomes had fewer personality disorder symptoms in seven of ten disorder categories, but the association between poor outcome and high number of personality symptoms was not always strong. Finally, we will examine current pharmacological and psychotherapeutic treatment options that may offer the best control of BD symptoms in patients with significant elements of axis II comorbidity.

No. 13C
KEY PSYCHOTHERAPY ISSUES IN PATIENTS WITH MAJOR DEPRESSION AND PERSONALITY PSYCHOPATHOLOGY

Michael B. Rosenbluth, M.D., *Department of Psychiatry, Toronto East General, 825 Coxwell Avenue, Toronto, ON M4C 3E7, Canada*

SUMMARY:

This presentation will address key assessment and psychotherapy issues in patients with major depressive disorder and comorbid personality psychopathology.

There are different models of the relationship between personality dimensions, disorders, and depression including the "scar hypothesis." The clinical implications of these models for assessment will be reviewed. How chronic states affect traits will also be explored. It is important to distinguish between a primary personality disorder with comorbid depression, versus chronic depression, which may be misdiagnosed as a personality disorder. Different personality presentations influence the goals of therapy, therapeutic alliance, and countertransferance.

Key psychotherapy challenges in working with patients with personality pathology and comorbid depressive disorder will also be discussed. These relate to clarifying and managing acute versus chronic suicidality; clarifying expectations; strategies for identifying comorbid PTSD issues, and staging of psychotherapy to deal effectively with trauma issues; ways to identify, understand, and utilize countertransferance; the importance of maintaining adaptive functioning and avoiding regression; and methods of nurturing strengths in this often demoralized and dispirited population. Psychotherapy with the complex depressed patient can be challenging but effective.

No. 13D
THE INFLUENCE OF PERSONALITY VARIABLES ON PHARMACOTHERAPHY OUTCOMES IN MAJOR DEPRESSION

Sidney H. Kennedy, M.D., *Department of Psychiatry, UHN, 200 Elizebeth Street, EN8-222, Toronto, ON M5G 2C4, Canada;* R. Michael Bagby, Ph.D.

SUMMARY:

Differences in personality dimensions and disorders among depressed patients influence help seeking, symptom presentation, treatment choice, and adherence as well as treatment outcome. Despite this, structured assessments of personality are rarely performed in clinical trials or in clinical practice. Pharmacologic challenges and neuroimaging techniques have been utilized to investigate the biological underpinnings of personality and to suggest appropriate pharmacotherapies.

Personality dimensions have been examined as predictors of antidepressant response. In some, but not all studies, high reward dependence and harm avoidance predicted good outcome. Elsewhere, high neuroticism and low extraversion predicted a less favorable outcome.

Although the presence of comorbid personality disorders was previously seem as a predictor of poor outcome in a current major depressive episode (MDE), several investigators have found this not to be the case. Antidepressant, mood stabilizer, and atypical antipsychotic agents successfully reduce impulsivity and aggression in borderline personality patients with and without current MDE, although a delayed response to treatment has been reported. There is also evidence that individuals with Cluster B personality disorders respond better to SSRI compared with TCA therapies.

Routine assessment of personality dimensions or disorders in depressed patients may contribute to better matching of patient profiles and optimal therapeutics.

REFERENCES:

1. Noblett K, Coccaro EF: Psychobiology of personality disorders, in M. Bagby, S. Kennedy and M. Rosenbluth (eds). Personality Disorders and Depression, APPI Press, Inc., Arlington, Va, in press.
2. Akiskal HS, Pinto O: The evolving bipolar spectrum. Prototypes I, II, III and IV. Psychiatric Clinics of North Am. 1999; 22:517–534.
3. Rosenbluth M, Silver D: Assessment and treatment of borderline personality disorder, in Treating Difficult Personality Disorders. Edited by Rosenbluth M. San Francisco, Jossey Bass, 1997, pp 1–25.
4. Mulder RT, Joyce PR, Luty SE. The relationship of personality disorders to treatment outcome in depressed outpatients. J Clin Psychiatry 2003; 64:259–264.

SYMPOSIUM 14—DIAGNOSIS, ASSESSMENT, MANAGEMENT, AND QUALITY-OF-LIFE ISSUES IN ADULT ADHD

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand diagnostic criteria and assessment tools available for diagnosing ADHD in adults, recognize functional impairments associated with ADHD, evaluate various treatment options available to manage ADHD in adults, and understand quality-of-life measurements in adults with ADHD.

No. 14A
DIAGNOSING ADULT ADHD

Thomas J. Spencer, M.D., *Department of Psychiatry, Mass General Hospital, 15 Parkman Street, WACC 7251, Boston, MA 02114*

SUMMARY:

Since adult ADHD is vastly underrecognized and undertreated, a greater understanding of the process of diagnosing adult ADHD is critical. An accurate diagnosis cannot be made without a thorough clinical interview. During screening, clinicians should consider current functioning and presenting symptoms, family history, academic and vocational indicators, marital functioning, and physical signs. ADHD is often undiagnosed because physicians focus on cross-sectional questions and neglect developmental questions that would identify inattention, hyperactivity, and impulsivity. Some of the most commonly used current-symptom surveys are the Brown ADD Scale (BAS), Conners Adult ADHD Rating Scale (CAARS), Wender-Reimherr Adult Attention Deficit Disorder Scale (WRAADS), ADHD Rating Scale (ADHD-RS), Barkley's Current Symptoms Scale Self-Report Form (Barkley's CSS). The Copeland Symptom Checklist for Attention Deficit Disorders (Adult Version), and The Adult Self-Report Scale (ASRS). This presentation will review recent advances in the clinical diagnosis of adult ADHD. Topics will include the change in diagnostic criteria of adult ADHD over time, the current specific *DSM-IV* criteria, critical aspects of making the diagnosis in adults, clinical vignettes of patients presenting for ADHD evaluations, pitfalls in the evaluation process, and the role of rating scales and neuropsychological testing in making the diagnosis of ADHD.

No. 14B
FUNCTIONAL IMPAIRMENT IN ADULTS WITH ADHD

Margaret D. Weiss, M.D., *Children's and Women's Mental Health, 4500 Oak Street, Box 178-B430, Vancouver V64 3H1, Canada*

SUMMARY:

Until recently, clinical trials in adults with ADHD have focused on improvement in core symptoms and overall change; however, ADHD in adulthoods is often associated with a wide range of associated symptoms that need to be included as targets of effective treatment. To determine the true potential of new treatments for this population, physicians need to know whether impairments commonly seen in areas such as driving, smoking, delinquency, substance use, family functioning, work, and education are going to be prevented with adequate treatment. Additionally, physicians need measures of functioning specific to the types of impairment that are associated with ADHD to understand how symptom improvement may translate into functional growth. A synopsis of research findings pertaining to treatment effects on functioning will be presented and supplemented by new data from a study evaluating behavioral. SSRI, and stimulant treatment of adult ADHD. These new research data will specify the association between change in symptomatology and change in functional impairment between treatments and across functional domains. It not only needs to be determined if treatments are safe and effective in managing ADHD symptoms, but also whether they have the potential to mitigate the personal and public health costs associated with the disorder.

No. 14C
PHARMACOLOGIC TREATMENT OF ADULTS WITH ADHD

David Goodman, M.D., *Johns Hopkins Greenspring Sta, Falls Concourse #306, 10751 Falls Rd, Lutherville, MD 21093-4517*

SUMMARY:

Although medication therapy is well studied in treating ADHD in children and adolescents, the use of pharmacotherapeutics for adults with ADHD remains less well established. A review of the literature identified 44 studies (comprising 1,916 subjects) of stimulant and nonstimulant medications, including amphetamines, methylphenidate (MPH), antidepressants, noradrenergic reuptake inhibitors (NRIs), antihypertensives, amino acids, and wake-promoting agents for the treatment of ADHD in adults. Controlled clinical trials with stimulants, antidepressants, and NRIs demonstrated significant short-term improvement in ADHD symptoms compared with placebo. The two long-term trials with MPH in adults support the ongoing effectiveness and tolerability of stimulants. Long-term studies of atomoxetine have also established effectiveness. All catecholaminergic agents had a mild pressor and chronotropic effect on cardiovascular vital signs. Considerable variability was found between the various studies in the diagnostic criteria for ADHD in adults, dosing, and response rates. Under controlled conditions, the aggregate literature comprised mainly of short-term studies shows that the stimulants, NRIs, and specific antidepressants have a clinically and statistically significant beneficial effect in treating ADHD in adults. Further studies are necessary to evaluate long-term effectiveness, functional and neuropsychological outcome, tolerability, effectiveness, and use in specific subgroups.

No. 14D
MEASURING QUALITY-OF-LIFE IN ADULTS WITH ADHD

Jeanne Landgraf, M.A., *Healthact, Inc, 205 Newbury Street, 4th Floor, Boston, MA 02116*

SUMMARY:

Adults with ADHD approach life and problems from a unique and often misjudged perspective. Although they are known to be at an increased risk for a myriad of negative life outcomes due to low self-esteem and poor interpersonal relationships and academic underachievement, adults with ADHD are also extremely bright and creative and exhibit a deap desire to excel and an enhanced facility for problem solving. There is still much to learn with regard to the current prospective quality of life for adults. Our understanding is limited in part by the absence of well-validated adult measures that go beyond symptomatology to assess the impact of common ADHD symptoms on the everyday quality of life (QOL) for adults. The objective of the project discussed, using a scientifically rigorous approach, was to develop a questionnaire that would capture key aspects of life (as defined by adult patients themselves) most impacted on a daily basis because of ADHD. The new measure can be used by practicing clinicians as part of a continuous monitoring program and by researchers. A review of the developmental criteria, key findings from in-depth interviews with adults and clinical experts, and an overview of the questionnaire will be discussed.

REFERENCES:

1. Adler LA, Chua H: Management of ADHD in Adults. J Clin Psych 2002; 63(12):29–35.
2. Murphy K, Barkley RA: Attention deficit hyperactivity disorder in adults: comorbidities and adaptive impairments. Compr Psychiatry 1996; 37:393–401.
3. Wilens TE: Drug therapy for adults with attention-deficit hyperactivity disorder. Drugs 2003; 63(22):2395–2411.
4. Landgraf JM, Rich M, Rappaport L: Measuring quality of life in children with attention-deficit/hyperactivity disorder and their families: development and evaluation of a new tool. Arch Pediatr Adolesc Med 2002; 156:384–391.

SYMPOSIUM 15— ETHNOPSYCHOPHARMACOLOGY: AN UPDATE ON CROSS-CULTURAL ASPECTS OF MOOD AND ANXIETY DISORDERS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand principles of ethnopsychopharmacology, and to recognize and understand the impact of cross-cultural issues in the treatment of mood and anxiety disorders.

No. 15A
ETHNOPSYCHOPHARMACOLOGY UPDATE

David C. Henderson, M.D., *Department of Psychiatry, Massachusetts General Hospital, 25 Staniford Street, Boston, MA 02114*

SUMMARY:

Ethnopsychopharmacology involves understanding basic psychopharmacology principles and the impact of race, sex, and culture on metabolism, response, adverse events, medication interactions, and medication compliance. Ethnopsychopharmacology examines biological and non-biological differences across race, ethnicity, sex, and culture and is critical for safe prescribing practices. A growing body of published evidence is documenting important inter- and intra-group differences in how patients from diverse racial and ethnic backgrounds experience health and illness, and is affected by pharmacologic treatment. Recommendations will be provided to improve compliance, reduce adverse events and medication interactions, and to improve clinical outcomes. Depression and anxiety are some of the most common medical/psychiatric disorders and occur across all populations, though symptom clusters may vary greatly. Pharmacologic interventions are critical in the treatment of depression. An expanded understanding of the interactions between psychopharmacological treatment and gender, and ethnic and cultural diversity informs conceptualizations of psychopharmacological treatments of various populations. This paper will review principles of ethnopsychopharmacology and highlight issues influenced by race, gender, and culture in the pharmacologic treatment of depressive disorders and anxiety disorders.

No. 15B
PSYCHIATRIC MANAGEMENT OF HISPANIC PATIENTS: CROSS-CULTURAL ISSUES AND ETHNOPSYCHOPHARMACOLOGY

David Mischoulon, M.D., *Department of Psychiatry, Massachusetts General Hospital, 50 Staniford Street, Suite 401, Boston, MA 02114*

SUMMARY:

Increasing numbers of psychiatrists nowadays work with Hispanic patients, either on a regular basis through their outpatient clinic, or by serving as consultants to general internists who are called upon to manage psychiatric disorders in patients seen in the primary care setting. This session will review the demographics of the Hispanic-American population; discuss the different challenges and obstacles faced by clinicians who work with Hispanics, including the language barrier, cultural and interpersonal factors, gender roles, and differing beliefs and attitudes about mental health; review difficulties in diagnosis, including the impact of culture-bound syndromes (such as "ataque de nervios", and "susto") on assessment; and review different approaches to treatment, including relevant principles of ethnopsychopharmacology, and the role of natural remedies and folk healing. The topics covered should allow the clinician to effectively diagnose and treat psychiatric disorders in Hispanic patients and communicate more effectively with these patients in the clinical setting.

No. 15C
IMPACT OF CULTURAL BELIEFS ON THE TREATMENT OF DEPRESSED CHINESE AMERICANS

Albert Yeung, M.D., *Department of Psychiatry, Massachusetts General Hospital, 50 Standord Street, Suite 401, Boston, MA 02114*

SUMMARY:

In European and North American cultures, depression is a well-accepted psychiatric syndrome characterized by specific affective, cognitive-behavioral, and somatic symptoms. In many non-European cultures, including Nigerians, Chinese, Canadian Eskimos, Japanese, and Southeast Asians, equivalent concepts of depressive disorders are not found (Marsella et al., 1985). Studies exploring illness beliefs among depressed Chinese Americans with a low degree of acculturation have shown that many of them were unaware of, or were unfamiliar with the concept of major depression. The discrepancy of illness beliefs between less acculturated Chinese Americans and their physicians has led to under-recognition and under-treatment of depression among Chinese Americans. Possible solutions to improve treatment of depressed Chinese Americans will be discussed.

No. 15D
MOOD AND ANXIETY DISORDER DIAGNOSIS AND TREATMENT IN THE ASIAN-INDIAN POPULATION

Rajesh M. Parikh, M.D., *Department of Psychiatry, Jaslok Hospital Research Center, 15 Dr. G. Deshmukh Marg, Bombay 400026, India*

SUMMARY:

Asian Americans from the Indian subcontinent are a growing ethnic group in the U.S., representing about 8% of the population. This sub-group of individuals have their own set of cultural norms, family traditions, and religious belief systems, with diversity within subgroups; all these factors may influence manifestation of depression and impact treatment outcome. Mood and anxiety disorders are under-diagnosed and under-treated in this population, and mental illness is frequently viewed as an embarrassment or stigma. Young women often face unique pressures in the system, both from the family as well as from society. Family involvement is important in all stages of treatment of mental illness, including interactions with the treating physician and compliance with treatment. Herbal remedies and alternative treatments are widely used. Data on ethnopsychopharmacology, although limited, suggest differences in metabolism, dose requirements, and adverse-event profiles for antidepressant medications in this population. Understanding the complex cultural belief systems may allow clinicians to assess some of the cultural factors in treatment and potentially increase treatment acceptability and compliance, particularly with antidepressant medications. Suggested modifications for managing depression in the Indian population will be discussed. Findings from cross-cultural studies comparing depression in college students in India and the U.S. will be discussed.

REFERENCES:

1. Ruiz P (ed): Ethnicity and Psychopharmacology. Washington, DC: American Psychiatric Press, 2001.
2. Ruiz P: Assessing, diagnosing, and treating culturally diverse individuals: a Hispanic perspective. Psychiatric Quarterly 1995; 66:329–341.

3. Kleinman A: Patients and Healers in the Context of Culture: An Exploration of the Borderland Between Anthropology, Medicine, and Psychiatry. University of California Press, Ltd. London, England, 1980.
4. US Census Bureau: Profiles of general demographic characteristics: 2000 census of population and housing. May, 2001.

SYMPOSIUM 16—PSYCHOSOMATIC MEDICINE: MANAGING THE HIGH RATES OF MORTALITY AND MORBIDITY

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to identify the signs and symptoms of depression as well as the morbidity and mortality rates associated with cerebrovascular and cardiovascular disease. They will also know the latest treatment to reduce mortality and morbidity associated with these disorders.

No. 16A
POSTSTROKE DEPRESSION AND MORTALITY

Robert G. Robinson, M.D., *Department of Psychiatry, University of Iowa School of Medicine, 200 Hawkins Drive, #2887 JPP, Iowa City, IA 52242*

SUMMARY:

A 10-year follow-up study of 91 of 103 patients evaluated for depression within the first two weeks following stroke revealed that patients with major or minor depression had died at a significantly higher rate that patients who were nondepressed. Patients who had survived 10 years of follow up (n=43) were not significantly different than the patients who had died (n=48) in any of their background characteristics at the time of the acute stroke including age, gender, race, or marital status. The survival curves for patients with major or minor depression were significantly different than the survival curves of nondepressed patients at 10 years of follow up (odds ratio 3.4, 95% CI, 1.4–8.4, p=.007). Other factors that were associated with increased mortality were significantly fewer social ties (p=.03) and cognitive impairment (p=.08). A logistic regression revealed that depression was significantly and independently associated with mortality outcome (adjusted odds ratio 3.7, 95% CI, 1.5–12.2, p=.03). Other investigators have also reported increased mortality associated with depression following stroke including a study of 99 patients by Morris et al. (1993) in an Australian rehabilitation hospital over 15-month follow up. House et al., (2001) examining 448 hospitalized patients using the General Health Questionnaire found logistic regression showed that more severe depression on the GHQ was independently associated with increased mortality.

No. 16B
HEART FAILURE AND MAJOR DEPRESSION

Carolyn L. Turvey, Ph.D., *Department of Psychiatry, University of Iowa College of Medicine, Psychiatry Research-MEB, Iowa City, IA 52242*

SUMMARY:

Heart failure affects 4 to 5 million Americans and is the number one cause of hospitalization in people aged 65 and older. People with heart failure also suffer significant depressive morbidity with an estimated 11 to 36% meeting criteria for major or minor depression. This presentation will discuss the correlates of depression in heart failure with an emphasis on the relation between functional impairment and depression. The talk will also present data on the long-term outcome of depression in heart failure and the relation between depression and cardiac morbidity. The effectiveness of current treatments will be discussed. This will include discussion of pharmacotherapy and innovative psychosocial treatments for homebound heart failure patients.

No. 16C
MORTALITY AND CHD: NEW TARGETS FOR TREATMENT STUDIES

Francois Lesperance, M.D., *Department of Psychiatry, Centre Hospitalier de l'Université de Montréal, 3850 St-Urbain, Montreal, QC H2W 1T8, Canada*

SUMMARY:

Patients with coronary heart disease (CHD) are about three times more likely to experience depression than people in the general community. While common, depression is not a normal reaction to CHD events. Depression is associated with at least a doubling in risk of subsequent cardiac events, even after taking measures of cardiac disease severity into account. Changes in autonomic regulation, vascular disease of the brain, sub-chronic inflammation, reduced omega-3 free fatty acid levels, and enhanced platelet responsiveness may all be involved. We assessed depression and markers of inflammation, endothelial function, hemostasis and omega-3 fatty acid levels in 600 men, two months following acute myocardial infarction or high-risk unstable angina episode. Increased inflammation, decreased endothelial function, and decreased levels of omega-3 fatty acids were significantly associated with both major depression (DSM-IV criteria) and depression symptoms (Beck Depression Inventory). Only one large clinical trial has attempted to alter CHD prognosis by treating depression. It succeeded in reducing depression symptoms, but had no impact on subsequent CHD events. Our results suggest that treatments for depression that also target inflammation and endothelial function (for example, omega-3 fatty acid supplements) provide a promising approach for improving prognosis and mood in depressed CHD patients.

No. 16D
THE EFFECT OF ANTIDEPRESSANTS ON MORTALITY AFTER STROKE

Ricardo Jorge, M.D., *Department of Psychiatry, University of Iowa, 500 Newton Road, Iowa City, IA 52242-1000*

SUMMARY:

Poststroke depression has been shown to increase mortality for more than five years after the stroke. We assessed whether antidepressant treatment would reduce poststroke mortality over nine years of follow up. A total of 104 patients were randomly assigned to receive a 12-week, double-blind course of nortriptyline, fluoxetine, or placebo early in the recovery period after a stroke. Mortality data were obtained for all 104 patients nine years after initiation of the study.

Of the 104 patients, 50 (48.1%) had died by the time of the nine-year follow-up. Of 53 patients who were given full-dose antidepressants, 36 (67.9%) were alive at follow-up, compared with only 10 (35.7%) of 28 placebo-treated patients, a significant difference. Logistic regression analysis showed that the beneficial effect of antidepressants remained significant both in patients who were depressed and in those who were nondepressed at enrollment, after the effects of other factors associated with mortality (i.e., age, coexisting diabetes mellitus, and chronic relapsing depression) were controlled. There were no intergroup differences in severity of stroke, impairment in cognitive functioning and activities of daily living impairment, and other medications received. Treatment with antidepressants during

the first six months poststroke significantly increased the survival of both depressed and nondepressed patients.

REFERENCES:

1. Robinson RG: The Clinical Neuropsychiatry of Stroke. Cambridge: Cambridge University Press, 1998, p. 491
2. Turvey CL, Klein DM, Pies C: Attitudes about impairment and depression in elders suffering from chronic heart failure. International Journal of Psychiatry in Medicine 2003; 33:117–132.
3. Frasure-Smith N, Lespérance F, Julien P: Major depression is associated with lower omega-3 fatty acid levels in patients with recent acute coronary syndromes. Biol Psychiatry 2004.
4. Jorge RE, Robinson RG, Arndt S, Starkstein SE: Mortality and post-stroke depression: a placebo controlled trial of antidepressants. Am J Psychiatry 2003; 160:1823–1829.

SYMPOSIUM 17—NOVEL TARGETS FOR NOVEL NEUROPSYCHIATRIC DRUGS

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to identify certain neuropeptides, their degrading enzymes, and their receptors as targets for novel drugs to treat depression, anxiety, pain, and schizophrenia. The participant will also understand use of expressed sequence tags (EST) for psychiatric drug discovery.

No. 17A
NEUROKININ RECEPTOR ANTAGONISTS AS ANTIDEPRESSANTS AND ANXIOLYTICS

Klaus Lieb, M.D., *Departments of Psychiatry and Psychotherapy, University of Freiburg Medical School, Hauptstr. 5, Freiburg 79104, Germany*

SUMMARY:

There is increasing evidence that the neuropeptides substance P (SP) and Neurokinin-A (NKA) are of potential interest for the etiopathology of affective and anxiety disorders. This evidence comes from both animal and human studies demonstrating that antagonists at the respective Neurokinin-1 and Neurokinin-2 receptors exert antidepressant profiles similar to classical antidepressants. In this review, the current evidence of SP and NKA as potential depressiogenic peptides and the role of NK-1 and NK-2-receptor-antagonists to treat major depressive disorders will be critically discussed. This discussion will also include preclinical data showing a complex interplay between the three neurokinin receptors (NK-1-, NK-2, NK-3-receptor) which is probably of critical importance for the further development of NK-receptor antagonists as antidepressants.

No. 17B
INHIBITORS OF ENKEPHALIN-DEGRADING ENZYMES AND DELTA OPIOID RESPONSES

Florence Noble, Ph.D., *UMR8015 CNRS, Université René Descartes, 4 Avenue de L'Observatoire, Paris 75006, France*

SUMMARY:

Objective: The endogenous opioid peptides enkephalins, by interacting with mu and delta receptors, play a major role in pain perception, cognitive functions and affective behaviors. Intensive studies have been carried out to elucidate the role of enkephalins, and to develop putative novel effective treatments mainly in the field of analgesia, and CNS disorders. However, it remains a controversy regarding the respective role of mu and delta receptors in emotional and/or motivational responses.

Method: Interruption of cell signaling by enkephalins is ensured by two enzymes. The physiological role of enkephalins can be investigated by comparing results obtained using peptidase inhibitors (RB101) with those obtained using mice in which genes encoding the various components of the opioid system have been deleted.

Results: The behavioral responses triggered by forced swimming were attenuated by treatment with inhibitors of enkephalin catabolism. Other experiments performed in mu receptor knockout mice gave similar responses in wild-type and knockout mice on RB101-induced hyperlocomotor activity, antidepressant- and anxiolytic-like effects. In contrast, RB101 induced antinociceptive responses only in wild-type animals.

Conclusions: Defects in the enkephalinergic system may be involved in the pathogenesis of various mental diseases. These results could open new perspectives in the treatment of mood disorders.

No. 17C
DISCOVERY OF NONPEPTIDE CRF1 RECEPTOR ANTAGONISTS AS NOVEL PSYCHOTHERAPEUTIC AGENTS

Dimitri E. Grigoriadis, Ph.D., *Pharmacology & Lead Discovery, Neurocrine Biosciences Inc., 12790 El Camino Real, San Diego, CA 92130*

SUMMARY:

Stress and stress-related disorders have long been associated with a dysregulation of neurotransmitter systems in the central nervous system. CRF has long been identified as the key mediator of an organism's response to stress and within the last decade, the cloning of multiple receptor subtypes, and the identification of related peptide ligands (the urocortins), have precipitated a new era in CRF research. From the first descriptions of the stress axis to its hypothesized role in human disease, the characterization of the receptors and ligands for this system have enabled the discovery of small molecule, orally active non-peptide molecules that now have the potential of providing novel therapeutics. Despite intense efforts by multiple pharmaceutical companies and research institutions, no compounds have yet progressed beyond initial clinical Phase IIA testing in any human disorder. Notwithstanding these apparent difficulties, the CRF system is still considered to hold tremendous potential for the identification of novel therapeutics. Various pharmacological and molecular methodologies including small molecule radioligand binding, pharmacophore modeling, and mutational studies have defined specific features of small molecule antagonist interaction with this Class-B GPCR. Current efforts and future strategies for the development of these novel molecules for neuropsychiatric and stress-related disorders will be discussed.

No. 17D
NEUROTENSIN AGONIST NT69L: A DRUG FOR NEUROPSYCHIATRIC DISEASES

Elliott Richelson, M.D., *Department of Psychiatry, Mayo Clinic, 4500 San Pablo Road, Jacksonville, FL 32224*

SUMMARY:

Neurotensin is a peptide neurotransmitter in the CNS, where it interacts with central dopaminergic systems. Neurotensin functionally antagonizes DA in the mesolimbic system, while increasing dopaminergic transmission in the nigrostriatal system. There are presently three subtypes of receptors for neurotensin that have been molecularly cloned. Neurotensin given into brains of animals has effects similar to the atypical antipsychotic drug, clozapine. Thus,

neurotensin is implicated in the pathophysiology of psychosis. Neurotensin may also play a role in Parkinson's disease and in the actions of psychostimulants. In fact, neurotensin has been called the "reward peptide." We have developed a peptide analog of neurotensin(8–13), called NT69L, which crosses the blood-brain barrier in laboratory animals, including primates. This peptide has high affinity for neurotensin receptor subtypes 1 and 2. Rodent studies show that NT69L has properties similar to those of atypical antipsychotic drugs. In addition, NT69L in animal models has potent antiparkinsonian and potent antinociceptive effects. It also blocks the expression of behavioral sensitization to nicotine and to D-amphetamine, without having rewarding effects in rhesus monkeys. These data suggest that a neurotensin receptor agonist could have multiple indications for treating human disease.

Supported by the Mayo Foundation for Medical Education and Research.

No. 17E
ANTIDEPRESSANT-ELICITED CHANGES IN GENE EXPRESSION

Mitsuhiko Yamada, M.D., *Department of Psychogeriatrics, National Center of Neurology and Psychiatry, 1-7-3 Kohnodai, Ichikawa, Chiba 272-0827, Japan*

SUMMARY:

Although antidepressants have been used clinically for more than 50 years, no consensus has been reached concerning their precise molecular mechanism of action. Pharmacogenomics is a powerful tool that can be used to identify genes affected by antidepressants or by other effective therapeutic manipulations, i.e., chronic lithium treatment, repeated ECT, and rTMS. Using this tool, we and others have identified as candidate molecular targets several genes or expressed sequence tags that are induced by chronic antidepressant treatment. In this symposium, we review antidepressant-elicited changes in gene expression, focusing especially on the remodeling of neuronal circuits that results. This refocusing motivates our hypothesis that this plasticity represents the mechanism for drug efficacy, and thus a causal event for clinical improvement. Defining the roles of these molecules in drug-induced neural plasticity is likely to transform the course of research on the biological basis of antidepressants. Such detailed knowledge will have profound effects on the diagnosis, prevention, and treatment of depression. Consideration of novel biological approaches beyond the "monoamine hypothesis" of depression is expected to evoke paradigm shifts in the future of antidepressant research.

REFERENCES:

1. Herpfer I, Lieb K: Substance P and Substance P receptor antagonists in the pathogenesis and treatment of affective disorders. World J Biol Psychiatry 2003; 4:56–63.
2. Roques BP, Noble F: Inhibitors of enkephalin-inactivating enzymes and delta opiod responses, in The Delta Receptor (Eds. K.J. Chang, F. Porrreca, J.H. Woods) Marcel Dekker, New York 2004, pp 277–296.
3. McMahon BM, Boules M, Warrington L, Richelson E: Neurotensin analogs: indications for use as potential antipsychotic compounds. Life Sciences 2002; 70:1101–1119.
4. Yamada M, Higuchi T: Functional genomics and depression research-beyond the monoamine hypothesis. Eur J Neuropsychopharmacol 2002; 12, 235–244.

SYMPOSIUM 18—USE OF CONCOMITANT OR ADJUNCTIVE MEDICATIONS IN SCHIZOPHRENIA

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to treat patients with schizophrenia who require concomitant medications, based on the latest scientific data rather than anecdotal reports.

No. 18A
USE OF COMBINATION ANTIPSYCHOTICS

Alexander L. Miller, M.D., *Department of Psychiatry, University of Texas Health Science Center, 7703 Floyd Curl Drive, San Antonio, TX 78284-7792*

SUMMARY:

Use of combination antipsychotics in schizophrenia is common and increasing in frequency. The few controlled trials and multiple case reports of this practice will be critically reviewed. Potential advantages and disadvantages of using combination antipsychotics will be explored. Clinical issues in rationally starting and stopping combination antipsychotics will be discussed. There will be an emphasis on objective documentation of the effects of antipsychotic polypharmacy, for purposes of providing good clinical care and to lessen medicolegal risks.

No. 18B
UTILIZATION OF COMBINATIONS OF ANTIPSYCHOTICS IN THE DEPARTMENT OF VETERANS AFFAIRS

Andre Tapp, M.D., *VA Puget Sound, 9600 Veterans Dr. A-116-R, Tacoma, WA 98493*

SUMMARY:

Within the Department of Veteran Affairs and other large agencies providing mental health treatment, the practice of prescribing combinations of antipsychotic medications varies across geographical areas and in accordance with patient characteristics. Data reviewing these utilization patterns will be presented and discussed. A recent study surveyed and analyzed the types of combinations utilized in a large VA health system. Significant findings from that survey will be presented. In the same study, a survey was administered to practitioners to investigate their rationale for combining antipsychotic medications and their perceptions about the efficacy of antipsychotic combinations. Overall, this study found that there are significant disparities between the expert guidelines regarding antipsychotic polypharmacy and the prescribing practices of clinicians. In addition, the survey found that prescribers frequently do not follow well-formulated treatment plans when prescribing combinations of antipsychotic medications. In a second study, a chart review of a small number of patients receiving combination antipsychotic medications revealed that while a minority of patients showed significant clinical response to combination antipsychotic therapy, the majority of patients did not exhibit significant improvements. The presenter will explore what conclusions can be drawn from these studies, focusing on current clinical practice and directions for future research.

No. 18C
THE USE OF ANTIDEPRESSANTS IN CHRONIC SCHIZOPHRENIA

Samuel G. Siris, M.D., *Department of Psychiatry, Zucker-Hillside Hospital, 75-15 263rd Street, Glen Oaks, NY 11004;* Paul C. Bermanzohn, M.D.

SUMMARY:

Increasingly, associated syndromes have been noted to be present in a substantial proportion of individuals diagnosed, by current criteria, as suffering from schizophrenia. These associated syndromes can, in fact, be the source of substantial suffering and dysfunction above and beyond that which is mediated by the psychotic elements of the condition. The question then logically arises as to when and how to use specifically targeted adjunctive medications therapeutically.

This paper will consider the differential diagnosis of apparent mood states and anxiety states, which arise in the course of schizophrenia, and which may be considered for treatment with antidepressant medications. These include depression, obsessive-compulsive syndromes, panic conditions, PTSD, and social anxiety. Guidelines will be presented, based on evidence in the literature, as to the appropriate use of adjunctive antidepressant medications as a component of the therapeutic array, which it is appropriate to use in our efforts to be helpful to such individuals.

No. 18D
USE OF ADJUNCTIVE MEDICATIONS FOR ANXIETY, AGITATION, AND SLEEP IN SCHIZOPHRENIA

Del D. Miller, M.D., *Department of Psychiatry, University of Iowa, 500 Newton Road #2–105 MEB, Iowa City, IA 52242-1000*

SUMMARY:

Despite the advances seen with the availability of the second- and third-generation antipsychotic medications, many people with schizophrenia have inadequate response to treatment. This inadequate response has led clinicians to use adjunctive medications and combinations of medications. This presentation will focus on treating anxiety, agitation, and sleep problems in persons with schizophrenia with adjunctive antianxiety agents and sleeping medications.

Evidence from short-term, double-blind, placebo-controlled trials suggests that there may be a subgroup of persons with chronic schizophrenia who benefit from the addition of a benzodiazepine to antipsychotic medication. However, the addition of benzodiazepines has also been associated with adverse effects such as social disinhibition, aggression, sedation, and ataxia. Sleep disturbances are common during acute exacerbations of schizophrenia, and while controlled studies are lacking, there is anecdotal evidence that a sedating antidepressant or a benzodiazepine sedative-hypnotic may be helpful. The presentation will review the results from controlled trials examining the usefulness of adjunctive antianxiety agents and sleeping medications in schizophrenia, and guidelines for optimizing their use will be offered.

No. 18E
EFFICACY OF CONCOMITANT MEDICATIONS FOR STABILIZED PATIENTS WITH SCHIZOPHRENIA

Ira D. Glick, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Suite 2122, Stanford, CA 94305-5723*

SUMMARY:

The NIMH CATIE project is a two-year study examining the relative effectiveness of a first-generation antipsychotic (FGA) to clozapine and four second-generation antipsychotics (SGAs) for patients with schizophrenia. The CATIE design allows for the uncontrolled use of concomitant (or adjunctive) psychotropic medications (CPMs). Since there are meager controlled and/or systematic data on the effectiveness of those agents, we decided to do a natural experiment by systematically, gradually tapering all CPMs (except antianxiety agents) for all patients who stabilized after switching from their pre-study antipsychotic to the study double-blind antipsychotic. The aim was to determine if the CPM improved outcome, was ineffective, or worsened outcome using the clinical global improvement scale (CGI)

Of the 16 patients on antidepressants, all 16 were successfully tapered. Of these, 13 out of 16 noted no change, while three actually improved. Of the nine patients on mood stabilizers, seven out of nine noted no change after discontinuing, while two worsened. One patient was on modafinal and on trazadone and reported no change after tapering each in separate discontinuation trials, while another patient was taking temazepam and also noted no change after discontinuation.

For most stabilized, chronic patients with schizophrenia, adjunctive medications do not improve outcome.

REFERENCES:

1. Miller AL, Craig CS: Combination antipsychotics: pros, cons and questions. Schizophrenia Bulletin 2002; 28:105–108.
2. Tapp A, Wood AE, Secrest L, Erdmann J, Cubberley L, Kilzieh N: Combination antipsychotic therapy in clinical practice. Psychiatr Serv 2003; 54:55–159.
3. Siris SG: Depression in schizophrenia: perspective in the era of "atypical" antipsychotic agents. American Journal of Psychiatry 2000; 157:1379–1389.
4. Miller DD, Schultz S, Alexander B: Rational pharmacological approaches in the management of treatment-resistant schizophrenia. Psychiatric Clinics of North America 1996; 3:89–118.
5. Glick ID, Zaninelli R, Hsu C, et al: Patterns of concomitant psychotropic medication use during a two year study comparing clozapine and olanzapine for the prevention of suicidal behavior. J Clinical Psychiatry 2004; 65:679–685.

SYMPOSIUM 19—MALADAPTIVE PERSONALITY TRAITS: DRUG TREATMENT, GENETICS, AND BIOLOGY

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should have a better knowledge of drug treatment of personality traits with emphasis on the SSRIs and mood stabilizers. Recent genetic and biological findings on personality traits and how drug treatment interacts with psychotherapy are reviewed.

No. 19A
GENERAL APPROACH TO DRUG TREATMENT OF MALADAPTIVE PERSONALITY TRAITS

James H. Reich, M.D., *Department of Psychiatry, Stanford Medical School, 2255 North Point Street, Unit 102, San Francisco, CA 94123*

SUMMARY:

This presentation will be on drug treatment of personality disorder traits. Recent work on the biology of personality disorders has uncovered biological abnormalities in many personality disorders. These new findings have been followed by new drug treatments to reduce personality disorder symptoms. Drugs that have some role in reducing personality disorder traits include traditional neuroleptics, atypi-

cal neuroleptics, tricyclic antidepressants, selective seritonergic response inhibitors, monoamine oxidase inhibitors, mood stabilizers, naltrexone, benzodiazepines, and others Although not a cure for personality disorders, drug treatments are quite useful in reducing some disabling symptoms. Drug treatment should be used as part of an overall treatment program involving psychotherapy. The presentation will first describe an approach to diagnosing personality traits and how to decide those that might be amenable to treatment. It will then describe the different theoretical and practical approaches that can be taken to treat these traits. It will also discuss how drug treatment must be modified for treatment of personality traits.

No. 19B
ANTIPSYCHOTIC AND ANTIDEPRESSANT USE IN PERSONALITY TRAITS TREATMENT

Alan F. Schatzberg, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Stanford, CA 94305-5717*

SUMMARY:

There is actually a long history of drug treatment of what we would now characterize as maladaptive personality traits. There was some early success with traditional neuroleptics and monoamine oxidase inhibitors. These, however, had potential side effects that reduced the number of situations where the risk-benefit ratio was acceptable. The introduction of atypical antipsychotics and selective seritonergic response inhibitors (SSRIs) has created classes of drugs that may well have benefits treating personality traits, but without as serious side-effect profiles. This presentation will update us on the empirical evidence supporting use of these newer medications for treatment personality traits. After reviewing what we do and do not know about the uses of these agents for personality traits, there will be some suggestions for the practicing clinician.

No. 19C
MOOD STABILIZERS IN PERSONALITY DISORDER TREATMENT

Eric Hollander, M.D., *Department of Psychiatry, Mount Sinai School of Medicine, One Gustave L. Levy Place, Box 1230, New York, NY 10029;* Daphne Simeon, M.D., Bryann Baker, M.D.

SUMMARY:

Mood stabilizers, including anticonvulsants and lithium, have a defined role in the treatment of symptom domains within the personality disorders. In particular, within the cluster B personality disorders, anticonvulsant mood stabilizers and lithium have demonstrated efficacy in the treatment of impulsive aggression and affective instability symptoms. Baseline characteristics, including trait impulsivity (BIS) and state aggression (OAS-M) predict a differential valproate vs placebo response in borderline personality disorder. Mood stabilizers also have a defined role in other impulsive conditions, including binge-eating disorder and alcohol abuse, which frequently are comorbid with axis II disorders. This treatment response of mood stabilizers may ultimately influence the way we conceptualize personality disorders.

No. 19D
NEW RESEARCH PERSPECTIVES ON THE NEUROBIOLOGY OF PERSONALITY DISORDERS

Larry J. Siever, M.D., *Department of Psychiatry, Mt. Sinai School of Medicine, One Gustave Levy Place, Box 1230, New York, NY 10029*

SUMMARY:

Neurobiologic research on the personality disorders has benefited from a more sophisticated understanding of the nature of these disorders and their temperamental underpinning as well as advances in the neuroscience-based tools that can be used to study these disorders. Several new research strategies/perspectives on the personality disorders will be presented with examples from our laboratory. One promising approach has been that of identifying underlying dimensions to these disorders and intermediate phenotypes for underlying susceptibility genes. Such intermediate or endophenotypes can include laboratory tests as well as specific clinical characteristics/dimensions and examples will be given of their association with catecholamine and serotonin-related genotypes. Analogously, indices of cognitive function can be linked to underlying genotypes in the schizophrenia spectrum of personality disorders such as schizotypal personality disorder. The clinical expression of genetic susceptibility factors will also depend on the environment and examples of the effect on critical neurobiologic systems of environmental stressors such as early abuse and neglect will be provided. Finally, functional and neurochemical imaging can be used to define underlying brain circuitry, which usually involves frontal cortical modulation of limbic structures (e.g., amygdala) in relation to emotional reactivity in borderline personality disorder and striatum in relation to psychotic-like symptoms in schizotypal personality disorder.

No. 19E
THE NEUROBIOLOGY OF SOCIAL AND EMOTIONAL DYSFUNCTION IN BPD

Michael J. Minzenberg, M.D., *Department of Psychiatry, Mt. Sinai School of Medicine, Bronx VAMC, 130 W. Kingsbridge Road (OOMH), Bronx, NY 10468;* Antonia S. New, M.D., Harold W. Koenigsberg, M.D., Jin Fan, Erin Hazlett, Ph.D., Larry Siever, M.D.

SUMMARY:

Objective: Borderline personality disorder (BPD) is distinguished by disturbances in social and emotional functions. Variation in the temporal and spatial dynamics of social and emotional processing may form the basis for individual differences in personality measures, and offers a target for investigating the clinical features of BPD.

Methods: Clinically stable, unmedicated adult outpatients with BPD were compared with healthy controls on emotion perception behavioral tasks, an emotion-modulated acoustic startle paradigm, and functional MRI using emotional visual stimuli.

Results: BPD patients exhibit an altered recognition of facial expressions of emotion. In the startle paradigm, exposure to emotional words leads to physiological activation (skin conductance) and an augmented withdrawal-related eyeblink reflex response, both heightened in BPD compared with controls. In fMRI, BPD patients exhibit increased hemodynamic activation in medial prefrontal cortex in response to emotional images with social significance.

Conclusions: Using diverse methodologies, BPD patients exhibit altered processing of social and emotional information. This is consistent with clinical observations and may result from altered levels of physiological activation, and possibly exaggerated neural effects on self-referential processes, in response to emotional stimuli. These initial results appear promising for the study of spatial and temporal neural dynamics of social and emotional processing as a basis for social and emotional dysfunction in BPD.

No. 19F
PSYCHOTHERAPY AND COMBINED TREATMENT IN BPD: POSSIBLE EFFECTS

Marianne Goodman, M.D., *Department of Psychiatry, Mt. Sinai School of Medicine, Bronx VAMC, 130 W. Kingsbridge Road*

(OOMH), Bronx, NY 10468; Antonia S. New, M.D., Harold W. Koenigsberg, M.D., Erin Hazlett, Ph.D., Janine Flory, Ph.D., Larry Siever, M.D.

SUMMARY:

This presentation discusses the effects of psychotherapy treatment with and without a pharmacological agent on core biological factors that predispose an individual to borderline personality disorder (BPD); impulsivity, aggression, and lability of affect. While there exist exciting developments in pharmacological strategies for BPD, investigation of the effect of psychotherapy and combined treatment on the underlying neurobiology of BPD remain limited. We are unaware of any published study on BPD to date that includes biological outcome measures for psychotherapy treatment or compares efficacy of combined treatment modalities except for one small open-label trial (Soler et al, 2001).

Dialectical Behavioral Therapy (DBT) is an empirically validated treatment approach for individuals with BPD and there exist several placebo-controlled replication studies. This approach assumes BPD is a disorder of emotional regulation and uses techniques of behaviorism, skills training, mindfulness, and problem solving to improve emotional control.

Data will be presented on an ongoing project in which subjects with BPD receive DBT, and also are randomized to six months of treatment with either escitalopram or placebo. Treatment effects on impulsivity, aggression, cognitive processing, and affective instability are measured by a variety of modalities including assessment thorough clinical/self ratings, and analogue laboratory tasks. Psychophysiologic measures will be discussed.

REFERENCES:

1. Reich J: Drug treatment of personality disorder traits. Psychiatric Annals 2002; 32(10):590–596.
2. Schatzberg A, Cole O, DeBattista C (eds.): Manual of Clinical Psychopharmacology, fourth edition. American Psychiatric Press, 2003.
3. Hollander E, et al: Impact of trait impulsivity and state aggression on divalproex vs placebo response in borderline personality disorder. Am J Psychiatry 2004, in press.
4. New AS, Siever LJ: The neurobiology and genetics of borderline personality disorder. Psychiatric Annals 2002; 32:6.
5. Soler J, Campins MJ, Perez V, Puigdemont D, Perez-Blanco E, Alvarez E: Olanzapine and cognitive-behavioural group therapy in borderline personality disorder. Actas Esp Psiquiatr 2001; 29(2):85–90.

SYMPOSIUM 20—THE END OF THE BIOPSYCHOSOCIAL MODEL? AN ASSESSMENT AND ALTERNATIVES
Association for the Advancement of Philosophy and Psychiatry

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to critically assess the strengths and limitations of the biopsychosocial model, as well as proposed alternative models (pluralism, pragmatism, perspectivism).

No. 20A
THE LIMITATIONS OF THE BIOPSYCHOSOCIAL MODEL IN PSYCHIATRY

G. Scott Waterman, M.D., *Department of Psychiatry, University of Vermont College of Medicine, 89 Beaumont Avenue, Given E215, Burlington, VT 05405*

SUMMARY:

In this presentation, I will examine the ill-founded premises and adverse effects of the biopsychosocial model in psychiatry. Despite laudable intentions, this model has developed into a form of eclecticism that does not provide useful guidance to clinicians. It also fails to serve as a useful organizing framework for teaching medical students or psychiatry residents, as it reifies a dualistic conceptualization of the determinants and expressions of psychopathology. Contrary to views expressed by Gabbard and others, neuroscience research does not provide support for the axioms of the biopsychosocial model. I will discuss the relevance of modern neuroscience to efforts at replacing the biopsychosocial model with one that is both more valid and more useful.

No. 20B
THE BIOPSYCHOSOCIAL MODEL: STRENGTHS VERSUS WEAKNESSES RELATED TO ASSUMPTIONS ABOUT GOOD SCIENTIFIC CATEGORIES

Peter Zachar, Ph.D., *Department of Psychology, Auburn University Montgomery, P. O. Box 244023, Montgomery, AL 36124*

SUMMARY:

Models of psychiatric disorders can be rated with respect to their standing on seven underlying dimensions of categorization. An example of an underlying dimension is casual versus descriptive. A model on the causal side identifies a category of disorder by etiology. A model on the descriptive side identifies a category of disorder by signs, symptoms, time course, and prognosis. Preferences among psychiatrists for one or the other side of a dimension are associated with what they consider to be an adequate category. The biopsychosocial model has been defended for where it stands with respect to some underlying dimensions, and often critiqued because of where it stands on other dimensions. The seven dimensions will be described, and the usefulness of these dimensions for understanding the biopsychosocial model and alternative models of psychiatric disorders will be explored.

No. 20C
KARL JASPERS AND A PLURALIST MODEL OF PSYCHIATRY

S. Nassir Ghaemi, M.D., *Department of Psychiatry, Cambridge Health Alliance/Harvard, 1493 Cambridge St, Cambridge, MA 02139*

SUMMARY:

I will examine a pluralist model of psychiatry based on the work of Karl Jaspers. The basic idea of pluralism shares features with the biopsychosocial model but goes beyond it. Like the biopsychosocial model, Jaspers' pluralism holds that no single method or approach in psychiatry sufficiently explains the entire field. On the other hand, unlike the biopsychosocial model, pluralism holds that for any specific condition or case, a single method or approach is better than all others and is to be preferred and applied systematically. Jaspers holds that all methods have strengths and limitations, and one should use the best method that maximizes its strengths and minimizes its limitations. The two basic methods he proposed for psychiatry, based on the work of the sociologist Max Weber, were the methods of causal explanation (Erklaren) and meaningful understanding (Verstehen). I will explore his use of these methods and their application to current psychiatry. Another idea used by Jaspers, and derived from Weber, is the concept of ideal types, whose utility I will describe in relation to the evolution of views regarding psychiatric nosology since the

introduction of DSM III. I will compare and contrast Jaspers' pluralism with the biopsychosocial model throughout this presentation.

No. 20D
HEALING PSYCHIATRY: THE NEED FOR PRAGMATISM

David H. Brendel, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont, MA 02478*

SUMMARY:

I will examine some key scientific and ethical principles of clinical explanation in 21st century psychiatry. Recent works in philosophy of science, clinical psychiatry, and psychiatric ethics are critically reviewed in order to elucidate conceptual underpinnings of contemporary explanatory models. Many explanatory models in psychiatry are reductionistic or eclectic. The former restrict options for diagnostic and therapeutic paradigm choice, while the latter lack a well-defined theoretical basis. These two methodological approaches stand in a dialectical relation to one another insofar as clinicians often move from one approach to its antithesis, ultimately seeking a synthesis of the two approaches that satisfies clinical needs. Pragmatic considerations can help to transcend the reductionism/eclecticism dialectic. In the absence of a completed science of mental disorders, psychiatrists must tolerate ambiguity and uncertainty as they strive to integrate diverse explanatory concepts in a rigorous and evidence-based fashion. A pragmatic explanatory model in clinical psychiatry must focus on favorable treatment outcomes for patients by respecting the pluralistic, participatory, and provisional nature of psychiatric explanation.

No. 20E
SIX QUESTIONS FOR CLINICAL MODELS

John Sadler, M.D., *Department of Psychiatry, UT Southwestern, 5323 Harry Hines Boulevard, Dallas, TX 75390-9070*

SUMMARY:

In the effort to produce workable clinical "models" for practice, questions about their proper functions, ideals, and goals have been relatively overlooked. What should a clinical model for medicine or mental health do? I present six questions as a framework for discussing the adequacy of "models" for mental health practice. (1) How well does this model aid the defining of clinical problems? (2) How well does this model aid the prioritizing clinical problems? (3) How well does this model situate the clinical problem in a justifiable moral context? (4) How well does this model situate the clinical problem in a manageable practical context (including that of other clinical problems)? (5) How effectively does the model draw from applicable sciences and other disciplines? (6) Does this model generate questions for the field as a whole? Several conclusions follow from considering these six questions against the biopsychosocial and other extant clinical models. Extant clinical models focus primarily upon the substance of questions 5 and 6. The biopsychosocial model in particular presupposes the answers to questions 1 and 2. The largely conceptual nature of questions 3 and 4 points to the marginality of practical and moral reasoning in current clinical models.

REFERENCES:

1. Waterman GS, Batra J: Biopsychosocial psychiatry. Am J Psychiatry 2003; 160(1):185.
2. Zachar P: Psychological concepts and biological psychiatry: a philosophical analysis. Amsterdam: John Benjamins, 2000.
3. Ghaemi SN: The Concepts of Psychiatry. Baltimore: Johns Hopkins Press, 2003.
4. Brendel DH: Reductionism, eclecticism, and pragmatism in psychiatry: the dialectic of clinical explanation. J Med Philos 2003; 28(5–6):563–80.
5. Fulford B, Morris K, Sadler J, Stanghellini G: Nature and Narrative: An Introduction to the New Philosophy of Psychiatry. Oxford: Oxford University Press, 2003.

SYMPOSIUM 21—BEHIND CLOSED DOORS: THE HIDDEN FAMILY: VIOLENCE AND ABUSE ISSUES WORLDWIDE
APA Alliance

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participant will have an international perspective on critical problems relating to the mental and physical health of families, specifically family violence and abuse issues, which often go unreported and untreated, due to stigma, cultural beliefs and taboos, lack of mental health education and treatment facilities, poverty, and politics.

No. 21A
HUMAN TRAFFICKING IN WOMEN: BEHIND CLOSED DOORS

Donna E. Stewart, M.D., *Department of Women's Health, University Health Network, 200 Elizabeth Street, Toronto, ON M5G 2N2, Canada;* Olga Gajic-Veljanoski

SUMMARY:

Trafficking in women is an international challenge that increasingly affects North America. The United Nations Protocol to Prevent, Suppress, and Punish Trafficking in Persons defines trafficking as "the recruitment or transportation of persons by means of threat or other forms of coercion for the purpose of exploitation, (including sexual exploitation, forced labor or services, practices similar to slavery, servitude, or the removal of organs)".

It is estimated that approximately one million individuals worldwide and 15,000 in the U.S. are trafficked annually. The majority (80%) are females trafficked for sexual exploitation. Most of these girls and women originate in poor countries where they may be recruited, or sold by their families, to agents who often have links to organized crime. Some women, or their families, know their ultimate employment as sex workers; others may be deceived and recruited falsely as "waitresses, entertainers, or homemakers."

Having arrived in the destination country, their passports are confiscated by their agents until their grossly inflated "travel debt" is repaid. They work in dreadful conditions and often suffer serious physical and psychiatric health problems. This presentation will provide recent information on human trafficking prevalence, issues, health risks, and suggested policies for prevention, suppression, and amelioration.

No. 21B
DOMESTIC ABUSE IN THE LAND OF THE DEVIS

Surinder S. Nand, M.D., *Department of Psychiatry, University of Illinois, Chicago, 900 South Wood Street, Chicago, IL 60612*

SUMMARY:

India, like many other nations in the world, has encountered its share of domestic abuse in a variety of forms and at various stages of life. Not unlike other nations, India, the land of "Devis" (women deities who are worshipped), women are the main victims of domestic

abuse. Sex-selective abortions, effects of battery during pregnancy on birth outcomes, female infanticide, child marriage, and child prostitution and pornography are some examples of abuse of Indian women prior to adolescence. Adolescent girls and adult women may face date rape, incest, sexual abuse, and sexual harassment in the workplace, forced prostitution, forced sex by spouse, pornography, dowry and honor killings. Elderly women may be subjected to forced suicide and homicide. The presenter will provide unique examples of domestic abuse among women in India; unique cultural beliefs about domestic abuse in India, and ways women and non-governmental and governmental agencies are dealing with prevention and eradication of domestic abuse in India.

No. 21C
BEHIND CLOSED DOORS IN AFRICA: THE CASE OF WOMEN AND CHILDREN

Frank G. Njenga, M.D., *Upperhill Medical Center, Ralph Bunche Road, Nairobi 00200, Kenya*

SUMMARY:

In traditional African societies, roles and responsibilities of its members were carefully regulated, giving the community a sense of cohesion, continuity, and integrity. Following the periods of colonization, wars of liberation, independence, and post-colonial self-governments, many countries in Africa have disintegrated into volatile autocratic dictatorships that have led to many wars, genocide, internal and external displacements of the people, recently complicated by natural and man-made disasters. AIDS is a recent entrant to the equation. In the midst of these changes (and traumas) the family unit has been denuded of its security, continuity, and order. African traditional education systems have been replaced by ill-tested western models of education, while time-tested rites of passage have been declared health hazards (e.g. circumcision) in many parts of Africa. Marriage systems that traditionally conferred stability derived from the nature of the marital bonds have been replaced by fragile western monogamous unions. These changes have affected relationships "behind closed doors." This paper describes the effects of this type of globalization on Africans, by taking Kenya as a case example exploring domestic violence and the abuse of children.

No. 21D
SPECIFIC ASPECTS RELATED TO TRAUMATIZED WOMEN AND THEIR CHILDREN

Marianne C. Kastrup, M.D., *Centre for Transcultural Psychiatry, University Hospital, Rigshospitalet, Blegdamsvej, Copenhagen DK-2100, Denmark*

SUMMARY:

Female and male refugees face different life situations and are exposed to different traumatic situations. Yet, surprisingly little attention has been paid to the interaction of gender and life as a refugee.

Furthermore, little emphasis has been given in the literature to gender-specific stressors in refugee women, and findings of gender differences with respect to mental health among persons exposed to political violence are inconsistent.

The complexity of the social context in which women live should be a therapeutic focus as women are key providers of emotional support in the family, and exposure to disaster may overload their capacity to cope as mothers.

Refugee women in mental health settings often share common traits and may experience direct fear for safety of themselves and their children, and continuous harassment that may lead to further disempowerment.

In order to empower them, the therapist and the patient have to look for common ground and agree on goals for treatment in recognition of cultural incongruities.

The paper will give an overview of the different kinds of traumata migrant women and children are exposed to both in country of origin and exile, and outline ways to optimize the fulfillment of refugee women's need for treatment with a particular focus on the rights of these women.

No. 21E
CLINICAL AND PUBLIC HEALTH ASPECTS OF INTIMATE PARTNER VIOLENCE

Helen Herrman, M.D., *Department of Psychiatry, University of Melbourne, P.O. Box 2900 Fitzroy, Melbourne Victoria 3065, Australia*

SUMMARY:

Freedom from discrimination and violence is among the social and economic factors recognized as particularly important for good mental health, along with social inclusion and economic participation. Conversely, violence in its various forms is linked with poor mental health and depression and associated risk behaviors including alcohol and drug abuse.

Violence against women and especially domestic violence is especially common and has serious effects on physical and mental health. Recent studies suggest that while intimate partner violence directed against women is often trivialized or seen as normal, in many countries it is common, has severe and persistent effects on women's physical and mental health, and has a high coat in terms of premature death and disability, for the woman and her family.

Systematic evaluation is needed of the mental health impact of violence reduction programs. Interventions include advocacy; addressing attitudes and social policies that condone violence; training clinical care staff to recognize understand, and manage the problems; introducing social policy and legal reforms and programs that focus on strenghtening intimate relationships, including parent training and marriage counseling.

REFERENCES:

1. Trafficking in Persons Report. Department of State, Washington, D.C. 2004.
2. Bhattacharya R (ed): Behind Closed Doors: Domestic Violence in India. New Delhi, Sage, 2004.
3. Njenga FG: Focus on psychiatry in East Africa. British Journal of Psychiatry 2002; 181:354-359.
4. Arcel LT, Genefke I, Kastrup M: Psychiatric problems related to torture, in Contemporary Psychiatry. Edited by Henn F, et al. Berlin, Springer Verlag, 2000.
5. World Health Organization: World Report on Violence and Health. WHO Geneva, 2002.

SYMPOSIUM 22—LARGE OBSERVATIONAL STUDIES OF ADHD: METHODOLOGY AND RESULTS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to compare and contrast ADHD as diagnosed and treated in the U.S. versus Europe.

No. 22A
EFFECT OF ATOMOXETINE IN A NATURALISTIC PEDIATRIC ADHD TREATMENT SETTING

Douglas K. Kelsey, M.D., *Department of Neuroscience, Eli Lilly and Company, Lilly Corporate Center, Indianapolis, IN 46285*; S. Malcolm, B.S., Rosalie Bakker, PH.D., M. Paczkowski, M.P.H., Virginia Sutton, Ph.D., Calvin R. Sumner, M.D.

SUMMARY:

Objective: The effectiveness of atomoxetine, a nonstimulant medication indicated for treatment of attention-deficit/hyperactivity disorder (ADHD), was evaluated in pediatric patients, as measured by the Physician Global Impression: ADHD Severity (PGI-ADHD-S) and parent reports.

Methods: Data were collected from children and adolescent patients in this non-interventional, prospective, observational, longitudinal, open-label study.Patients' physicians had decided to prescribe atomoxetine as initial treatment or to change to atomoxetine after trying another type of medication for treatment of ADHD, such as stimulants or antidepressants. Patients taking medications for treatment of various comorbid conditions were included in the stuey and could continue taking other medicatios concomitantly with atomoxetine. Pregnant and lactating females were excluded. Data were collected during routine psysician visits. Drug administration, dosing, and timing of follow-up visits were at physicians' discretion.

Results: Efficacy and comorbidity data, as well as additional results, will be presented.

Discussion: Although randomized, controlled trials have shown atomoxetine to be safe and efficacious for ADHD treatment, there have been no systematic studies gathering real-world information on its effectiveness in naturalistic treatment settings. Results of this first systematic study of atomoxetine in actual community practice will be discussed and compared to those of prior well-controlled clinical trials.

No. 22B
A TWO-YEAR, PAN-EUROPEAN, OBSERVATIONAL STUDY OF ADHD: OVERVIEW AND BASELINE

Ulrich Preuss, M.D., *Oberarzt, Kinder-u. Jugendpsych. Poliklinik, Effingerstrasse 12, Berne 3011, Switzerland*

SUMMARY:

Objective: To provide an overview of the ADORE study. The overall goal of ADORE is to describe who is the typical ADHD patient in Europe and how they are treated.

Methods: ADORE is a two-year, prospective, observational study. Approximately 1,500 patients were enrolled by 250 physicians across Europe. Patients were primarily enrolled if in the judgment of the investigator the patient has hyperactive/inattentive/impulsive symptos/problems; not been formally diagnosed with ADHD symptoms in the pasr; aged 6-18 years.

Results: Of all countries, the majority of patients came from Germany (27%), France (17%), Netherlands (15%), and United Kingdom (15%). Mean age is 9.0 years (SD 2.5). Patients are primarily boys (84%). A diagnosis utilizing the DSM-IV diagnostic criteria was given most frequently (46%). Mean ADHD rating scale score was 35.8 (SD 9.2). Most patients were prescribed pharmacotherapy (51%), psychotherapy (44%), or other treatment. An assessment of baseline and longitudinal information will be reported in the oral presentation.

Conclusion: Reported information highlights that ADHD is recognized, diagnosed, and treated in Europe.

No. 22C
A FACTORIAL AND GRAPHICAL MULTIDIMENSIONAL ANALYSIS OF PATIENTS IN ADORE

Bruno Falissard, M.D., *Unite de Sante Publique, Hopital Paul Brousse, 14 Av Paul Vaillant Couturier, Paris 94804, France*

SUMMARY:

Objective: To provide results from the attention-deficit/hyperactivity disorder observational research in Europe (ADORE) on the relationship between clinical rating scales and health outcomes/Quality-of-life scales.

Methods: ADORE is a two-year, prospective, observational study, with many research questions and a very large multidimensional dataset. Of formal scales, information was collected from the ADHD Rating Scale, Clinical Global Impression-Severity, Child Global Assessment Scale, the Strengths/Difficulties scale (SDQ), and Child Health and Illness Profile—Child Edition (CHIP-CE).

Results: In the oral presentation, descriptive item statistics and internal consistency (Cronbach's alpha) will be reported for the ADHD Rating-Scale, CHIP-CE, SDQ, CGI-S and CGAS. Additionally outcomes variables will be assessed such as: family burden, school and social activity. Additionally, factor analyses (exploratory/confirmatory) will be reported from the aforementioned scales. Intercorrelations between these scales will be assessed.

Conclusions: The presented analyses will help to provide more information on the relatioship between the scales used in ADORE. Additionally, this information will provide an interesting insight into the type of data being collected and the most important characteristics of enrolled patients.

No. 22D
OUTCOMES AND REGRESSION ANALYSIS: ADHD OBSERVATIONAL RESEARCH IN EUROPE

Manfred Doepfner, M.D., *Kindes-und Jugendalters der Universitat zu Ko, Robert-Koch-Str. 10, Koln 50931, Germany*

SUMMARY:

Objective: To present outcoes and regression analysis information on patients from the attention-deficit/hyperactivity disorder observational research in europe (ADORE) study.

Methods: ADORE is a two-year, prospective, observational study of 1,500 patients with attention-deficit/hyperactivity disorder (ADHD).

Results: Mean age was 9.0 years (SD 2.5) and primarily boys (84%). In school, 26% experienced some exclusions from lessons, 18% were in a special education, 5% were requested to change to a special needs school. For bullying, 24% were found to be the victim, whereas 23% were found to be the bully. For social activities, 28% reported no invites in the past four weeks, whereas 44% reported тthree invites. Information on parents found that 40% of mothers and 22% of fathers reported emotional problems. In the oral presentation, results of a regression analysis will be reported in order to predict the most important patient characteristics: ADHD severity, total problems, academic performance and general health.

Conclusions: ADHD is a diagnosable, neuyrobiological disorder, which if left untreated, can impact upon school performance, social interactions and parental outcomes.

REFERENCES:

1. Michelson D, Faries D, Wernicke J, Kelsey D, Kendrick K, Sallee FR, Spencer T, and the Atomoxetine ADHD Study Group: Atomoxetine in the treatment of children and adolescents with ADHD: a randomized, placebo-controlled, dose-response study. Pediatrics 2001; 108:e83.

2. Ralston SJ, Lorenzo MJ: ADORE-Attention-deficit hyperactivity disorder observational research in Europe. Eur Child Adolesc Psychiatry 2004; 13 Suppl 1:136–142.
3. Goodman R: The strengths and difficulties questionnaire: a research note. Journal of Child Psychology and Psychiatry 1997; 38:581–586.
4. Matza LS, Rentz AM, Secnik K, Swensen AR, Revicki DA, Michelson D, Spencer T, Newcorn JH, Kratochvil CJ. The link between health-related quality of life and clinical symptoms among children with attention-deficit hyperativity disorder. J Dev Behav Pediatr 2004; 25:166–174.

SYMPOSIUM 23—IMPROVING CARE FOR TRAUMA-RELATED PSYCHIATRIC DISORDERS IN GENERAL MEDICAL SETTINGS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to: (1) name the common trauma-related psychiatric disorders, (2) identify a common barrier to care for trauma-related psychiatric disorders, (3) describe a lesson from depression care to apply to primary care of trauma-related psychiatric disorders, and (4) explain "stepped care" and how it can help improve outcomes of acute traumatic injury survivors.

No. 23A
BARRIERS TO CARE AND PSYCHIATRIC DISORDERS AMONG IRAQ AND AFGHANISTAN VETERANS

Charles W. Hoge, M.D., *Department of Psychiatry & Behavioral Science, Walter Reed Army Institute of Research, 503 Robert Grant Avenue, Silver Spring, MD 20910-7500;* Carl A. Castro, Ph.D., Stephen C. Messer, Ph.D.

SUMMARY:

Objectives: To evaluate the barriers to care for trauma-related psychiatric disorders among U.S. soldiers returning from military operations in Iraq and Afghanistan.

Methods: Soldiers were surveyed before and three and six months after returning from Iraq or Afghanistan (n>4,000) using the Patient Health Questionnaire (PHQ) and PTSD checklist (PCL) and were asked about common barriers to mental health care.

Results: Overall, psychiatric disorders were common among soldiers returning from Afghanistan and Iraq. Among soldiers meeting survey criteria for depression, generalized anxiety disorder, and PTSD, 44% expressed interest in services and 24% accessed any services (including chaplains) in the past year. Significant barriers to care were reported, particularly for those most in need; 61% of soldiers who screened positive felt that seeking services would harm their career.

Conclusions: A significant proportion of combat soldiers returning from Iraq and Afghanistan met survey criteria for one or more psychiatric disorders. Significant barriers to use of mental health services were identified, speaking to the need to reassess service delivery and barrier and stigma reduction strategies.

No. 23B
IMPROVING PRIMARY CARE FOR PTSD: LESSONS FROM THE RESPECT-DEPRESSION PROJECT

Allen J. Dietrich, M.D., *Department of Community and Family Medicine, Dartmouth Medical School, 7250 Strasenburgh, Hanover, NH 03755*

SUMMARY:

Recent evidence from primary care settings suggests that PTSD, like depression, is often unrecognized and inadequately treated. The RESPECT-Depression Project (Re-Engineering Systems for the Primary Care Treatment of Depression) is an evidence-based model for systematic depression care that may serve as a model for improving the primary care recognition and management of PTSD. The approach uses psychiatrist-supervised case managers and codified collaboration between psychiatrists and primary care clinicians. In the RESPECT-Depression study, 59.9% of patients in intervention practices had improved 50% or more at six-month follow up compared with 46.6% in usual care practices (p=0.021). Six-month remission rates were 37.3% vs. 26.7% for usual care (p=0.014). Of intervention practice patients, 90% rated their depression care as good/excellent at six months versus 75% with usual care (p=0.0003). This presentation will review the RESPECT-Depression experience and current efforts to pilot a similar approach for improving PTSD care.

No. 23C
EARLY PTSD AND RISK BEHAVIOR INTERVENTION AFTER ADMISSION FOR ACUTE SURGICAL TRAUMA

Douglas F. Zatzick, M.D., *Harborview Medical Center, 325 9th Avenue, Box 359911, Seattle, WA 98104*

SUMMARY:

We conducted a randomized effectiveness trial of a stepped combined intervention for acutely injured trauma survivors. A population-based sample of 120 injured surgical inpatients were recruited from a level I trauma center. Intervention patients (N=59) received a stepped-care intervention that included: (1) continuous post-injury case management, (2) evidence-based pharmacotherapy and CBT targeting PTSD, and motivational interviewing targeting alcohol consumption. Control patients (N=61) received care as usual. Regression analyses demonstrated that over time intervention patients were significantly less symptomatic compared with controls with regard to PTSD (p<0.02) and alcohol abuse (p<0.05). Intervention patients also demonstrated a non-significant reduction in injury recurrence as documented by automated trauma center health service utilization records (adjusted odds ratio = 0.43, 95% CI = 0.10, 1.96). Early mental health interventions can be feasibly and effectively delivered from acute care centers. Future investigations that refine routine acute care treatment procedures may improve the quality of care for injured civilians and military personnel.

REFERENCES:

1. Engel CC, Jaffer A, Adkins J, Sheliga V, Cowan D, Katon WJ: Population-based health care: a model for restoring community health and productivity following terrorist attack, in Terrorism and Disaster: Individual and Community Mental Health Interventions. Ursano RJ, Fullerton CS, Norwood AE, Editors. New York: Cambridge University Press. 2003; pp. 287–307.
2. Hoge CW, Castro CA, Messer SC, McGurk D, Cotting DI, Koffman RL: Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. New England Journal of Medicine 2004; 351(1):13–22.

3. Dietrich AJ, Oxman TE, Williams JW Jr, Schulberg HC, Bruce ML, Lee PW, Barry S, Raue PJ, Lefever JJ, Heo M, Rost K, Kroenke K, Gerrity M, Nutting PA: Re-engineering systems for the treatment of depression in primary care: cluster randomised controlled trial. BMJ 2004; 9(2).
4. Zatzick, DF, Roy-Byrne P, Russo J, Rivara F, Droesch R, Dunn C, Wagner A, Jurkovich G, Uehara E, Katon W: A randomized effectiveness trial of stepped collaborative care for acutely injured trauma survivors. Archives of General Psychiatry 2004 61: 498–506.

SYMPOSIUM 24—THE PSYCHIATRIC EFFECTS OF THE WORLD TRADE CENTER ATTACK IN DISASTER RELIEF WORKERS
Collaborative Session With the National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants will be able to describe the psychiatric consequences of exposure to the WTC attack, appreciate the utility of various assessment methods of PTSD, and describe the variables that predict treatment readiness in this sample of disaster relief workers.

No. 24A
PREVALENCE AND PREDICTORS OF PTSD IN 2,960 MALE DISASTER RELIEF WORKERS FOLLOWING THE WORLD TRADE CENTER ATTACK

JoAnn Difede, Ph.D., *Department of Psychiatry, Weill Medical College of Cornell University, 525 East 68th Street, Box 200, New York, NY 10021*

SUMMARY:

The goal of this study was to identify the prevalence of PTSD and related symptoms among utility workers following the September 11th terrorist attack. Participants were 2,960 Consolidated Edison employees who were deployed to the site. Interviews were conducted as part of a medical screening program during an 18-month period commencing in June 2002 and included the Clinician Administered PTSD Scale (CAPS), selected modules of the SCID, and the Trauma History Interview, as well as self-report measures, including the Beck Depression Inventory (BDI) and PTSD Check List (PCL).

Using the full DSM-IV criteria, the CAPS yielded PTSD prevalence estimates of 8.0%. When only two of three Cluster C symptoms were required, the prevalence was 11.6%, while prevalence for subsyndromal PTSD (defined as meeting criteria for 2/3 symptom clusters) was 18.9%. Seven percent of participants (6.5%) reported current depression, 3.5% reported current GAD, and 2.5% reported current panic attacks. Results of a regression analysis indicate that prior psychiatric history, prior trauma history, feeling that ones life is in serious danger and witnessing body parts were predictors of PTSD. Our results underscore the importance of establishing screening programs for disaster relief workers and conducting controlled clinical trials for the treatment of PTSD.

No. 24B
CHILDHOOD SEXUAL ABUSE AS A PREDICTOR OF PSYCHIATRIC SYMPTOMS IN A SAMPLE OF DISASTER RELIEF WORKERS FOLLOWING A TERRORIST ATTACK

Pamela Leck, Ph.D., *Department of Psychiatry, Weill-Cornell Medical Center, 525 E. 68th ST Box 200, New York, NY 10021*

SUMMARY:

Recent research in the area of male childhood sexual abuse (CSA) suggests multiple long-term psychological sequelae. The current study examined the role of CSA in the symptomatology of utility workers deployed to the WTC site following the attacks of September 11th. The data presented include 847 subjects screened with self-report as well as clinician interview measures. Variables included extent of exposure to the site, past and current psychiatric diagnoses, and self-reported history of CSA. Frequency of CSA was reported at a rate of 4.8%. A statistically significant relationship ($F(846)= 5.34$, $p<.05$) was found between high scores on the Beck Depression Inventory (BDI) and endorsement of CSA. However, no significant relationship ($F(344)=1.8$, $p >.05$) was found between CSA and current posttraumatic stress disorder as measured on the Clinician Administered PTSD Scale (CAPS). These findings support previous research showing a significant relationship between CSA and depression throughout the life-span. The fact that a significant relationship was not found between PTSD and CSA is inconsistent with current literature. However, regression analysis revealed that CSA approached significance ($p=.072$) as a predictor of PTSD. Implications of these findings as well as further research into the effects of CSA in this population.

No. 24C
TREATMENT READINESS IN WORLD TRADE CENTER ATTACK DISASTER WORKERS

Nimali Jayasinghe, Ph.D., *Department of Psychiatry, Weill Medical College, 425 East 61st Street, 1358B, New York, NY 10021*

SUMMARY:

This study assessed treatment readiness in disaster workers referred for psychotherapy following the World Trade Center attacks. It addresses the concern that people enter psychotherapy out of self-indulgence rather than need—a concern reinforced in the disaster community by the view that stress brings out the best in workers. Three hundred and seventy-four disaster workers who had been deployed at the WTC in the aftermath of 9/11/01 and who were subsequently screened and diagnosed with posttraumatic stress disorder (PTSD) or related conditions were offered free psychotherapy. Forty-seven percent accepted referral, 29% only considered referral, and 25% declined. ANOVAs indicated the groups differed significantly on clinician and self-report measures of PTSD ($p < .001$) and post-hoc analyses showed workers who accepted or considered referrals had more severe PTSD symptoms than those who rejected referrals. In a follow-up screening, conducted one year later, approximately 54.5% of workers offered referrals accepted, while 20% considered, and 25.5% declined. Again, workers who accepted had more severe symptoms than those who rejected referrals ($p < .05$). Results suggest that disaster workers who accept psychotherapy referrals are those who are most distressed and, thus, underscore the value of making treatment available to this population.

No. 24D
SELF-REPORT VERSUS CLINICAL ASSESSMENT OF WORLD TRADE CENTER DISASTER WORKERS WITH PTSD

Frank W. Weathers, Ph.D., *Department of Psychology, Auburn University, 226 Thach Hall, Auburn, AL 36830*

SUMMARY:

This study presents data on the utility of structured clinical interviews as compared with self-report data in the assessment of PTSD among disaster relief workers (DRWs). Five hundred and nineteen utility workers who were deployed to the WTC site following the attacks of September 11, 2001, were assessed for PTSD symptoms through self-report with the Posttraumatic Stress Disorder Checklist (PCLC), and by interview with the Clinician Administered PTSD Scale (CAPS). Results showed similar prevalence estimates for a PTSD diagnosis, with an estimate of 9.6% for both the PCL and the CAPS. However, prevalence estimates of individual symptoms varied widely. Among Cluster B symptoms, the PCL yielded significantly higher prevalence than the CAPS for four of five symptoms ($p<.01$). For Cluster C, the PCL and the CAPS each yielded higher prevalence for three symptoms ($p<.05$). For Cluster D, the PCL and CAPS yielded similar prevalence estimates for all symptoms, with the exception of hypervigilance ($p<.001$). Our results suggest that both self-report and clinical measures yielded accurate clinical information. However, the use of the interview format allowed us to motivate the patient for treatment where appropriate. Thus, we conclude that the format chosen should be determined by the goal of the assessment.

REFERENCES:

1. Difede J, Roberts J, Jayasinghe N, Leck P: Evaluation and treatment of emergency services personnel following the World Trade Center attack, in Y. Neria, R. Gross, R. Marshall, & E. Susser (Eds.), September 11, 2001: Treatment, Research and Public Mental Health in the Wake of a Terrorist Attack. New York: Cambridge University Press, 2004.
2. Holmes W, Slap G: Sexual abuse of boys: definition, prevalence, correlates, sequelae, and management. Journal of American Medical Association 1998; 280(21): 1855–1862.
3. Koenen KC, Goodwin R, Struening E, Hellman F, Guardino M: Posttraumatic stress disorder and treatment seeking in a national screening sample. Journal of Traumatic Stress 2003; 16:5–16.

SYMPOSIUM 25—RESEARCH UPDATE ON PEDIATRIC BIPOLAR DISORDER
Collaborative Session With the National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the most up-to-date research in the phenomenology, pathophysiology, treatment, and outcome of pediatric bipolar disorder.

No. 25A
COURSE AND OUTCOME OF BIPOLAR YOUTH

Boris Birmaher, M.D., *Department of Psychiatry, University of Pittsburgh Medical School, 147 Vanderbilt Avenue, Pittsburgh, PA 15243;* Martin Retter, M.D., Michael Strober, Ph.D., David A. Axelson, M.D., Neal D. Ryan, M.D., Henrietta L. Leonard, M.D., Mary K. Gill, R.N., Sylvia Valeri, Ph.D.

SUMMARY:

Despite the growing evidence that the consequences of bipolar disorder (BP) arising during childhood can be devastating, the long-term course of BP in youth has been insufficiently studied. The main goal of this study was to assess the clinical course and predictors of outcome in a large sample of adolescents with bipolar spectrum disorders (BP-I, II, and NOS) recruited at three centers: Brown University, University of California Los Angeles (UCLA), and University of Pittsburgh Medical Center, Western Psychiatric Institute and Clinic (WPIC). For this presentation, we will show the preliminary analyses of the intake data of the first 300 children and adolescents recruited into the study and follow-up every six months for approximately 2.5 years. We found that children and adolescents with BP spectrum disorders are significantly impaired with high levels of mood and other psychiatric disorders, poor global functioning, high rates of suicidal behaviors and psychosis, and high family history of mood disorders. About 70% of the subjects showed recovery; however, of the subjects that recovered about 80% show at least one recurrence. During follow-up period subjects continued to show recurrent subsyndromal symptoms of BP disorder, particularly depression. At intake and during follow up children and adolescents with BP-NOS have levels of impairment, comorbidity, and family history comparable with the BP-I and II group. For this presentation, we will also analyze the effects of comorbid disorders and pharmacological treatment on outcome.

No. 25B
PREPUBERTAL MANIA: DIAGNOSIS, PROGNOSIS, FAMILY, AND MOLECULAR GENETICS

Barbara G. Geller, M.D., *Department of Psychiatry, Washington University School of Medicine, 660 South Euclid Avenue, Box 8134, Saint Louis, MO 63110*

SUMMARY:

Data from NIMH funded studies, begun in 1995, of a prepubertal and early adolescent bipolar disorder phenotype (PEA-BP) will be presented. PEA-BP was defined by current DSM-IV BP-I (manic or mixed phase) with elation and/or grandiosity to avoid diagnosing mania only by symptoms that overlapped with those for ADHD. Subjects were obtained by consecutive new case ascertainment to enhance generalization. Symptoms that best differentiated PEA-BP (N=93, age 10.9 [SD=2.6]) from ADHD (N=81) and healthy controls (N=94) were elation, grandiosity, decreased sleep need, racing thoughts/flight of ideas, and hypersexuality on WASH-U-KSADS separate interviews of parents and of children. PEA-BP resembled the severest form of adult BP with respect to chronicity (manic diagnoses mean 67% of weeks during four-year follow up), long episode duration (mean 79 consecutive prospective weeks), and ultradian cycling (77.4% had multiple cycles/day). Validation of PEA-BP was established by unique symptoms, stability of the diagnosis over four-year follow up (i.e., subjects did not become only ADHD), family study, and molecular genetic findings. Specifically, there was significantly higher familial aggregation of BP diagnoses among first-degree relatives of PEA-BP subjects compared with those of the ADHD and healthy control groups and the BDNF Val66Met polymorphism was in linkage disequilibrium with PEA-BP.

No. 25C
PHARMACOLOGICAL TREATMENT OPTIONS FOR CHILDREN AND ADOLESCENTS WITH BIPOLAR DISORDER

Melissa P. DelBello, M.D., *Department of Psychiatry and Pediatrics, University of Cincinnati, College of Medicine, 231 Albert Sabin Way, PO Box 670559, Cincinnati, OH 45267-0559*

SUMMARY:

Bipolar disorder is a common, often chronic, disorder with significant morbidity and mortality. Although the onset of bipolar disorder typically occurs during adolescence, relatively few placebo-controlled studies of pharmacological agents for the treatment of children or adolescents with bipolar disorder have been published. Recent investigations have identified a growing number of medications that

have demonstrated efficacy, effectiveness, and tolerability for treating adults with bipolar disorder. Moreover, each agent has specific adverse effects that may be less tolerable in children and adolescents than in adults. Additionally, children and adolescents with bipolar disorder commonly present with co-occuring attention deficit/hyperactivity and disruptive behavioral disorders, which complicates the diagnosis and treatment of bipolar disorder. We will examine the efficacy and tolerability of medications commonly used to treat children and adolescents with bipolar disorder. We will also examine recent data describing rational treatment strategies for treating children and adolescents with bipolar disorder and commonly co-occuring disorders.

No. 25D
PEDIATRIC BIPOLAR DISORDER AND THE UTILITY OF CARDINAL SYMPTOMS

Janet Wozniak, M.D., *Department of Psychiatry, Mass General Hospital, 185 Alewife Brook Parkway, Boston, MA 02138;* Joseph Biederman, M.D., Anne Kwon, M.S., Eric Milk, Ph.D.

SUMMARY:

This presentation examines the utility of cardinal symptoms in the symptom profile, patterns of comorbidity, and family history of a large sample of children and adolescents with bipolar disorder (N= 95) and their first-degree relatives (N=257). The sample is stratified by the presence or absence of euphoria, irritability, grandiosity, and classic cycling (versus chronicity) in order to examine whether these proposed cardinal symptoms result in meaningful subtypes of pediatric bipolar disorder. Results demonstrate no differences in symptom presentation, comorbidity, or family history. Outcome suggests few differences when stratifying by these characteristics and calls into question the usefulness of these cardinal symptoms in defining genetic subtypes of pediatric bipolar disorder.

No. 25E
NEUROBIOLOGICAL EVIDENCE OF PEDIATRIC PHENOTYPES

Daniel P. Dickstein, M.D., *Loma Linda University Medical Center, 25829 Van Leuven Street, Suite 164, Loma Linda, CA 92354;* Brendan Rich, Ph.D., Michael Milham, M.D., Erin McClure, Ph.D., Daniel S. Pine, M.D., Ellen Leibenluft, M.D.

SUMMARY:

Given the diagnostic controversy surrounding pediatric bipolar disorder (BPD), we are investigating clinically differentiable phenotypes of pediatric BPD. Specifically, we are studying two groups: narrow phenotype BPD subjects—meeting full DSM-IV mania criteria for elevated, expansive mood, and episode duration—and broad phenotype BPD subjects—meeting research criteria for chronic, rather than episodic, irritability and hyperarousal. We evaluated these phenotypes of pediatric BPD clinically, neuropsychologically, and neuroanatomically. Our results demonstrate that narrow and broad phenotype subjects are clinically distinct, as evidenced by different case presentations, including comorbid anxiety and its clinical correlates. Behavioral tasks indicate that narrow and broad phenotype subjects differ in how they respond to frustration. Neuroimaging data, including structural magnetic resonance imaging analyzed with voxel-based morphometry, shows that these two groups have volume reduction in different brain structures.

In conclusion, our study supports a clinically relevant model of emotion regulation deficits in phenotypes of pediatric BPD based upon neuropsychological and neuroimaging data.

REFERENCES:

1. Geller et al: Four-year prospective outcome and natural history of mania in children with a prepubertal and early adolescent bipolar disorder phonotype. Archives of Gen Psychiatry 2004; 61:459–467.
2. Geller B, Tillman R, Craney JL, Bolhofner K: Four-year prospective outcome and natural history of mania in children with a prepubertal and early adolescent bipolar disorder phenotype. Arch Gen Psychiatry 2004; 61:459–467.
3. Kowatch RA, DelBello MP: The use of mood stabilizers and atypical antipsychotics in children and adolescents with bipolar disorders. CNS Spectr 2003; 8:273–280.
4. Leibenluft E, Charney DS, Towbin KE, Bhangoo RK, Pine DS: Defining clinical phenotypes of juvenile mania. Am J Psychiatry 2003; 160(3):430–7, review.
5. Leibenluft E, Charney DS, Towbin KE, Bhangoo RK, Pine DS: Defining clinical phenotypes of juvenile mania. Am J Psychiatry 2003; 160:430–437.

SYMPOSIUM 26—THE BIOETHICS OF TREATING PSYCHOSES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe basic ethical concepts involved in treating patients with schizophrenia, including *autonomy, beneficence,* and *justice* in acute and long-term settings; review evidence on the efficacy and side effects associated with oral and depot antipsychotics in long-term treatment.

No. 26A
INFLUENCE OF MOOD STATE ON CAPACITY TO CONSENT TO RESEARCH IN BIPOLAR PATIENTS

Sahana Misra, M.D., *Department of Psychiatry, Oregon Health & Science University, 3140 South West Dosch Road, Portland, OR 97239;* Linda K. Ganzini, M.D.

SUMMARY:

Manic patients must be included in research; in their absence, advances cannot be made. Yet concern has been raised regarding the capacity of manic patients to consent to participation in research. We compared manic and euthymic bipolar patients in their understanding and appreciation of important components of three hypothetical research protocols, their reliance on others to make the decision to participate, and their susceptibility to influence by motivators, such as payment. In this cross-sectional survey, manic (Young Mania Rating Scale ≥ 7) and euthymic bipolar patients were asked to imagine that they were invited to participate in three different research protocols. Studies were described through hypothetical consent forms. The low risk protocol described a blood draw study. Higher risk protocols described two studies: one comparing an experimental medication with their current medication, and the other a placebo-controlled medication trial. We assessed patients' understanding and appreciation of risks and benefits, their willingness to participate, and the influence of motivating factors and people, such as mental health providers and family, on their decisions to agree or not agree to participate in the hypothetical studies. To date, 19 manic patients and 14 euthymic patients have completed participation. Information will be analyzed and presented.

No. 26B
THE UNINTENDED CONSEQUENCES OF ANTIPSYCHOTIC THERAPY FOR SCHIZOPHRENIA

Michael R. Arambula, M.D., *Department of Psychiatry, University of Texas Health Science, 14800 U.S. 281 North, #110, San Antonio, TX 78232*

SUMMARY:

Schizophrenia perhaps poses a more difficult challenge to the treating clinician than other mental illnesses. Psychopathology typically possesses both positive and negative symptoms that wax and wane over the course of a lifetime; and by inference ever-changing variables so important in the informed consent process. Complicating matters, antipsychotic agents carry some risk of exposing patients to unintended, potentially harmful effects. Depending on clinical circumstances, the treating clinician may need to consider more paternalistic treatment approaches to nurture patient autonomy; paralleling clinical approach to the pattern of positive/negative symptom patterns that exist then. Certainly, legal standards appear far more concrete than the sea of ethical considerations that lay beneath their shared spirit. This brief presentation will attempt to elucidate the basis for utilizing this unbalanced, yet balanced treatment approach.

No. 26C
THE UNIQUE CASE OF PSYCHOTIC CRIMINAL DEFENDANTS

Paul S. Appelbaum, M.D., *Department of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, MA 01655*

SUMMARY:

Treatment of psychotic defendants to render them competent to stand trial implicates a complex set of ethical concerns. Defendants may have an interest in receiving treatment, but may also have strategic worries about the effects of treatment. State interests range from protecting other inmates and staff from dangerous psychotic prisoners to rendering defendants competent so a trial can take place. Prior to the 1980s, state interests were assumed to be dominant, and treatment was usually administered on the authorization of the attending physician. However, once courts began to define a right for civilly committed patients to refuse medication, questions immediately arose about its applicability to incarcerated defendants. In Riggins v. Nevada, the U.S. Supreme Court held that if treatment is to be administered, it must be in the defendant's medical interest to do so, but whether treatment could be refused for strategic legal purposes was left undecided. More recently, in Sell v. U.S., the Court returned to this question, holding that there may be instances when the state can override refusal by incompetent, psychotic defendants, but setting limits on those instances and erecting procedural barriers. This presentation considers how the conflicting interests of defendants and state can best be accommodated.

REFERENCES:

1. Misra S, Ganzini L: Capacity to consent to research among patients with bipolar disorder. J Affective Disorders 2004; 80:115–123.
2. Caro J, Ward A, Levinton C, Robinson, Kopala L: The risk of developing diabetes in users of atypical antipsychotics. Annual meeting of the American College of Neuropsychopharmacology (ACNP). San Juan, Puerto Rico, 2000. p. 332.
3. Appelbaum PS: Treating incompetent defendants: the Supreme Court's decision is a tough *sell.* Psychiatric Services 2003; 54: 1335–6, 1341.

TUESDAY, MAY 24, 2005

SYMPOSIUM 27—NEUROSCIENCE FOR THE PSYCHIATRIST, PART 1: NEUROIMAGING FROM GENOMICS TO THERAPY
Collaborative Session With the National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the impact of recent advances in functional neuroimaging on current and future psychiatric practice.

No. 27A
IMAGING GENOMICS IN PSYCHIATRY

Andreas Meyer-Lindenberg, M.D., *6CAP, National Institute of Mental Health, 9000 Rockville Pike, 10-4C101, Bethesda, MD 20892-1365*

SUMMARY:

The continued progress in charting the sequence and variation of the human genome transforms all branches of medicine, but none more so than psychiatry, where the elucidation of genetic factors not only aids research into susceptibility and therapy but also delivers invaluable pointers to the basic pathophysiology and definition of the disorders themselves. Neuroimaging, which accesses brain function on the level of neuronal systems, is ideally positioned to help answer the uniquely psychiatric problem of understanding how genomic mechanisms lead, through a multitude of intermediate steps, to abnormal mental and behavioral states. The presenter reviews recent work of the NIMH Genes, Cognition, and Psychosis program in this field, focusing on two lines of inquiry: 1) the mapping of neural effects of genomic variation assessed with single nucleotides (SNPs) and haplotypes, examining both brain function (MRI, PET) and structure (voxel-based morphometry) and 2) strategies and results in studying small deletion syndromes to narrow down the search for genes responsible for aspects of cognitive function, with Williams syndrome and visuospatial construction as examples.

No. 27B
FMRI: BASICS AND BEYOND

Peter A. Bandettini, Ph.D., *FMRIF, National Institute of Mental Health, 10 Center Drive, Building 10, Room 1080, Bethesda, MD 20892-1148*

SUMMARY:

Functional MRI (fMRI) has been in existence since 1992. Since then, the technique has experienced explosive growth. The reasons for this growth include: 1) demonstrated robustness and reproducibility, 2) minimal invasiveness, 3) the wide availability of the necessary hardware, 4) the unique functional spatial and temporal resolution niche of fMRI, 5) the continually increasing accuracy of the interpretation of the functional contrast, and most important 6) the potential that it promises.

The evolution of fMRI as a whole can perhaps be better understood as the co-development of four components: technology, methodology, interpretation, and applications. The technology component consists of the hardware, pulse sequences used, and techniques used

for subject interface. The methodology component consists of methods by which the fMRI experiment is carried out—from paradigm design to processing. The interpretation component is essentially how neuronally meaningful and useful the fMRI signal change dyanamics, magnitude, linearity, and heterogeneity are. Last, the application component is the receiver of this understanding and the driver of the development of the other three components.

The presenter provides an overview of fMRI from this four-component perspective. The most innovative utility of fMRI has been in studies where there has been a balance and clear integration of each component. The presenter highlights the basics of fMRI as they relate to these components and discusses, within the structure of these components, some of the current limitations, opportunities, and prospects of fMRI. Last, an overview of how fMRI has been and could be used in the context of psychiatric research and clinical applications is provided.

No. 27C
UNDERSTANDING SCHIZOPHRENIA USING FUNCTIONAL BRAIN IMAGING

Cameron Carter, M.D., *Department of Psychiatry, University of California-Davis, 4701 X Street, Sacramento, CA 95817*

SUMMARY:

Over the past decade it has become possible to noninvasively image the function of the human brain in close to real time as subjects perform psychological tasks. This approach has been particularly informative in understanding abnormal brain behavior relationships in schizophrenia. It has begun to provide important clues as to the causes of schizophrenia and potentially may become an important way to increase our understanding of the effects of treatment for the illness and to facilitate the development of novel treatments for refractory symptoms. Cognitive deficits are among the most disabling and treatment refractory aspects of schizophrenia, and functional MRI studies have shown that there is a close relationship between the function of the dorsolateral prefrontal cortex (DLPFC) and these deficits. These deficits are linked, in turn, to behavioral disorganization in the illness. Hence functional imaging studies have identified a behavioral phenotype of schizophrenia (disorganization) linked to an impairment of cognitive functions supported by the DLPFC. New data are presented that shed light on the neurobiological underpinnings of this phenotype and its relationship to illness-related genes, and the clues that these data provide for possible treatments for impaired cognition in schizophrenia are reviewed.

No. 27D
LINKING IMAGING AND TREATMENT MECHANISMS FOR DEPRESSION

Helen S. Mayberg, M.D., *Department of Psychiatry, Emory University, 101 Woodruff Circle, WMRB Suite 4313, Atlanta, GA 30322*

SUMMARY:

Although there are many effective options for treating a major depressive episode, there are no brain-based markers that either help guide treatment selection or monitor treatment response. In prioritizing a future role for direct measures of brain functioning using neuroimaging in the development of new algorithms for clinical management of depressed patients, a systematic characterization of brain changes associated with response and nonresponse to specific treatments, as well as of pretreatment patterns predictive of such responses, is the necessary first step. Toward this goal, the presenter's group has characterized two distinct brain change patterns using positron emission tomography (PET) measures of resting state brain glucose metabolism that are associated with depression remission in patients treated with cognitive therapy and SSRI pharmacotherapy, respectively. In addition, pretreatment brain subtypes have been characterized that appear to predict response and nonresponse to these two treatments. These findings are discussed and interpreted in the context of a putative limbic-cortical neural systems model involving the interactions of the subgenual cingulate (BA25) with the rostral anterior cingulate (BA24), hippocampus, and medial (BA10), orbital frontal (BA11), and lateral prefrontal cortex (BA9). This work is an example of the use of neuroimaging methods to elucidate the circuitry underlying treatment mechanisms and improve our ability to predict treatment response.

REFERENCES:

1. Meyer-Lindenberg A, Kohn P, Mervis CB, et al: Neural basis of genetically determined visuospatial construction deficit in Williams syndrome. Neuron 2004; 43:623–631.
2. Mayberg HS: PET imaging in depression: a neurosystems perspective. Neuroimaging Clin N Am 2003; 13:805–815.
3. Bellgowan PS, Saad ZS, Bandettini PA: Understanding neural system dynamics through task modulation and measurement of functional MRI amplitude, latency, and width. Proc Natl Acad Sci USA 2003; 100:1415–1419.
4. MacDonald AW 3rd, Pague-Geile MF, Johnson MK, et al: A specific deficit in contex processing in the unaffected siblings of patients with schizophrenia. Arch Gen Psychiatry 2003; 60:57–65.

SYMPOSIUM 28—REAL LIFE MEDICAL MANAGEMENT OF HIV

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) understand the medical, epidemiological, and treatment issues associated with HIV/AIDS; (2) recognize the challenges psychiatrists face when diagnosing and treating people living with HIV; and (3) identify practical tools for treating HIV-related mental illness.

No. 28A
HIV TREATMENT UPDATE

Jeffrey L. Lennox, M.D., *Department of Medicine, Emory University School of Medicine, 341 Ponce de Leon Avenue, N.E., Atlanta, GA 30308-2012*

SUMMARY:

Psychiatrists often have limited resources and clinical expertise to provide care for people living with HIV. Antiretroviral regimens are highly complex. This session offers an update on current and future epidemiological trends. The presenter reviews the pathogenesis of HIV infection, HIV RNA testing, and current antiretrovirals available to patients. The presenter reviews treatment guidelines, offers recommendations for antiretroviral therapy, and suggests goals in caring for HIV-infected patients. The focus throughout the session will be on current vulnerable and at-risk populations. This session provides up-to-date epidemiological information and guidelines for antiretroviral therapy. A question-and-answer period provides participants with the opportunity to discuss individual clinical concerns with the expert panel.

No. 28B
MANAGING MOOD DISORDERS

Sanjay M. Sharma, M.D., *Department of Psychiatry, Emory University School of Medicine, 341 Ponce de Leon Avenue, N.E., Atlanta, GA 30308*

SUMMARY:

Mood disorders are the most frequent psychiatric complication associated with HIV infection. Multiple effective therapeutic strategies are available to manage the psychiatric complications of HIV-related mood disorders. Mood disorders may be secondary to HIV complications or its treatment. The presenter reviews probable risk factors for depression in HIV, DSM-IV depressive disorders, and differential diagnosis and describes diagnosis and treatment options for minor cognitive motor disorder and mania. The session ends with a review of general points on psychopharmacology. The session provides diagnostic evaluation and pharmacologic treatment information for psychiatrists working with HIV/AIDS patients.

No. 28C
MANAGING HEPATITIS C, SYPHILIS, AND HIV INFECTION

Annette M. Matthews, M.D., *Department of Psychiatry, Oregon Health Science, 3591 S.E. Francis, #E, Portland, OR 97202*

SUMMARY:

As HIV becomes a global problem, co-infection will become a global problem. The presenter examines the problem of co-infection in HIV-positive-patients. Hepatitis C virus coinfection, for example, is present in about 30% of those with HIV. The presenter offers guidelines for the differential diagnosis of the HIV-infected patient and outlines treatment strategies for the patient. Tools for evaluating the patient who has co-occurring HIV/AIDS and hepatitis C infection are assessed. Successful treatment interventions and models are shared with the audience. The workshop closes with a question-and-answer period, providing participants with the opportunity to discuss individual clinical problems.

No. 28D
MANAGING PSYCHOSIS

Shahrad R. Amiri, M.D., *Department of Psychiatry, Cedars-Sinai Medical Center, 8730 Alden Dr. w-101, Los Angeles, CA 90048*

SUMMARY:

Approximately 8% of HIV-infected patients have a type of psychosis diagnosed. It may be particularly difficult to diagnose and treat patients with HIV-related psychosis. The presenter reviews how to diagnose psychosis, including differential diagnosis, treatment concerns, the use of antipsychotics, and the prognosis of people living with HIV. Finally, the presenter looks at future directions in the treatment and care of people living with HIV who develop psychosis. Current information on risk reduction and treatment adherence are included in this segment. After the didactic portion of this session, time is provided for participants to ask questions and review individual clinical cases.

No. 28E
MANAGING METABOLIC SYNDROMES

Marshall Forstein, M.D., *Department of Psychiatry, Harvard Medical School, 24 Olmstead Street, Jamaica Plain, MA 02130-2910*

SUMMARY:

HIV infection and antiretroviral therapy are associated with a variety of metabolic disorders, including, but are not limited to, AIDS wasting syndrome, metabolic dysregulation, lipodystrophy, abnormalities of serum lipids, and lactic acidosis. The presenter discusses issues that arise for HIV-infected patients who are diagnosed with a metabolic syndrome. These issues include body image, impact on mood, and reproductive concerns. Treatment therapies that can be used to improve long-term health in individuals infected with HIV are discussed. The session includes a lecture and a question-and-answer period providing participants with the opportunity to discuss individual clinical concerns with the expert panel.

REFERENCES:

1. Panel on Clinical Practices for Treatment of HIV Infection: Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents. Bethesda, MD, Department of Health and Human Services, Henry J. Kaiser Family Foundation, 2004.
2. Slotten R: Coping with depression. Posit Aware 2004; 15:38–41.
3. Rockstroh JK, Spengler U: HIV and hepatitis C virus co-infection. Lancet Infect Dis 2004; 4:437–444.
4. Kane JM, Leucht S, Carpenter D, et al: Expert consensus guideline series. Optimizing pharmacologic treatment of psychotic disorders. Introduction: methods, commentary, and summary. J Clin Psychiatry 2003; 64(suppl 12):5–19.
5. Nolan D: Metabolic complications associated with HIV protease inhibitor therapy. Drugs 2003; 63:2555–2574.

SYMPOSIUM 29—PSYCHOSOMATIC MEDICINE: INTEGRATING EPIDEMIOLOGY, PSYCHIATRY, AND MEDICINE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to promote the combination of disciplines in the investigation of psychosomatic medicine.

No. 29A
RISK OF MYOCARDIAL INFRACTION ASSOCIATED WITH PANIC DISORDER

Andres Gomez-Caminero, Ph.D., *Bristol-Myers Squibb, 311 Pennington Rocky Hill Road, Pennington, NJ 08534;* William Blumentals, Ph.D., Leo Russo, Ph.D., Ruby C. Castilla-Puentes, M.D.

SUMMARY:

Panic disorder (PD) has been associated with an increase of coronary artery disease. However, a causal relationship has not been demonstrated up to now. The presenter describes a study in which a cohort of patients with a diagnosis of panic disorder were followed and the occurrence of a subsequent myocardial infarction diagnosis was noted. The association between PD and acute myocardial infarction (AMI) was examined in the Integrated Health Care Information Services National Managed Care Benchmark Database (IHCIS), a fully de-identified, HIPAA-compliant database. A total of 39,920 PD patients and a comparison cohort of patients without PD were included in the retrospective cohort study. Cox regression models were conducted to obtain the adjusted risk of AMI after accounting for age at PD diagnosis, smoking, obesity, depression, and use of medications. The cohort of patients with PD were observed to have a twofold increase in the risk for AMI (HR = 1.87, 95% CI = 1.80–1.91) after adjustment for age at PD diagnosis, smoking, obesity, and use of ACE inhibitors, beta-blockers, and statins. The risk of AMI associated with a diagnosis of PD suggests the need for close monitoring by psychiatrists of these patients in order to ensure a reduction in the risk of AMI.

No. 29B
PREVALENCE OF DEPRESSIVE DISORDERS IN PATIENTS WITH DEMENTIA IN IHCIS

Dimitri Bennett, M.D., *Department of Epidemiology, GlaxoSmith-Kline, 1250 South Collegeville Road, UP4305, Collegeville, PA 19426;* Tim Sampson, B.S.

SUMMARY:

Objective: To determine one-year prevalence of Alzheimer's disease, vascular dementia, and unspecified dementia, and prevalence of depressive disorders in patients over age 60 with a diagnosis of dementia in the Integrated Health Care Information Services (IHCIS) population.

Design: Cross-sectional analysis of the IHCIS population age 60 years or older, restricted to the year 2001.

Methods: We used the IHCIS claims database to estimate one-year prevalence of dementia subtypes for the year 2001 and the prevalence of depressive disorders.

Results: Among the 488,091 patients with a full year of eligibility during 2001, 6,440 (1.3%) were identified with a diagnosis of dementia and 63.6% were women. The prevalence of dementia by age group was 0.16% (60–64), 0.38% (65–69), 1.06% (70–74), 2.21% (75–77), and 5.97% (78 and older); the prevalence of Alzheimer's disease was 0.60%, vascular dementia 0.15%, and unspecified dementia 0.57%. The prevalence of depressive disorders was much higher in the vascular dementia group (44.14%) and unspecified dementia group (32.48%), compared with Alzheimer's group (18.53%). The prevalence of depressive disorders in a random selection of matched nondemented patients was 3.45%.

Conclusions: Depressive disorders are common comorbidities or complications of dementia, especially in patients with vascular and unspecified dementia, and physicians should be alert to the presence of this clinically important disease.

No. 29C
DIABETES AND LIPID PROFILE RISKS WITH NEUROLEPTICS: TWO- TO FIVE-YEAR OUTCOME

Robert C. Joseph, M.D., *Cambridge Health Alliance, 1493 Cambridge Street, Cambridge, MA 02139;* Nicole Danforth, M.D., Gayle Goren, M.D., Marianne Kardos, M.D., Tamara B. Pardo, B.A., Grace Wyshak, Ph.D., Nassir Ghaemi, M.D.

SUMMARY:

The presenter describes a cross-sectional assessment of hemoglobin A_{IC}, fasting blood sugar, and lipid profile in patients with bipolar disorder or schizophrenia who received antipsychotic monotherapy ≥ 3 months. Medications assessed were clozapine (N=31), olanzapine (N=18), risperidone (N=13), and conventional antipsychotics (N=11). Mean duration of treatment was 3.4 years. Patients with preexisting diabetes were excluded. Analyses included univariate analyses and multivariable linear regression models to adjust for confounders and identify predictors. In the univariate analyses, clozapine was associated with elevated diabetes risk and olanzapine was not associated with elevated cholesterol levels. However, in the regression models, numerous confounding factors were identified, including BMI, ethnicity, and duration of treatment. The strongest predictor of hypoglycemia appeared to be ethnicity, and the strongest predictor of hypercholesterolemia was past diagnosis with that condition. After adjustment for these variables and other confounding factors, the effect of clozapine on diabetes risk was attenuated and the effect of olanzapine on risk of hypercholesterolemia appeared more evident. Risperidone and traditional neuroleptics were not associated with those risks in any analysis. These findings highlight the importance of adjustment for confounding factors in epidemiological studies of antipsychotics and metabolic syndrome, both to avoid false positive associations and to more clearly bring out real associations.

No. 29D
SOMATIC COMPLAINTS IN TRAUMATIZED CHILDREN

Ruby C. Castilla-Puentes, M.D., *World Wide Epidemiology, Glaxo-SmithKline, PO Box 5089, Collegeville, PA 19426;* Ivan S. Gomez, M.D., Sandra R. Castilla-Puentes, M.D., Wilma I. Castilla-Puentes, M.D., Gilma R. De Contreras, M.S.W., Maria C. Caballero, R.N., Miguel Habeych, M.D.

SUMMARY:

The presenter describes the results of a study to identify the most common physical complaints in a sample of children and adolescents living in a rural area of Colombia, South America. Whether somatic symptoms are more likely to be associated with the witness of traumatic events, high levels of anxiety, or high levels of depression was also explored. A total of 300 school-aged children/adolescents from a stratified, random sample of schools in a rural area in Belen, Boyacá, Colombia, were ascertained. Children and their parents and teachers were assessed with the Screen for Child Anxiety Related Emotional Disorders (SCARED), Children's Depression Inventory (CDI), a screen for alcohol and substance abuse, as well as a sociodemographic questionnaire and an inventory of traumatic events and somatization symptoms. The most common somatic complaint was in the gastrointestinal category. In simple regression analyses, anxiety level as measured with the SCARED significantly predicted the presence of somatic symptoms. Although the correlation between depression from the CDI score and somatic symptoms approached significance ($r = 0.11$, $p = 0.061$), the correlation between anxiety levels from the SCARED score and somatic symptoms was significant ($r = 0.36$, $p = 0.001$). The finding that somatic complaints are commonly an expression of underlying anxiety may facilitate treatment and thereby help avoid unnecessary medical workups and sequelae in traumatized children.

No. 29E
A CASE-CONTROL STUDY OF ERECTILE DYSFUNCTION AMONG MEN DIAGNOSED WITH PANIC DISORDER

William Blumentals, Ph.D., *Department of Epidemiology, Proctor and Gamble, Cincinatti, OH 45267;* Andres Gomez-Caminero, Ph.D., Leo Russo, Ph.D., Regina Brown, M.S., Vanni Jannappagari, M.S.

SUMMARY:

The association between panic disorder and erectile dysfunction (ED) among men was examined in the Integrated Health Care Information Services National Managed Care Benchmark Database (IHCIS). A total of 60,949 ED patients and 243,796 control subjects were included in the analysis. Unconditional logistic regression analyses were first performed to assess the crude risk of ED and adjusted risks of ED that accounted for comorbid conditions and comedications. A second set of analyses measured the crude and adjusted risks after restricting the patient population to men who received a diagnosis of panic disorder at least 1 month before an ED diagnosis. In the first set of analyses, men with panic disorder were observed to have more than a twofold increase in risk for ED (OR = 2.29, 95% CI = 2.03–2.58). After adjusting for comorbid conditions, a 52% increase in risk of ED was observed (OR = 1.52, 95% CI = 1.34–1.72). Following subsequent adjustment for comorbidities and comedications, a 33% increased risk of ED was detected (OR = 1.33, 95% CI = 1.17–1.51). In the second set of analyses studying panic

disorder that preceded ED, only a 13% higher risk was noted (OR = 1.13, 95% CI = 0.97–1.31).

REFERENCES:

1. Druss BG, Rohrbaugh RM, Levinson CM, et al: Integrated medical care for patients with psychiatric illness. Arch Gen Psychiatry 2001; 58:861–868.
2. Fleet R, Lavoie K, Beitman BD: Is panic disorder associated with coronary artery disease? A critical review of the literature. J Psychosom Res 2000; 48:347–356.
3. Üstün TB, Rehm J, Chatterji S, et al: Multiple-informant ranking of the disabling effects of different health conditions in 14 countries. Lancet 1999; 354:111–115.
4. McIntyre RS, McCann SM, Kennedy SH: Antipsychotic metabolic effects: weight gain, diabetes mellitus and lipid abnormalities. Can J Psychiatry 2001; 46:273–281.
5. Bernstein GA, Borchardt CM, Perwien AR: Anxiety disorders in children and adolescents: review of the past 10 years. J Am Acad Child Adolesc Psychiatry 1996; 35:1110–1119.

SYMPOSIUM 30—THE ART AND SCIENCE OF BRIEF THERAPIES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to have a working overview of three eminently schematized and teachable approaches to short-term therapy: solution-focused therapy, behavior therapy, and cognitive therapy.

No. 30A
EXPECTANCY, THE IGNORED COMMON FACTOR: CREATING HOPE IN PSYCHOTHERAPY

Roger P. Greenberg, Ph.D., *Department of Psychiatry, State University of New York, Upstate Medical, 750 East Adams Street, Syracuse, NY 13210*

SUMMARY:

Research has consistently shown that psychotherapy is beneficial to patients. For example, a classic meta-analysis of 375 studies found that 75% of patients receiving psychotherapy treatments did better than those who did not. However, head-to-head studies comparing different models of psychotherapy have typically demonstrated equivalent outcomes among different brands of psychotherapy. This finding has led to the speculation that psychotherapy benefits are more a product of factors common to different approaches than to ingredients unique to any single psychotherapy model. Objectives for this presentation are to review the case for the common-factors explanation of psychotherapy benefits and to highlight the importance of variables such as patient expectations and pretherapy patient characteristics in determining how successful psychotherapy will turn out to be. The presentation also looks at the placebo effect. The presenter suggests that the placebo effect is a potent (and not inert) factor in generating therapeutic results for psychotherapy, as well as medication treatments. Implications for practice are addressed in terms of therapist behaviors that have proven to be either helpful or harmful.

No. 30B
SOLUTION-FOCUSED BRIEF THERAPY: DOING WHAT WORKS

Brett Steenbarger, Ph.D., *Department of Psychiatry, State University of New York, Upstate Medical, 750 East Adams Street, Syracuse, NY 13210*

SUMMARY:

Solution-focused therapy is a highly manualized approach to brief therapy that is particularly applicable for patient populations with adjustment disorders and normal developmental life concerns. Accordingly, it is one of the easiest and least threatening therapies for residents who are beginning to learn psychotherapy. In this presentation, the practice essentials of solution-focused therapy are outlined in engaging flow charts and case examples, mirroring the way in which they are taught to developing therapists. Particular emphasis is placed on using the practice elements of solution-focused brief therapy to teach, model, and practice such core therapeutic skills as establishment of a working relationship, assessment, development of a treatment focus, active intervention, and relapse prevention. The presentation also highlights process and outcome research into solution-focused therapy and implications for practice. These implications include ways in which solution-focused methods can be adapted for use in inpatient therapy and in the context of longer-term supportive modalities.

No. 30C
BRIEF INTERPERSONAL THERAPY

Scott Stuart, M.D., *Department of Psychiatry, University of Iowa, 200 Hawkins Drive, Iowa City, IA 52242*

SUMMARY:

Interpersonal therapy (IPT) is a time-limited, dynamically informed therapy that focuses specifically on interpersonal relationships to bring about change, by helping patients to either modify their interpersonal relationships or change their expectations. IPT also assists patients in improving their support network. In this presentation, the strong empirical validation of this therapy and the theoretical underpinnings are briefly discussed and a detailed, step-by-step description is provided of the essentials of assessment and the tasks to be completed in initial sessions, intermediate sessions, at completion of acute treatment, and in the maintenance phase. Specific therapeutic techniques that are valuable at each stage are discussed. Problem areas that are particularly well suited to IPT are grief, interpersonal disputes, role transitions, and interpersonal sensitivity. This presentation is richly illustrated with many clinical examples.

No. 30D
COGNITIVE THERAPY: PRACTICE AND TRAINING

Judith S. Beck, Ph.D., *Cognitive Therapy & Research, The Beck Institute, 1 Belmont Avenue, Suite 700, GSB Bldg, Bala Cynwyd, PA 19004-1610*

SUMMARY:

Cognitive therapy has demonstrated clinical efficacy for a variety of presenting concerns, including depression, anxiety, and personality disorders. This presentation uses case examples to present the practice basics of cognitive therapy and seven components of teaching cognitive therapy to residents in psychiatry. These steps include formulating the case according to the patient's diagnosis, conceptualizing individual patients according to the cognitive model, using case formulation to plan treatment within and across sessions, establishing and maintaining a strong therapeutic alliance, structuring therapy sessions effectively, implementing cognitive and behavioral techniques, and assessing the efficacy of treatment. Specific strategies for conducting and teaching cognitive therapy are reviewed for each of the steps. These strategies include the use of didactic lectures, text material on cognitive therapy, demonstration roleplays, audio and videotapes of master cognitive therapists, conceptualization worksheets, and case formulation exercises. Also highlighted is the

use of the Cognitive Therapy Rating Scale, a standardized instrument for assessing competency and guiding clinical supervision.

REFERENCES:

1. Miller SD, Hubble M, Duncan BL (eds): Handbook of Solution-Focused Brief Therapy. San Francisco, Jossey Bass, 1996.
2. Stuart S, Robertson M: Interpersonal Therapy: A Clinician's Guide. London, Edward Arnold, 2003.
3. Dewan M, Steenbarger B, Greenberg R (eds): The Art and Science of Brief Psychotherapies. Arlington, VA, American Psychiatric Publishing, 2004.

SYMPOSIUM 31—POSTTRAUMATIC STRESS AND MEDICAL ILLNESS: INTERDISCIPLINARY PERSPECTIVES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the symptoms of posttraumatic stress disorder in medically ill patients.

No. 31A
PTSD IN MEDICALLY ILL ADULTS AND CHILDREN: A REVIEW

Eyal Shemesh, M.D., *Department of Psychiatry, Mount Sinai Medical Center, Box 1230, 1 Gustave Levy Place, New York, NY 10029*

SUMMARY:

Symptoms of PTSD have been reported in adults and children who are suffering from a variety of medical illnesses or have undergone medical procedures. The presenter focuses on the traumatic impact of the illness itself, although PTSD in medically ill patients can also occur as a result of unrelated traumas. First, the presenter reviews existing reports on the prevalence of significant PTSD symptoms across several disease processes (such as malignancy, myocardial infarction, transplant operations) and discusses the effect of timing of the assessment of prevalence. Second, the presenter's group's findings as they relate to the manifestations and outcome of PTSD symptoms in children who had a transplant and in adults who had a myocardial infarction are reviewed. The apparent impact of PTSD symptoms on medical outcome, and in particular published findings linking PTSD symptoms to poor adherence to medical recommendations in children and adults, are discussed. The presenter's group has been studying PTSD symptoms in both adults and children, and the presentation ends with a discussion of differences in the phenomenology as well as progression of PTSD symptoms across the lifespan in medically ill patients.

No. 31B
PTSD SYMPTOMS IN CHILDREN WHO HAD TRANSPLANTS: ONE CENTER'S EXPERIENCE

Sukru Emre, M.D., *Recanati-Miller Transplant Institute, Mount Sinai Medical Center, Box 1104, 5 East 98th Street, New York, NY 10029-6574*

SUMMARY:

Under the presenter's directorship, the Mount Sinai Medical Center's pediatric liver transplant program has been engaged in the study of PTSD symptoms and their effects on patients' medical and psychosocial outcomes. While the research effort is being pursued, the focus on posttraumatic reactions has also led to modifications to and additions of clinical programs. In a pilot survey, center researchers found that as many as 30% of patients report significant PTSD symptoms and that these symptoms are associated with nonadherence to medical recommendations. The presenter's group therefore decided to focus clinical and research efforts on early identification of nonadherence and posttraumatic stress in patients. The presenter describes a typical course of a child with a diagnosis of liver disease who goes through a transplant operation, and discusses the specific points along this course that are reported as most traumatic by patients. The presenter then describes clinical and research efforts that target the early identification of psychosocial distress (including posttraumatic stress) and nonadherence posttransplant. Experience in the Center's pediatric liver transplant program clearly suggests that a close collaboration between the medical and psychosocial teams can improve patient care and support an academic focus.

No. 31C
THE STUDY OF PTSD IN THE MEDICALLY ILL: CHOICE OF OUTCOME MEASURES

Gad Cotter, M.D., *Department of Cardiology, Duke University Medical Center, Duke University North, Ervin Street, Rm 7401, Durham, NC 27710*

SUMMARY:

PTSD symptoms may influence the mental as well as the physical health of patients with medical illnesses. The study of PTSD or its treatment poses a challenge in choosing the right outcome variables when dealing with medically ill patients. The presenter reports data from three different cohorts of patients with myocardial infarction, in whom PTSD symptoms were evaluated and treatment attempted. Outcome measures in these studies included specific psychiatric symptom scales (i.e., the Impact of Event Scale), more comprehensive scales (i.e., Symptom Checklist-90-Revised), service utilization measures (i.e., admission rates), rates of cardiovascular adverse events, platelet thromboxane production, and a risk-control scale derived from the American Heart Association's recent guidelines for prevention of recurrent ischemia. The pros and cons in using each measure are discussed. The presenter addresses the use of self-reported or clinician-determined measures of outcome that are frequently used in psychosocial research, compared with laboratory data that are more readily available to biomedical researchers. Finally, the presenter discusses the important impact that selection of outcome measures had on the outcome and conclusions of several published psychosocial studies of patients with cardiovascular illnesses.

No. 31D
THE NATIONAL CHILD TRAUMATIC STRESS NETWORK MEDICAL TRAUMA TOOLKIT

Margaret L. Stuber, M.D., *Department of Psychiatry, UCLA Medical Center, Box 951759, 48-240A, NPI, Los Angeles, CA 90095-1759*

SUMMARY:

Children and parents dealing with life-threatening pediatric illness or injury often report finding the treatment as well as the event traumatic, resulting in clinically significant emotional distress. Many of these traumatic reactions can be prevented, and the unavoidable distress quickly treated if the system is alert to what families find traumatic. However, providers of care to medically ill children are often not aware of the impact of seemingly routine procedures on children and parents.

The National Child Traumatic Stress Network, with support from the U.S. Substance Abuse and Mental Health Services Administration, has developed a "toolkit" for hospitals. Simple tools are in-

cluded for medical personnel in the emergency department, intensive care units, and pediatric floors to use to help children and families throughout the hospital experience. Such tools increase awareness of potential sources of medical traumatic stress and increase medical care providers' confidence in being able to help children and families. The components of the toolkit are presented, and the rationale for its development and the methods used to develop its content and focus are discussed.

REFERENCES:

1. Shemesh E, Lurie S, Stuber ML, et al: A pilot study of posttraumatic stress and nonadherence in pediatric liver transplant recipients. Pediatrics 2000; 105:E29.
2. Shemesh E, Rudnick A, Kaluski E, et al: A prospective study of posttraumatic stress symptoms and nonadherence in survivors of a myocardial infarction (MI). Gen Hosp Psychiatry 2001; 23: 215–222.
3. Stuber ML, Shemesh E, Saxe GN: Posttraumatic stress responses in children with life-threatening illnesses. Child Adolesc Psychiatr Clin N Am 2003; 12:195–209.

SYMPOSIUM 32—MEDICAL COMORBIDITY IN THE U.S. AND FRANCE: VIVE LA DIFFERENCE!
French Federation of Psychiatry

EDUCATIONAL OBJECTIVES:

At the end of this symposium the participant should be able to understand the differences and similarities in France and the United States in the assessment of, research about, and treatment of medical comorbidities common in mentally ill patients, such as those linked to health behaviors (weight, smoking, exercise), diabetes and other metabolic problems, and HIV/AIDS and hepatitis C.

No. 32A
MORTALITY IN A COHORT OF PATIENTS WITH SCHIZOPHRENIA

Frederic Limosin, M.D., *Department of Psychiatry, Albert Chenenier, 40 Rue de Mesly, Creteil F75015, France;* Jean-Yves Lore, M.D., Alain Philippe, Frederic Rouillon, M.D., Francoise Casadebaig

SUMMARY:

Because of the lack of national data, a specific research project concerning the mortality of schizophrenia patients cared for in the French community health system was undertaken in 1993. A total of 3,470 patients with ICD-10 schizophrenia, included at random, as inpatients or outpatients ages 18–64 years, were registered. Observations concerning physical health, suicidal behavior, drug consumption, and psychotropic medication use were registered at inclusion and followed-up every three years. National data on specific causes of mortality in this cohort are available only until 1999. A comparison of mortality between patients and the general population was made by the standardized mortality ratio (SMR). The Cox model was used for multivariate analyses. A total of 307 deaths were observed during the six-year follow-up, versus 83.2 expected. The SMR was 3.5 for men and 4.4 for women. Suicide represented one of three deaths. The percentage of suicides in the total number of deaths was more than half during the first year of observation (54%). In the fifth year, suicide represented only one case of four. All natural causes of death were overrepresented, including cancer. The results show that mortality among schizophrenia patients remains high and must still be documented.

No. 32B
PREVALENCE, TREATMENT, AND PREVENTION OF HIV/HEPATITIS IN THE U.S.

Lisa B. Dixon, M.D., *Department of Psychiatry, University of Maryland, 685 West Baltimore Street MSTF/Room 300, Baltimore, MD 21201;* Stanley Rosenberg, Ph.D., Richard L. Goldberg, M.D.

SUMMARY:

Since the first published report in 1989, numerous studies have found that people with severe mental illness are at elevated risk for HIV infection, with current estimates ranging from 3.1% to more than 8%, or approximately eight to more than 20 times the U.S. population rate. In the last several years, a number of studies have also reported high prevalences of hepatitis B virus and hepatitis C virus in clients with severe mental illness. These studies suggest that the prevalence of hepatitis C among people with severe mental illness is approximately 20%, or 11 times the U.S. population estimate. In three recent studies assessing dually diagnosed clients, rates of hepatitis C infection were 30% (St. Louis and Bridgeport/Hartford, Conn.), 36% (Baltimore), and 38% (Oregon State Hospital). Coinfection is also common; among those clients who tested positive for HIV, research has found that 59.1% were coinfected with hepatitis C. Among the dually diagnosed clients in Baltimore, this percentage was 67%. These rates are approximately double the population average of 30% for coinfection in persons with HIV and are closer to the reported 80% coinfection rate in injection drug users. The Centers for Disease Control and Prevention, the Department of Veterans Affairs, and the National Institutes of Health concur in recommending the following key services for people at elevated risk for HIV/AIDS, as well as those at risk for hepatitis: (1) screening for risk, (2) testing those who have ever been at risk, (3) immunization to prevent hepatitis A and B, (4) risk reduction counseling, and (5) referral and support for medical care. Unfortunately, appropriate treatment is rarely provided. Five studies suggested that the majority of community mental health care providers do not regularly address HIV and hepatitis risk or illness issues with persons with severe mental illness, even when the prevalence of HIV or AIDs is known to be high. Only one study reported on awareness and response to hepatitis, and it documented inadequate levels of testing and immunization among severely mentally ill clients. Most persons with severe mental illness and hepatitis C do not have a regular source of medical care. A new brief intervention that holds promise for the treatment and prevention of these disorders — Screen, Test, Immunize, Reduce risk, and Refer (STIRR) — is presented.

No. 32C
ADVERSE METABOLIC EFFECTS OF ANTIPSYCHOTICS IN SCHIZOPHRENIA

Marie France Poirier, M.D., *75014, Shu-E117 Ch St Anne, Cabanis 1, Paris, France;* Celine Goldberger

SUMMARY:

The antipsychotic drugs are fundamental tools in the treatment of psychosis. Weight gain as a side effect has been described with both conventional and atypical antipsychotics. The atypical antipsychotic drugs represent important progress in the treatment of psychotic disorders. However, adverse metabolic effects, such as weight gain, increased waist circumference, lipid abnormalities, increase in peripheral insulin resistance, and diabetes mellitus, have been recognized with the use of these compounds, increasing numbers of cardiovascular complications. Weight gain may reduce treatment adherence. The dysmetabolic syndrome most likely results from interplay between several genes and an affluent environment. Intrinsic risk factors are linked to the psychiatric pathology (sedentary state, nicotine addiction, diabetes). Common variants in a number

of candidate genes influencing fat and glucose metabolism can probably, together with environmental triggers, increase the susceptibility to the syndrome. Appetite stimulation is probably a major mechanism of body weight gain observed with the antipsychotic drugs, and this effect is correlated with their affinity for neurotransmitter receptors. It is increasingly important to understand the impact of antipsychotic drugs on weight gain and to identify the clinical and genetic vulnerability factors.

No. 32D
DIABETES AND OTHER METABOLIC DISORDERS IN SCHIZOPHRENIA

Michael J. Sernyak, M.D., *Department of Psychiatry, Yale University, VACT Psychiatry Service, #116A, West Haven, CT 06516*

SUMMARY:

For several years there has been a growing awareness that patients with schizophrenia are at increased risk for metabolic disorders such as diabetes, dyslipidemias, and the metabolic syndrome. Although much of the emphasis has been on the role of the newer, atypical antipsychotics, the presenter explores the possibilities that schizophrenia itself, along with the older, typical antipsychotics may also increase risk. In addition, underlying conditions (such as obesity) that may represent critical preconditions for the development of these disorders, are addressed. The presenter explores recommendations for screening and managing these metabolic disorders in patients with schizophrenia and discusses models of comanagement with primary care providers or general internists.

No. 32E
THE IMPACT OF SMOKING IN PATIENTS WITH SCHIZOPHRENIA

Alain Dervaux, M.D., *Department of Psychiatry, Hopital Sainte Anne, Shu, 1 Rue Cabanis, Paris F-75014, France*

SUMMARY:

Rates of cigarette smoking range from 60% to 90% in schizophrenia patients, compared with 25% to 30% of the general population in the United States or in Europe. Schizophrenia patients also smoke more cigarettes on average, and smoke more deeply, thereby increasing their exposure to harmful elements in tobacco smoke. As a result, smoking raises several problems in schizophrenia patients. Rates of related illnesses such as cardiovascular disease, particularly coronary heart disease, and certain cancers, appear to be higher in schizophrenia patients than in the general population. Thus, smoking contributes to their reduced life expectancy. Smoking also increases the metabolism of the antipsychotic medications by inducing the cytochrome P450 1A2 isoform. Thereby, smoking lowers the blood levels of the typical or atypical antipsychotics. Accordingly, smoking appears to reduce neuroleptic-induced parkinsonism. In contrast, smoking is a risk factor for tardive dyskinesias, independent of neuroleptic exposure. Although smoking may transiently improve processing of auditory stimuli abnormalities, reduce cognitive deficits by increasing dopaminergic neurotransmission in the prefrontal cortex, and alleviate negative symptoms in schizophrenia patients, the risks outweigh the benefits. Because smoking is the most important lifestyle variable and the greatest contributor to excess mortality from cardiovascular causes, the development of efficacious smoking cessation strategies is of great importance.

No. 32F
MEDICAL COMORBIDITIES AND HEALTH BEHAVIORS: SMOKING, EXERCISE, AND WEIGHT

Gail L. Daumit, M.D., *Department of Medicine, Johns Hopkins University, 2024 East Monument Street 2-500, Baltimore, MD 21205*

SUMMARY:

Individuals with schizophrenia and other severe mental illnesses have a high burden of comorbid somatic conditions, including diabetes, chronic pulmonary disease, hypertension, and coronary artery disease. These conditions are potentially preventable through reduction in the behavioral risk factors of smoking, poor diet, and sedentary lifestyle. Tobacco smoking is endemic among patients with severe mental illness, with prevalence estimates ranging from 50% to 90%. The long-term effects of smoking are likely to blame for much of the burden of coronary disease and chronic pulmonary disease in patients with severe mental illness. Coronary disease risk is also increased by the epidemic of overweight and obesity in this population. Recent estimates suggest men with severe mental illness have a 60% higher and women with severe mental illness have twice the prevalence of obesity, compared to persons without severe mental illness. Weight problems are multifactorial, psychotropic medication effects contribute to increased caloric intake, and lack of physical activity is also responsible. The burden of these unhealthy behaviors in an already challenged population may seem overwhelming, especially given that tobacco smoking may improve some schizophrenia symptoms and antipsychotic medications (needed on an ongoing basis) are partially responsible for weight gain. However, new evidence suggests that tailored interventions for smoking cessation and weight loss can be effective in patients with severe mental illness. An evidence-based review of the epidemiology of smoking, obesity, nutrition, and exercise in this population is presented, accompanied by a review of recent interventions for healthy lifestyles in this population.

REFERENCES:

1. Montout C, Casadebaig F, Lagnaoui R, et al: Neuroleptics and mortality in schizophrenia: prospective analysis of deaths in a French cohort of schizophrenic patients. Schizoph Res 2002; 57:147–156.
2. Rosenberg SD, Goodman LA, Osher FC, et al: Prevalence of HIV, hepatitis B, and hepatitis C in people with severe mental illness. Am J Public Health 2001; 91:31–37.
3. Keck PE, Buse JB, Dagogo-Jack S, et al: Managing Metabolic Concerns in Patients With Severe Mental Illness. Postgraduate Medicine Special Report. Minneapolis, Healthcare Information Programs, 2004.
4. Daumit GL, Clark JM, Steinwachs DM, et al: Prevalence and correlates of obesity in a community sample of individuals with severe and persistent mental illness. J Nerv Ment Dis 2003; 191:799–805.

SYMPOSIUM 33—MEDICAL AND PSYCHIATRIC ISSUES IN THE MEXICAN-AMERICAN POPULATION IN THE U.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe common medical and psychiatric issues affecting Mexican Americans in the U.S.

No. 33A
HEALTH STATUS OF MEXICAN AMERICANS

Michael P. Stern, M.D., *Department of Medicine, UT Health Science Center at San Antonio, 7703 Floyd Curl Drive, San Antonio, TX 78229-3900*

SUMMARY:

It has long been known that type 2 diabetes and obesity are much more prevalent in the Mexican American population than in the European-origin population of the U.S. Although the reasons for the excess risk of type 2 diabetes among Mexican Americans are still imperfectly understood, it appears to have a genetic basis. The basis for this hypothesis is that Native Americans have exceptionally high rates of type 2 diabetes and obesity, and the rates in Mexican Americans, who have from 20% to 40% Native American ancestry, are intermediate between those found in Native Americans and European-origin Americans. In addition to having high rates of diabetes, Mexican Americans with diabetes have high rates of diabetic complications. This phenomenon has been labeled "double jeopardy," i.e., excess risk of the disease itself, and then, once having acquired the disease, excess risk of its complications. Although there may be a genetic basis for the excess risk of complications, inadequate access to, utilization, and quality of health care probably also play an important role. Other diseases that have a high prevalence in Mexican Americans are gallstone disease and gallbladder cancer. It is apparent that the high rates of numerous common diseases among the rapidly growing Mexican American population, which is disadvantaged and which lacks adequate access to high-quality medical care, pose an important public health challenge that is deserving of urgent attention.

No. 33B
DEPRESSION AS COMORBID CONDITION WITH TYPE-TWO DIABETES IN A U.S.-MEXICO BORDER COMMUNITY CLINIC

Roberto Villarreal, M.D., *Department of Community Medicine, UT Health Science Center at San Antonio, 7703 Floyd Curl Drive, San Antionio, TX 78229-3900*

SUMMARY:

Depression and diabetes are two chronic illnesses that often co-occur. A health promotion and chronic disease prevention program was implemented in a community clinic located on the U.S.-Mexico border. The patient population was low income and mostly Spanish speaking, and all had a diagnosis of type 2 diabetes mellitus. The aim of the program was to develop a two-prong intervention: one designed to increase participation and adherence to medication, nutrition, and physical activity, and the other to help reduce the burden of depression and facilitate treatment. A group of 517 patients were randomly assigned to intervention and control groups. The control group received standard care, and the intervention group received a personalized intervention based on the Trans-Theoretical Model for behavioral change. Both groups were surveyed for depression. The prevalence of depression in this population was 42%, with 66% defined as mildly depressed and the rest as moderately to severely depressed. Surveys, interventions, and counseling were developed in Spanish. Data on cost-effective use of health promotions and the burden of disease on the clinic resources are presented, and final results are summarized.

No. 33C
INSIGHTS ON SCHIZOPHRENIA IN THREE COUNTRIES

Rolando A. Medina, M.D., *Department of Psychiatry, UT Health Science Center at San Antonio, 7703 Floyd Curl Drive, San Antonio, TX 78229-3900*

SUMMARY:

Using data from ongoing studies on the genetics of schizophrenia in Latino populations in several sites in the U.S., Mexico, and Costa Rica, the presenter highlights differences and similarities in demographic and psychosocial characteristics and in illness characteristics across sites. Differences in patterns of psychosis and alcohol and other substance abuse, as well as patterns of treatment, are described. An assessment of the magnitude of awareness that close family members of affected subjects have of their relatives' symptoms is presented. Implications for future research on the genetics of schizophrenia in Latinos are reviewed.

REFERENCES:

1. Burke JP, Williams KL, Gaskill SP, et al: Rapid rise in the incidence of type 2 diabetes from 1987 to 1996 in Mexican Americans and non-Hispanic whites. Arch Int Med 1999; 159:1450–1456.
2. Pignone MP, Gaynes BN, Rushton JL, et al: Screening for depression in adults: a summary of the evidence for the US Preventive Services Task Force. Ann Intern Med 2002; 136:765–776.
3. Medina RA, Dassori A, Escamilla MA, et al: Naturalistic heterogeneity of subjects diagnosed with DSM schizophrenia: factor-cluster analysis of lifetime dimensions of psychosis. Am J Med Genet 2003; 122B:175–176.
4. Vega WA, Sribney WM, Achara-Abrahams I: Co-occurring alcohol, drug, and other psychiatric disorders among Mexican-origin people in the United States. Am J Public Health 2003; 93: 1057–1064.

SYMPOSIUM 34—ATYPICAL ANTIPSYCHOTICS: TREATMENT OF AGITATION ACROSS MENTAL DISORDERS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium the participant should be able to understand the available information with regard to the use of atypical antipsychotics across three different mental disorders.

No. 34A
TREATMENT OF AGITATION WITH ATYPICAL ANTIPSYCHOTICS IN SCHIZOPHRENIA

Stephen R. Marder, M.D., *Department of Psychiatry, VA Greater LA Health Care System, M1 RECC 210A 11301 Wilshire Boulevard, Los Angeles, CA 90073-1003*

SUMMARY:

Agitation is one of the most common and severe behavioral symptoms of schizophrenia. The presence of agitation is often a major source of distress to patients and is associated with situations in which the patient becomes dangerous to self and others, leading to inpatient acute hospitalization. The presenter compares the anti-agitation efficacy of atypical antipsychotics in the treatment of agitation in schizophrenia. Data from the manufacturers of aripiprazole, risperidone, olanzapine, quetiapine, and ziprasidone are analyzed. Effect sizes are reported for each trial, based on scores on the Positive and Negative Syndrome Scale (PANSS) excitement component (EC) (or equivalent item). The analysis relies on data contributed by the sponsors of pharmaceutical industry trials. Results include demographics and means and standard deviations for the placebo group and each active group, with statistical significance reported for the PANSS total score, PANSS EC items, and the designated primary outcome variable used by the source study. Safety is described and

analyzed as a function of the observed efficacy. The results are discussed in the context of their utility in daily clinical practice.

No. 34B
TREATMENT OF AGITATION WITH ATYPICAL ANTIPSYCHOTICS IN BIPOLAR AFFECTIVE DISORDER

Gary S. Sachs, M.D., *Department of Psychiatry, Harvard-Massachusetts General Hospital, 50 Staniford Street, Suite 580, Boston, MA 02114*

SUMMARY:

Agitation is one of the most common and severe behavioral symptoms of bipolar disorder. The presence of agitation is often a major source of distress to patients and is associated to inpatient acute hospitalization. The presenter compares the anti-agitation efficacy of atypical antipsychotics in the treatment of agitation in the bipolar disorder population. Data from the manufacturers of aripiprazole, risperidone, olanzapine, quetiapine, and ziprasidone are analyzed. Effect sizes are reported as computed for each trial, based on scores on the Positive and Negative Syndrome Scale (PANSS) excitement component (EC) (or equivalent item). The analysis will rely on data contributed by the sponsors of pharmaceutical industry trials. Results include demographics and means and standard deviations for the placebo group and each active group, with statistical significance reported for the PANSS total score, PANSS EC items, and the designated primary outcome variable used by the source study. Safety is described and analyzed as a function of the observed efficacy. The results are discussed in the context of their utility in daily clinical practice.

No. 34C
TREATMENT OF AGITATION WITH ATYPICAL ANTIPSYCHOTICS IN ALZHEIMER'S DISEASE

Jacobo E. Mintzer, M.D., *Alzheimer's Research, Medical University of South Carolina, 5900 Core Road, Suite 203, N. Charleston, SC 29404*

SUMMARY:

Agitation is one of the most common and severe behavioral symptoms of Alzheimer's disease. The presence of agitation often precipitates caregiver "burn-out" and nursing home placement. The presenter compares the anti-agitation efficacy of atypical antipsychotics in the treatment of agitation in Alzheimer's disease. Data from the manufacturers of aripiprazole, risperidone, olanzapine, quetiapine, and ziprasidone are analyzed. Effect sizes are reported for each trial, based on scores on the Positive and Negative Syndrome Scale (PANSS) excitement component (EC) (or equivalent item). The analysis will rely on data contributed by the sponsors of pharmaceutical industry trials. Results include demographics and means and standard deviations for the placebo group and each active group, with statistical significance reported for the PANSS total score, PANSS EC items, and the designated primary outcome variable used by the source study. Safety is described and analyzed as a function of the observed efficacy. The results are discussed in the context of their utility in daily clinical practice.

No. 34D
ASSESSING THE DATA IN THE CONTEXT OF CLINICAL CARE

Eric D. Caine, M.D., *Department of Psychiatry, University of Rochester Medical Center, 300 Crittenden Boulevard, Rochester, NY 14642-8409*

SUMMARY:

The discussant summarizes the presented information and reviews the information in the context of the theoretical basis for agitation. The strengths and weakness of the specific approach used to evaluate the problem are assessed. The relevance of this treatment to clinical practice is discussed, and a risk-benefit assessment is presented for this specific type of treatment, by disorder and overall. Clinical scenarios in which this information may be relevant are presented.

REFERENCES:

1. Marder SR, Conley R, Ereshefsky L, et al: Clinical guidelines: dosing and switching strategies for long-acting risperidone. J Clin Psychiatry 2003; 64(suppl 16):41–46.
2. Tohen M, Chengappa KNR, Suppes T, et al: Efficacy of olanzapine in combination with valproate or lithium in the treatment of mania in patients partially nonresponsive to valproate or lithium monotherapy. Arch Gen Psychiatry 2002; 50:62–69.
3. Mintzer JE: Managing behavioral dyscontrol related to dementia. Prim Care Companion J Clin Psychiatry 2003; 5 (suppl 6):14–21.
4. Zimbroff DL: Management of acute psychosis: from emergency to stabilization. CNS Spectr 2003; 8(11 suppl 2):10–15.

SYMPOSIUM 35—THE MANY FACES OF DEPRESSION: DO ANTIDEPRESSANTS TREAT DIFFERENT SYMPTOMS?

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to identify symptoms that are especially responsive to specific antidepressants and select the medication most appropriate for the patient.

No. 35A
DO ANTIDEPRESSANTS TREAT DIFFERENT CORE SYMPTOMS OF DEPRESSION?

J. Craig Nelson, M.D., *Department of Psychiatry, University of San Francisco California, 401 Parnassus Avenue, Box 0984F, San Francisco, CA 94143*

SUMMARY:

Currently, the clinician has a number of antidepressants available for the treatment of depression. Yet selection of the best agent remains a challenge. Antidepressants differ in their side effects, but it has been unclear if there are patient characteristics that can be used as a guide to treatment. This issue is amplified by the emphasis on treating patients to remission. In theory, a patient's illness might be most likely to remit if the treatment selected was most effective for that individual's prominent symptoms. A previous review demonstrated that antidepressants selective for norepinephrine (NE) or serotonin (5-HT) appeared to have comparable efficacy. Those studies were also reviewed to determine if there were differences in the symptoms responding. Eight of the studies examined individual symptom response but found no symptoms that consistently differed. Data from two other studies were examined in detail. These two studies were similar in design. Both were eight-week studies comparing reboxetine (a NE-selective agent) with fluoxetine. One of these is the largest study of this sort reported. In these two samples of 421 patients with major depression, the two different agents had a similar pattern of effects on core depressive symptoms, that is, depressed mood, decreased interest, and psychic anxiety showed the greatest change with treatment, and the magnitude of change was similar for the two drugs for symptoms assessed with the Hamilton Depression Rating Scale. These findings suggest that either these

agents act through a final common pathway or that a major component of response is determined by the symptoms that are most common and most severe on common depression scales. Other symptom domains not assessed in these studies or on these scales might differ in their response to different selective agents.

No. 35B
ANGER ATTACKS IN DEPRESSION: DOES 5HT MATTER?

Maurizio Fava, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC-812, Boston, MA 02114*

SUMMARY:

Irritability and excessive anger are often observed in patients who suffer from major depressive disorder (MDD). Anger attacks are sudden, intense spells of anger that resemble panic attacks but lack the predominant affects of fear and anxiety associated with panic attacks. Anger attacks consist of behavioral, affective (irritability), and autonomic features, and specific criteria (using an Anger Attacks Questionnaire) have been designed to identify the presence of these attacks. The prevalence of anger attacks in depressed patients is approximately 30% to 40%, and the attacks disappear in 53% to 71% of depressed patients treated with antidepressants. MDD patients with anger attacks have been shown to have a blunted prolactin response to fenfluramine challenge, compared with depressed patients without these attacks, suggesting the presence of a greater serotonergic dysregulation in this depressive subtype. The presence of anger attacks in patients with depression appears to predict a good response to antidepressant treatment, particularly treatment with serotonergic antidepressants. The presenter discusses the development of the concept of depression with anger attacks, the clinical characteristics of this depressive subtype, the current treatment of both anger attacks and depressive symptoms, and possible differences in therapeutic efficacy across antidepressant classes.

No. 35C
POSITIVE AND NEGATIVE AFFECT AND ANTIDEPRESSANT RESPONSE

Pedro L. Delgado, M.D., *Department of Psychiatry, Case Western University, 11100 Euclid Avenue, Cleveland, OH 44106-5080*

SUMMARY:

Depression is associated with a variety of symptoms and behaviors beyond those included in the criteria for major depression. Some of these symptom domains maybe more responsive to certain antidepressant treatments than others and thus be useful for drug selection. One of the areas receiving recent attention in depression is the domain of positive and negative affects. Rating scales have been developed for these domains so that they can be reliably rated in depressed subjects. One study found that administration of paroxetine decreased negative affect in normal subjects, but positive affect was unaffected. Zald and colleagues (2001), however, found that an index of serotonin functioning was positively correlated with a decrease in both negative and positive affect in subjects without psychiatric disorder. The presenter's group has been interested in the possible effects of serotonergic drugs on positive and negative affect in depressed patients. In some patients SSRIs appear to inhibit positive affect, resulting in emotional blunting. This presentation examines the role of positive and negative affect in depression, reviews the evidence to date for the effects of drug treatment on these domains, considers possible interactions between the serotonin and catecholamine systems that might explain some of these effects, and, finally, proposes a rational approach to drug selection for treatment of these domains.

No. 35D
HOW DO ANTIDEPRESSANTS AFFECT THE PROCESSING OF POSITIVE AND NEGATIVE EMOTIONAL INFORMATION?

Catherine J. Harmer, D.Phil, *Department of Psychiatry, Oxford University, Oxford, United Kingdom OX3 7JX*

SUMMARY:

Monoamine neurotransmitters have long been associated with emotion and emotional disorders such as depression. Howeer, our understanding of the role of these neurotransmitters in processing emotional information is still in its infancy. A number of investigations with healthy volunteers revea that pharmacological manipulation sof serotonin and noradrenaline moderate emotional processing across a range of tasks involving attention, perception, and memory. For example, a single does of the noradrenergic reuptake inhibitor, reboxetine, as found to increase recall of positive self-referring personality characteristics improve identification of happy facial expressions, and facilitate speed to categorize positive social information in healthy vounteers. The role of serotonin in emotional processing appears more complex; after a single administration of the selective serotonin reuptake inhibitor citalopram, threat-relevent processing was increased in two separate paradigms (emotion potentiated startle and fearful facial expression recognition). However, after repeated administration, this effect was reversed with volunteers showing reduced recognition of threatening facial expressions and emotion-potentiated startle responses. This reversal of action is in line with results from preclinical animal models and with clinical effects of SSRIs in the treatment of anxiety. The neural correlates of this decrease in threat-relevant processing were further examined using functional magnetic resonance imaging in healthy volunteers. Consistent with reductions in fear recognition, blood oxygen level dependent (BOLD) amygdala resopnses to subliminal presentations of frear were reduced in healthy volunteers randomized to receive citalopram (20 mg/day/7days) compared with placebo. Taken toegether, these results suggest a modulatory role for serotonin in amygdala function and in the processing of emotionally valanced information. This approach may elp integrate cognitive and pharmacological theories of depression and its treatment.

No. 35E
THE ROLE OF DOPAMINE IN DEPRESSION: IMPLICATIONS FOR TREATMENT

Anthony J. Rothschild, M.D., *Department of Psychiatry, University of Massachusetts Medical Center, 361 Plantation Street, Worcester, MA 01605*

SUMMARY:

When the catecholamine hypothesis was proposed in 1965, the role of dopamine (DA) in depression was unclear. Abnormalities in the DA system were disregarded for many years as a possible cause of depression because tricyclic antidepressants are relatively ineffective as blockers of DA reuptake, compared with their effects on norepinephrine (NE) reuptake. However, after histochemical methods for visualizing catecholamine-containing cell bodies, axons, and terminals were perfected, it became clear that independent DA and NE pathways existed. In fact, much of the evidence that supported the role of NE in depression also supports the role of DA. The major DA forebrain projections support a variety of behavioral functions related to motivation and reward. An obvious prediction is that hypofunction of this system could mediate both the inability to experience pleasure and the loss of motivation that are a key part of major depressive disorder. Depletion of dopamine or its precursor tyrosine, blockade of DA receptors by neuroleptic agents, and the occurrence of Parkinson's disease are all associated with depression.

Conversely, treatment with dopamine agonists (amphetamine, bromocriptine, bupropion, pramipexole), dopamine reuptake inhibitors (nomifensine), and monoamine oxidase subtype B inhibitors (selegiline) alleviate the symptoms of depression. Finally, the implications of too much DA activity in depression and the relationship to the development of delusions in depressed patients are discussed.

REFERENCES:

1. Nelson JC: A review of the efficacy of serotonergic and noradrenergic reuptake inhibitors for treatment of major depression. Biol Psychiatry 1999; 46:1301–1308.
2. Fava M, Vuolo RD, Wright EC, et al: Fenfluramine challenge in unipolar depression with and without anger attacks. Psychiatry Res 2000; Apr 24; 94:9–18.
3. Zald DH, Depue RA: Serotonergic functioning correlates with positive and negative affect in psychiatrically healthy males. Personality and Individual Differences 2001; 30:71–86.
4. Harmer CJ, Shelley NC, Cowen PJ, Goodwin GM: Increased positive versus negative affective perception and memory in healthy volunteers following selective serotonin and norepinephrine reuptake inhibition. Am J Psychiatry 2004; 161(7):1256–63.
5. Kapur S, Mann JJ: Role of the dopaminergic system in depression. Biol Psychiatry 1992; 32:1–17.

SYMPOSIUM 36—UNDERSTANDING AND TREATING ALCOHOL DEPENDENCE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize neurochemical/cellular aspects of medication development for alcohol dependence, be aware of genetic factors predisposing to this and comorbid disorders, use pharmacological treatment strategies, and use craving as a measure treatment response and relapse likelihood.

No. 36A
NEUROPHARMACOLOGICAL BASIS OF ALCOHOL DEPENDENCE

George F. Koob, Ph.D., *Department of Neuropharmacology, Scripps Research Institute, 10550 North Torrey Pines Road, CVN7, La Jolla, CA 92037*

SUMMARY:

Alcoholism is a chronic relapsing disorder characterized by compulsive alcohol intake, loss of control over intake, and impairment in social and occupational function. Animal models have been developed for excessive drinking, with a focus on the motivational effects of drug dependence. In alcohol dependence, a dysregulated reward state with specific neuroanatomical and neurochemical components of brain reward and stress circuits is developed that provides a negative motivational system and drives excessive drinking. Decreases in reward neurotransmitters (such as opioid peptides, dopamine, and GABA), combined with recruitment of brain activating systems in specific elements of the amygdala extended circuitry (including as glutamate and brain stress transmitters such as corticotrophin-releasing factor [CRF]), are hypothesized to lay the foundation for excessive alcohol intake leading to abuse and dependence. Changes in glutamate and CRF function are thought to play key roles in animal models of protracted abstinence and relapse, the targets for novel medications for the maintenance of abstinence and relapse prevention. Neuropharmacological models that not only integrate molecular, cellular, and circuitry neuroadaptations in brain motivational systems, but also represent different stages of the addiction process provide the key to future treatments of alcoholism.

No. 36B
NEW PHARMACOLOGICAL STRATEGIES FOR TREATING ALCOHOL DEPENDENCE

Barbara J. Mason, Ph.D., *Department of Neuropharmacology, Scripps Research, 10550 North Torrey Pines Road TPC5, La Jolla, CA 92037*

SUMMARY:

Recent advances in neurobiology have led to the development of pharmacological treatments for alcohol dependence. Disulfiram relied on unpleasant side effects from the buildup of aldehydes while drinking. Newer, more successful approaches target the neurochemical basis for alcohol dependence. Naltrexone, a currently approved, selective opioid antagonist, is thought to reduce consumption while drinking by blocking the endogenous opioid reward system and diminishing the positive effects of alcohol intoxication. Nalmefene, a newer opioid antagonist with a longer half-life that is still in development, has also shown efficacy against relapse to heavy drinking in clinical studies. Acamprosate, a modulator of NMDA-mediated glutamatergic neurotransmission, has been used in Europe for over 10 years for the treatment of alcohol dependence and shows promise as a pharmacological treatment for alcohol dependence in the United States. Its effects in promoting abstinence are possibly mediated by attenuation of the negative reinforcement of alcohol withdrawal symptoms. Acamprosate has repeatedly been shown to improve outcomes in clinical studies, with significantly greater rates of treatment completion, increased time to first drink, and increased number of abstinent days. The presenter discusses data from clinical studies of the above compounds, both alone and in combination.

No. 36C
RECENT DEVELOPMENTS IN THE GENETICS OF ALCOHOL DEPENDENCE

Marc A. Schuckit, M.D., *Department of Psychiatry, VA San Diego HCS, 3350 La Jolla Village Drive, La Jolla, CA 92093*

SUMMARY:

Family, twin, and adoption studies suggest that about 60% of the risk variance for severe repetitive alcohol-related problems can be attributed to genetics. Similar to other complex disorders, it is likely that genetically influenced characteristics (phenotypes) arise from a variation in a genetic component. These include molecular variations in genes controlling alcohol-metabolizing enzymes and in genes that contribute to impulsivity or disinhibition (increasing the risk for all types of substance use disorders), influence the risk for several major Axis I psychiatric conditions (e.g., schizophrenia and manic depressive disease), and specifically enhance the risk for alcoholism by affecting the intensity of response to alcohol. Data supporting each of these categories are presented, along with a discussion of genes identified for intermediate phenotypes leading to alcohol dependence. Identification of specific genes operating through neurochemical mechanisms may lead to both more effective early interventions and improvements in the evaluation of pharmacotherapies for alcohol use disorders. The more that is known about the biological underpinnings of alcoholism, the greater the probability of accurately evaluating the effectiveness of pharmaceutical agents among subgroups of alcoholics and the greater the likelihood that new treatments aimed at the different neurochemical targets can be developed.

No. 36D
NEW MEDICATIONS: THE USE OF ANTICONVULSANTS, BOTH ALONE AND IN COMBINATION, WITH VARIOUS FORMS OF PSYCHOTHERAPY

Bankole A. Johnson, M.D., *Department of Psychiatry, University of Texas Health Science Center, 3939 Medical Drive, Suite 100, San Antonio, TX 78229-3900*

SUMMARY:

The use of anticonvulsants to treat alcohol dependence is emerging as a most promising area of development of new medications for the treatment of this syndrome. Principal among the properties of such agents is that they may have a dual role in treating alcohol dependence. These medications might ameliorate the symptoms of alcohol withdrawal and, by continuing the treatment, prevent relapse. These actions are related to the effects of the medications to antagonize glutamate or facilitate GABA, or both, within the cortico-mesolimbic system. The presentation includes new data showing the efficacy of a variety of compounds (e.g., topiramate, gabapentin, and valproate) as either antiwithdrawal or relapse prevention agents or both. Further, this presentation provides an opportunity to present new data showing that the unique pharmacological characteristic of GABA facilitation by of one of these agents, topiramate, appears to synergize with serotonin-3 antagonism (by ondansetron), perhaps through conjoint activity to modulate trafficking at the GABA transporter, to produce a highly efficacious medication combination for treating alcohol dependence. Finally, because this class of agents can be prescribed at almost any stage of the alcohol dependence syndrome, selective examples are presented to illustrate novel approaches to combining them with various "doses" of psychotherapy. Comments as to optimum treatment strategies are provided.

No. 36E
DIFFERENTIAL EFFECTS OF PHARMACOLOGICAL AGENTS ON CRAVING

Nassima Ait-Daoud, M.D., *Department of Psychiatry, University of Texas Health Science Center, 3939 Medical Drive, Suite 100, San Antonio, TX 78229*

SUMMARY:

Research studies have focused on the role of new therapeutic drugs that help alcoholics remain abstinent. However, very often during a period of forced abstinence, craving and protracted withdrawal increase the chances of relapse. In the last decade, there has been an increased interest in identifying anticraving medications for the effective treatment of alcoholism. With more knowledge being gained from human and animal studies on craving and the neurochemical pathways involved, including evidence for the involvement of midbrain and cortical neurochemical circuits, pharmacological agents targeting those specific neurochemical pathways have been tested — especially those that antagonize alcohol-induced central dopaminergic function. Also, more tools have been used to identify craving, encompassing its multiple facets. The presenter demonstrates how the clinical concept of craving can be used not only to develop neuropharmacological frameworks for developing medications to treat alcohol dependence but also as a barometer by which clinicians and psychiatrists in general practice can measure treatment response and predict the likelihood of relapse. Next, evidence that multicomponent craving rating scales have been proven more reliable than single-item measures is presented. The discussion is reinforced by evidence, from a variety of studies, that the multicomponent rating scales are reliable predictors of drinking behavior in treatment-seeking alcoholics in a clinical setting and, therefore, can be used to predict relapse. Finally, the presenter discusses various classes of medications (e.g., anticonvulsants, serotonergic agents, and atypical antipsychotics) to illustrate the concept of craving and how its interpretation and practicality differ by gender, social class, and ethnicity.

REFERENCES:

1. Koob GF: Alcoholism: allostasis and beyond. Alcohol Clin Exp Res 2003; 27:232–243.
2. Mason BJ: Acamprosate and naltrexone treatment for alcohol dependence: an evidence-based risk-benefits assessment. Eur Neuropsychopharmacol 2003; 13:469–475.
3. Schuckit MA: Vulnerability factors for alcoholism, in Neuropsychopharmacology: The Fifth Generation of Progress. Edited by Davis K. Baltimore, Lippincott Williams & Wilkins, 2002, pp. 1399–1411.
4. Johnson BA, Ait-Daoud N, Akhtar FZ, et al: Oral topiramate reduces the consequences of drinking and improves the quality of life of alcohol-dependent individuals: a randomized controlled trial. Arch Gen Psychiatry 2004, 61:905–912.

SYMPOSIUM 37—EVIDENCE-BASED PSYCHIATRY: WHAT IT IS AND WHAT IT IS NOT

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand basic concepts of evidence-based medicine (EBM) as applied to psychiatry, as well as to critically judge strengths and weaknesses of EBM.

No. 37A
EVIDENCE-BASED MEDICINE IN PSYCHIATRY: AN OVERVIEW

Gregory E. Gray, M.D., *Department of Psychiatry, Charles R Drew University, 1720 East 120th Street, AFHMHC Room 1021, Los Angeles, CA 90059*

SUMMARY:

Evidence-based medicine (EBM) has been described as a philosophy, a method, and a set of tools. It involves the application of medical informatics and clinical epidemiology to patient care. The presenter provides an overview of EBM in psychiatry, including its historical development and basic methods.

No. 37B
EVIDENCE-BASED APPROACHES TO TEACHING AND PRACTICING PSYCHOPHARMACOLOGY

David N. Osser, M.D., *Department of Psychiatry, Taunton State Hospital, 60 Hodges Avenue Extension, Taunton, MA 02780*

SUMMARY:

It is extremely time consuming and difficult for clinicians to keep up with the massive numbers of research findings in psychopharmacology and apply them appropriately to clinical situations. Yet, the alternative to evidence-informed reasoning is often a variety of faulty processes of decision-making that lead to a high rate of errors in judgment. And, clinical experience has been defined as "making the same mistakes over and over a remarkable number of times." The presenter's course in clinical psychopharmacology meets weekly for 1.5 hours for two years beginning in the PGY-2 year. The course emphasizes the development of skills in practicing EBM. However, it goes beyond traditional EBM and encourages the use of evidence-based practice guidelines and algorithms as primary resources con-

tributing to clinical decision-making. Rigorously-constructed algorithms are also used as a way of organizing knowledge in psychopharmacology: they provide contexts in which to place new information and compare it with previous knowledge. Results of a study comparing the attitudes toward EBM and use of EBM techniques in a sample of 17 psychiatrists who completed this course, with a sample of psychiatrists recently trained in another program, are presented. These results suggest the course had some success in achieving its goals.

No. 37C
USES AND ABUSES OF EBM IN PSYCHIATRY

S. Nassir Ghaemi, M.D., *Department of Psychiatry, Cambridge Health Alliance/Harvard, 1493 Cambridge St, Cambridge, MA 02139*

SUMMARY:

The presenter highlights concepts from EBM that are especially useful for psychiatry, as well as misinterpretations or misuses that can confuse clinicians and researchers. Examples from research and practice on bipolar disorder are highlighted. Specific concepts that are quite useful are the concepts of levels of evidence, the concept of systematic reviews of the literature, and a shift in statistical focus from hypothesis testing to effect estimation methods. Examples are provided of controversies in clinical research and practice in bipolar disorder in which these concepts from EBM can be quite helpful. The presenter also discusses some ways in which some EBM concepts are ignored, misunderstood, or manipulated in scientific studies, frequently sponsored by the pharmaceutical industry, leading to confusion on the part of peer reviewers and readers of the clinical literature. Among the issues discussed are overuse of p-values leading to lack of appreciation of false positive or false negative risks, lack of attention to primary versus secondary or post hoc analyses, resulting in misleading impressions about the findings of studies, and the general issue of lack of access to data and data analysis by academics in pharmaceutical clinical trials.

No. 37D
EVIDENCE-BASED MEDICINE: HOW IT CAN BE MISUSED

David T. Healy, M.D., *Department of Psychiatry, Cardiff University, Hergest Unit, Bangor, United Kingdom*

SUMMARY:

There are three problems with evidence-based medicine as it applies to psychopharmacology. First is an "Olympic medal" problem: ghostwriting and selective publication of the trial data has made it difficult to know the value of randomized clinical trials (RCTs). Second, the "ecological" problem: where drugs may have clear outcomes, as with hypnotics, RCTs seem unnecessary. However, there should be a further set of trials to determine the value patients put on these outcomes. Third, the "looking glass" problem: clear outcomes or not, trials are constructed based on a null hypothesis, leading to outcomes as evidence that it's not possible to say these drugs do nothing — these trials do not show drugs "work." Despite these three problems, EBM has increasingly become a juggernaut that risks steamrolling patients at odds with most of the values of medicine. EBM has the potential for misuse by special interest groups, such as pharmaceutical industries. The presenter uses the example of the SSRI drugs and hazards linked to them to develop these points.

No. 37E
EBM AND PHARMACEUTICAL INDUSTRY-SPONSORED CLINICAL TRIALS

Amir H. Kalali, M.D., *Global Scientific Head, Quintiles CNS Therapeutics, 10201 Wateridge Circle, San Diego, CA 92121*

SUMMARY:

Much of the research literature on treatment in psychiatry today is organized and conducted by the pharmaceutical industry and clinical research organizations. As the medical director of Quintiles, a clinical research organization, the presenter had the opportunity to observe and participate in the conduct of major clinical trials, as well as observe the reception of those data in the scientific community. In this presentation, he gives a perspective from outside academia about the nature of the relationship between private industry and academic researchers and the impact of this relationship on psychiatry's scientific knowledge base. He reviews the strengths and weaknesses of the academia-industry partnership and discusses ways in which the quality of scientific data derived from industry-sponsored trials can be enhanced. Among the topics discussed are authorship, rating scale development, the use of placebos, and coordination of large-scale studies.

REFERENCES:

1. Gray GE: The Concise Guide to Evidence-Based Psychiatry. Arlington, VA, American Psychiatric Publishing, 2004.
2. Osser DN, Patterson RD, Levitt JJ: Guidelines, algorithms, and evidence-based psychopharmacology training for psychiatric residents. Acad Psychiatry, in press.
3. Ghaemi SN, Soldani F: Meta-analysis of observational studies: the case of rapid-cycling bipolar disorder. Acta Psychiatr Scand 2003; 108:1–3.
4. Healy D: The Creation of Psychopharmacology. Cambridge, MA, Harvard University Press, 2002.
5. Buchkowsky SS, Jewesson PJ: Industry sponsorship and authorship of clinical trials over 20 years. Ann Pharmacother 2004; 38:579–585.

SYMPOSIUM 38—HOW TO LAUNCH A SUCCESSFUL PRIVATE PRACTICE, PART 3

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) develop an individual strategy for launching a successful private practice while maximizing one's strengths and interests, (2) learn techniques that will give the necessary edge to succeed in a competitive marketplace, and (3) learn to balance the functions of manager, technician, and entrepreneur in a small business.

No. 38A
PERSONAL FACTORS LEADING TO A SUCCESSFUL PRIVATE PRACTICE

William E. Callahan, Jr., M.D., *7700 Irvine Center Drive, Suite 530, Irvine, CA 92618*

SUMMARY:

The presenter discusses the biggest risks for failure and individual issues that must be accounted for if you are to be successful in private practice. Ways to avoid being pulled into unethical behavior are addressed. The need to have an attorney review your office contracts and ways to avoid getting taken advantage of in the business

and professional world are detailed. Broad issues for professional success are covered, including recognizing your own professional value, developing a business plan, and keeping your financial expectations realistic.

No. 38B
OFFICE LOCATION AND DESIGN FOR EFFICIENCY AND SUCCESS

Keith W. Young, M.D., *10780 Santa Monica Boulevard, #250, Los Angeles, CA 90025-4749*

SUMMARY:

The presenter discusses the details of office location and design. He provides a checklist of features often not thought about that are important to consider. Factors that are and are not important in locating an office and tips on how to make that decision are discussed. References to differences based on rural versus urban are addressed. The impact of the office on the success of the practice, as well as how well (or not) it represents the practitioner, is discussed.

No. 38C
STREAMLINING OVERHEAD AND MANAGING YOUR BUSINESS IN PRIVATE PRACTICE

Keith W. Young, M.D., *10780 Santa Monica Boulevard, #250, Los Angeles, CA 90025-4749*

SUMMARY:

The presenter discusses streamlining all aspects of one's practice to limit overhead while maximizing earnings and quality. Tips about minimizing personal and office expenses are offered. Setting fees, billing, scheduling appointments, missed appointments, and other areas are covered. The presenter also outlines necessary insurance, retirement, and banking systems, as well as taxes and areas of potential difficulty for psychiatrists starting a new practice. Finally, the roles of technician, manager, and entrepreneur, which are essential to success in a small business, are discussed as they apply to psychiatric practice.

No. 38D
MARKETING YOUR UNIQUE PRIVATE PRACTICE

William E. Callahan, Jr., M.D., *7700 Irvine Center Drive, Suite 530, Irvine, CA 92618*

SUMMARY:

The presenter highlights how to get the right patients through the door. Concepts of branding so that one can be distinguishable from one's peers are examined. Marketing also requires persistent visibility and developing name recognition within a region and then within segments of that region that the practitioner is best equipped to serve. The presenter has developed an extensive list of ideas and ways to do this, which the practitioner can tailor to his or her own area and strengths. The focus in the start-up phase of practice is on methods that will cost time, but not money, since time is usually more available than money in this phase.

REFERENCES:

1. Logsdon L: Establishing A Psychiatric Private Practice. Washington, DC, American Psychiatric Press, 1985.
2. Molloy P: Entering the Practice of Psychiatry: A New Physician's Planning Guide. Roerig and Residents, 1996.
3. Practice Management for Early Career Psychiatrists. Washington, DC, American Psychiatric Association, Office of Healthcare Systems and Financing, 1998.
4. Gerber ME: The E-Myth Revisited: Why Most Small Businesses Don't Work and What to Do About It. New York, Harperbusiness, 1995.

SYMPOSIUM 39—COMPLEX PHARMACOTHERAPY VERSUS POLYPHARMACY

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant will have a better understanding of complex pharmacotherapy and the pitfalls of polypharmacy.

No. 39A
POLYPHARMACY AND ETHNIC MINORITIES

William Lawson, M.D., *Department of Psychiatry, Howard University Hospital, 2041 Georgia Avenue, Washington, DC 20060*

SUMMARY:

Recent reports have shown that ethnic disparities exist in the illness burden of many mental disorders. These disparities are due in large part to disparities in the availability and appropriate use of treatment. African Americans with psychosis often receive excessive treatment. They are at risk for receiving higher doses, more medications, greater use of antipsychotics irrespective of diagnosis, and less use of antidepressants. This prescribing pattern often occurs despite pharmacokinetic data that indicate doses should be lower. African Americans often do not receive newer agents. When they are prescribed, they are often combined with older agents, thereby defeating the pharmacological benefit. Attitudinal factors and stereotypical beliefs are often the reasons for the inappropriate treatment. On the other hand, emerging metabolic risks of the newer antipsychotics have complicated treatment decisions. However, ethnic differences in the risk of some side effects may be overcome by combination therapy. Nevertheless, the lack of minority participation in research and the limited research on complex pharmacotherapy leaves little guidance for someone treating an inner-city population.

No. 39B
IMPULSIVE BEHAVIOR IN CHILDREN AND ADOLESCENTS

Janice G. Hutchinson, M.D., *Department of Psychiatry, Howard University, 2041 Georgia Avenue, NW, Washington, DC 20060;* William Lawson, M.D.

SUMMARY:

Recent research in pharmacotherapy has shown that children and adolescents are not simply little adults. The treatment response and side-effect profiles of children appear quite different from those of adults. Controversy still persists as to whether antidepressants are effective in children, and whether SSRIs in particular increase suicide risk. Multiple studies are now showing that second-generation antipsychotics have significant rates of extrapyramidal side effects and increased risk of weight gain. Unfortunately, children are often not included in clinical trials, so the research literature is often silent in addressing many of the issues facing children with complex psychiatric issues. Nevertheless, these findings suggest that polypharmacy may be a feasible approach to address their needs. The poor response to antidepressant therapy suggests the need for further exploration with combination therapy. The increased risk of side effects makes feasible the use of several agents with similar therapeutic effects but

different side-effect profiles. These agents may be useful at doses that individually may be ineffective. On the other hand, the risk of misdiagnosis because of differing presentations from adults and the poor treatment response for common agents can lead to excessive pharmacotherapy when that could be avoided with psychosocial interventions. The complexity of pharmacotherapy in attention deficit disorder comorbid with an affective disorder is discussed in detail.

No. 39C
POLYPHARMACY IN DEPRESSION AND ANXIETY: WHAT, WHEN, AND HOW TO IMPLEMENT

Gabriela Cora-Locatelli, M.D., *9999 NE 2nd Avenue, Suite #213, Miami Shores, FL 33138*

SUMMARY:

The term polypharmacy generally describes treatment with two drugs or more. Literally, the term means the use of many drugs or, alternatively, much poison. Although we may compare medications used for anxiety and depressive disorders with respect to their pharmacology, pharmacokinetics, adverse effects, drug interactions, and dosing, the comorbidity between depression and anxiety may tend to be the rule more than the exception. Nearly two-thirds of depressed patients experience anxiety symptoms. Selected studies report comorbidity rates ranging from 21% to 81% of patients with anxiety disorders also meeting the criteria for major depressive disorder, and rates from 15% to 33% of patients having recurrent panic attacks during a major depressive disorder episode. The difference in the course of illness of the underlying condition needs to be evaluated for the appropriate combination strategy. Multiple medications from the same class or different classes may be used to treat the same symptom cluster, others may be added to treat side effects from other medications or as augmentation to boost the response to a primary medication. Simultaneous comparison of daily mood fluctuations, the emergence of anxiety symptoms, and medications may help to optimize and rationalize complex pharmacological therapy and to better detect nuances of partial response.

No. 39D
COMPLEXITIES OF BIPOLAR ILLNESS TYPICALLY REQUIRE COMPLEX COMBINATION THERAPY

Robert M. Post, M.D., *Department of Biological Psychiatry, National Institute of Mental Health, 10 Center Drive MSC 1272, Bethesda, MD 20892-1272*

SUMMARY:

Bipolar illness is unique in its complexities of presentations (manias, depressions, and mixed states with an infinite variety of illness patterns and frequencies) in association with many comorbidities, including most prominently anxiety disorders and substance abuse. Patients with rapid and faster cycling in academic outpatient settings require an average of 4.5 different classes of medications, although patients without rapid cycling require three. In these naturalistically treated bipolar disorder outpatients, the amount of time depressed still exceeds that of the time manic by a factor of three, emphasizing the importance of treatments targeted to the depressive phase of the illness, including psychotherapeutic and psychoeducational approaches, which can augment and enhance treatment outcome.

Choice of appropriate first and second mood stabilizer combination therapy would appear to depend on matching the patients symptomatic and comorbid presentations with the existing, weak but useful clinical and family history predictors of likely responsivity. In addition to the recognized mood stabilizers lithium, carbamazepine, valproate, and lamotrigine, several anticonvulsants may have utility in assistance with weight loss (topiramate and zonisamide) or in decreasing alcohol or cocaine use (topiramate, even though it is not itself an effective antimanic agent). Moreover, a bimodal role of atypical antipsychotics in both mania and depression is increasingly recognized as another alternative to more traditional mood stabilizers, antidepressants, and anxiolytics. A variety of augmentation strategies, including thyroid and folate, may also play a useful role.

In navigating the complexities of evaluation of both efficacy of a new augmenting agent and its side effects, a consistent method of mood charting, such as the prospective daily version of the NIMH Life Chart Method, is critical to optimal clinical therapeutics and the involvement of the patient in the therapeutic process and alliance. A number of case examples are given in which less complex combination therapy left the patient still symptomatic, while greater treatment complexity using well-targeted and tolerated adjunctive strategies led to remission. Prospective studies of complex combination therapy in bipolar illness are needed.

No. 39E
POLYPHARMACY IN SCHIZOPHRENIA TREATMENT

David C. Henderson, M.D., *Department of Psychiatry, Massachusetts General Hospital, 25 Staniford Street, Boston, MA 02114*

SUMMARY:

Polypharmacy is becoming increasingly common in the treatment of schizophrenia. There is moderate evidence suggesting that serotonin reuptake inhibitors may be helpful for depression and for negative symptoms and that mood stabilizers may be helpful in some patients. Anecdotal reports also support the use of stimulants to counteract medication-induced sedation and, possibly, to improve attention. The combination of two different antipsychotic agents is not well studied but may be a reasonable approach in treatment-resistant or treatment-intolerant patients. A rationale for choosing antipsychotic agents for use in combination and a guide for conducting time-limited trials will be presented. Antipsychotic agent combinations may minimize the potential side effects, including weight gain, diabetes mellitus, and hyperlipidemia. In addition, results from recent investigations combining antipsychotic agents are briefly reviewed.

REFERENCES:

1. Lawson WB: Issues in the pharmacotherapy of African Americans, in Review of Psychiatry, Volume 19. Edited by Ruiz P. Washington, DC, American Psychiatric Press, 2000, pp. 37–53.
2. American Psychiatric Association: Practice Guidelines for the Treatment of Psychiatric Disorders Compendium. Arlington, VA, American Psychiatric Association, 2004, pp. 745–834.
3. Ghaemi SN (ed): Polypharmacy in Psychiatry. New York, Marcel Dekker, 2002.
4. Frye MA, Ketter TA, Leverich GS, et al: The increasing use of polypharmacotherapy for refractory mood disorders: 22 years of study. J Clin Psychiatry 2000; 61:9–15.
5. Freudenreich O, Goff DC: Antipsychotic combination therapy in schizophrenia: a review of efficacy and risks of current combinations. Acta Psychiatr Scand 2002; 106:323–330.

SYMPOSIUM 40—INTEGRATING AND SEQUENCING TREATMENTS FOR BORDERLINE PATIENTS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize empirically validated treatments for patients with

borderline personality disorder, and understand their potential combination and sequencing.

No. 40A
PHASES AND STAGES OF CHANGE IN THE TREATMENT OF PERSONALITY DISORDER

John Livesley, Ph.D., *Department of Psychiatry, University of British Columbia, 2255 Wesbrook Mall, Vancouver V64 1L1, Canada*

SUMMARY:

The evidence indicates that various therapies are effective in treating personality disorder, although none appears more effective than the others. This finding suggests that an eclectic approach that uses a combination of interventions from different frameworks may be indicated. The challenge for such an approach is to deliver interventions in an integrated and systematic manner. It is argued that combination of interventions is possible by using a phases and stages of change approach in which specific interventions are delivered in the context of general strategies that optimize the nonspecific component of therapy.

The overall treatment of personality disorder may be described in terms of five phases: (1) safety, (2) containment, (3) regulation and control, (4) exploration and change, and (5) integration and synthesis. This description provides a framework for combining interventions. During the earlier phases, structured interventions and medication predominate. As safety in ensured and impulses and affects are contained, attention shifts to improving regulation and control of affects and impulses through the use of additional cognitive and behavioral interventions. Once emotional regulation skills are acquired and the alliance develops, the focus gradually changes to exploration and change of maladaptive cognitions, interpersonal patterns, and trait-based behavior. This phase often requires the addition of psychodynamic and interpersonal interventions. Eventually in long-term treatments, attention focuses on the development of a more integrated and adaptive self structure or identity, which may require additional interventions drawn from self psychology and constructionist approaches.

No. 40B
ADAPTING DIALECTICAL BEHAVIOR THERAPY FOR THE PSYCHIATRIC PRACTITIONER

Barbara H. Stanley, Ph.D., *Department of Psychiatry, Columbia University, NYSPI Unit 42, 1051 Riverside Drive, New York, NY 10024*

SUMMARY:

Dialectical behavior therapy (DBT) is a form of cognitive behavioral therapy that was developed specifically for the treatment of self-injuring and suicidal individuals with borderline personality disorder. DBT combines acceptance strategies, including a nonjudgmental stance, with behavioral and cognitive change techniques, such as cognitive restructuring and behavioral analysis. DBT consists of individual psychotherapy, group skills training, therapist consultation, and patient coaching. Most DBT treatment research has found efficacy for suicidality and self-injury. These findings are not surprising, because DBT targets self-injury and suicidal behavior in the first stage of treatment, which can last up to a year. The presenter focuses on two areas: (1) when DBT is likely to be most useful to individuals with borderline personality disorders and (2) which techniques, strategies, and theoretical perspectives of DBT can be adopted and integrated into the practice of clinicians who use supportive psychotherapy or psychodynamic psychotherapy. A model of DBT-informed psychotherapy is described. In particular, the role of skills training, the use of behavioral analysis techniques, the development of safety plans and strategies, and the use of diary cards for tracking of self-destructive urges and behaviors are discussed. In addition, the use of multiple treatments either sequentially or in tandem with DBT is described, and cases demonstrating this successful combination are discussed.

No. 40C
COMMON MECHANISMS IN PSYCHOLOGICAL THEORIES: ATTACHMENT AND MENTALIZATION

Peter Fonagy, Ph.D., *Psychoanalysis Unit, University College of London, Gower Street, London WC1E 6BT, United Kingdom;* Anthony Bateman, M.D.

SUMMARY:

Borderline personality disorder may be conceived of as the consequence of hyperactivation of the attachment system. When activated, this behavioral system, underpinned by the mesolimbic dopaminergic reward pathways under the influence of oxytocin and vasopressin, causes deactivation of complementary systems linked to the integration of cognition and emotion on the one hand and social judgment, theory of mind, and mentalization on the other. Aspects of borderline personality disorder may be understood as the consequence of deficits in mentalization and integration of emotion and cognition in an attachment context. Mentalization-based therapy, a rehabilitative approach to the treatment of borderline personality disorder, can be used to help patients improve the capacity for social cognition in the context of attachment relationships either in relation to group or individual psychotherapy. The mentalization framework may be used as a generic approach, within which a variety of psychotherapeutic models can be accommodated.

No. 40D
TOWARD A RATIONAL PHARMACOTHERAPY OF BPD

Larry J. Siever, M.D., *Department of Psychiatry, Mt. Sinai School of Medicine, One Gustave Levy Place. Box 1230, New York, NY 10029*

SUMMARY:

Pharmacotherapy has long played a role in the symptomatic treatment of borderline personality disorder and the control of psychotic-like symptoms, affective dysregulation, impulsivity/aggression, anxiety, and depression. New neurobiologic studies of borderline personality disorder also hold out the promise of a more targeted and rational approach to the pharmacotherapy of borderline personality disorder. Comorbid depressive disorder is usually treated by selective serotonin reuptake inhibitors (SSRIs) but may sometime require antidepressants with catecholaminergic mechanisms. Psychotic-like symptoms and impulsive/aggressive symptoms may respond to atypical antipsychotic medications. Mood stabilizers and anticonvulsant medication may help to contain excessive affective lability as well as any bipolar mood dysregulation. Although benzodiazepines are to be avoided, buspirone and clonazepam may help in the regulation of anxiety. Opiate antagonists may play a role in reducing self-injurious behavior, and mixed agonist/antigonists hold promise for treatment of the anhedonia and self-injurious behavior sometimes seen in this disorder. New functional and neurochemical imaging studies are pinpointing the pharmacologic components and specific circuitry involved in the dysfunction of borderline personality disorder and may be pointing the way to newer, more specific treatments for these underlying temperamental vulnerabilities.

No. 40E
PSYCHOEDUCATION FOR FAMILY MEMBERS WITH A RELATIVE WITH BPD

Perry D. Hoffman, Ph.D., *Department of Psychiatry, Weill Medical College, 21 Bloomingdale Road, White Plains, NY 10605*

SUMMARY:

Psychoeducation for families of persons with mental illness is a mode of intervention that has become a well-established treatment component for a considerable number of psychiatric disorders. Although more recognized for use with Axis I disorders, the modality is relatively in its infancy with personality disorders but is becoming more prevalent either as a stand-alone treatment or as an adjunct to individual treatment with an Axis II population. The presenter outlines the psychoeducation programs available for the borderline personality disorder community. Options of conducting either an integrated, concurrent treatment or a free-standing program for family members, as well as the components of each treatment protocol, are discussed. Data are presented on one psychoeducation program, Family Connections, where participants attend a 12-week course to learn more about the disorder, to acquire coping skill techniques, and to develop a support network.

REFERENCES:

1. Livesley WJ: Practical Management of Personality Disorder. New York, Guilford, 2003.
2. Linehan MM. Cognitive-Behavioral Treatment of Borderline Personality Disorder. New York, Guilford, 1993.
3. Bateman A, Fonagy P: Psychotherapy for Borderline Personality Disorder: Mentalization Based Treatment. Oxford, UK, Oxford University Press, 2004.
4. Koenigsberg HW, Woo-Ming AM, Siever LJ: Pharmacological treatment for personality disorders, in A Guide to Treatments That Work, 2nd Edition. Edited by Nathan PE, Gorman JM. New York, Oxford University Press, 2002, pp. 625–641.

SYMPOSIUM 41—MATERNAL DEPRESSION AND COMORBIDITIES: IMPACT ON INFANTS

EDUCATIONAL OBJECTIVES:

At the end of this symposium the participant should be able to (1) identify maternal psychiatric disorders and the impact on pregnancy and mother infant interactions and (2) identify the impact of maternal stress and related disorders on infant attachment and development.

No. 41A
MATERNAL DEPRESSION AND COMORBIDITIES: PTSD AND BPD

Marian I. Butterfield, M.D., *Department of Psychiatry, Durham VA Medical Center, 508 Fulton Street, 116A, Durham, NC 27705;* Jennifer L. Strauss, Ph.D.

SUMMARY:

The presenter provides an overview of psychiatric disorders that may observed in women, specifically postpartum depression, posttraumatic stress disorder (PTSD), and borderline personality disorder. A common link to all these psychiatric disorders is often a history of traumatic stress and victimization. Sexual trauma and related victimization of women often results in PTSD but also in borderline personality disorder and depression. Life-threatening interpersonal traumas such as rape are associated with a 8.5-fold increase in PTSD risk, compared to other types of trauma. The impact of lifetime victimization on women as they become mothers is discussed. The theoretical impact of psychiatric symptoms, neurobiological correlates, and potential effects on attachment patterns across these three disorders are reviewed. Case material and research with women veterans are presented to illustrate the complexities and overlap of these disorders and the adverse effects as women become mothers. This overview of depression, borderline personality disorder, and PTSD emphasizes provider recognition and provides a background review for the ongoing attachment research that is presented in the symposium.

No. 41B
PERINATAL DEPRESSION: IMPACT OF MATERNAL DISTRESS ON NEONATAL OUTCOMES AND ATTACHMENT

Sheila M. Marcus, M.D., *Department of Psychiatry, University of Michigan, 900 Wall Street, Riverview Building, Ann Arbor, MI 48109-0722*

SUMMARY:

The presentation addresses the impact of maternal depression on pregnancy outcomes. Maternal distress and its impact on the development of the infant stress axis, regulation of sleep, feeding, and attachment are explored.

Approximately 135 pregnant women were enrolled in a study examining maternal distress, maternal and infant regulation of the limbic-hypothalamic-pituitary-adrenal axis, and implications for sleep, feeding, and attachment. A significant relationship between depression and premature delivery was found. Neurobiologic correlates of major depression (salivary cortisol) in neonates suggested blunting in AM circadian cortisol patterns in infants whose mothers were depressed. Neurodevelopmental and attachment milestones were monitored and are examined in relation to maternal depression.

Better understanding of depression in women both in terms of behavior and biological systems, could ultimately lead to better understanding of transmission of affective illness and lead to early identification of and intervention with a pediatric population at high risk.

No. 41C
IMPACT OF MATERNAL BPD ON INFANT EMOTIONAL REGULATION

Gisèle Apter-Danon, Ph.D., *Perinatal Psychiatry L'Aubier, Erasme Hospital University Paris 7, 121 bis Avenue du Général Leclerc, Bourg-La-Reine 92340, France;* Rozenn Graignic-Philippe, Marina Gianoli-Valente, Psy.D., Emmanuel Devouche, Ph.D., Annick Crivile-Le-Nestour, M.D.

SUMMARY:

The presentation includes instruction in how to look for personality disorder in association with perinatal depression and its impact on the mother-infant interaction. The presenter discusses how perinatal depression in mothers with borderline personality disorder introduces specificities in mother-infant interaction and produces dysregulation of emotion in young infants.

Ninety-six women were recruited during the second half of pregnancy for a propective study of mother-infant interaction. DSM-IV diagnoses were assessed with personality and depression instruments. Borderline personality disorder was highly correlated with major depressive disorder. Three-month-old infants showed more stressful behaviors during videoed interaction with mothers and less capability of reorganizing after a mild stressful experience.

Better assessment of different aspects of maternal psychopathology could enhance management of at-risk mother-infant situations. Screening and intervention could be planned as measures to prevent infant abuse and neglect.

No. 41D
HOW EARLY LIFE EXPERIENCE AFFECTS THE DEVELOPMENT OF OPTIMISM'S NEURAL CIRCUITRY

Susan C. Vaughan, M.D., *25 W 81st Street, Suite 1C, New York, NY 10024*

SUMMARY:

The presenter reviews research from animal models and humans about the development of brain structures in early life in response to attachment to primary caregivers. The evolving corticolimbic loops laid down in response to experiences with early life figures pave the way for affect regulation in later life, an ability that is notably impaired in adult patients with borderline personality disorder. Further, there is growing evidence that these early brain structures may link cortical representations of self and other to affect modulation so that emotional regulation is intrinsically connected with one's views of self and others. Clinical implications for intervention are discussed.

REFERENCES:

1. Butterfield MI, Becker ME, Marx CE: PTSD in women: current concepts and treatment. Curr Psychiatry Rep 2002; 4:474–485.
2. Texeira JM, Fisk NM, Glover V: Association between maternal anxiety in pregnancy and increased uterine artery resistance index: cohort based study. Br Med J 1999; 318:153–157.
3. Rosenblum KL, McDonough S, Muzik M, et al: Maternal representations of the infant: associations with infant response to the still face. Child Dev 2002; 73:999–1015.
4. Vaughan SC: Half Empty, Half Full: Understanding the Roots of Optimism. New York, Harcourt, 2002.

SYMPOSIUM 42—ADHD: FROM NEUROSCIENCE TO PRACTICE
Collaborative Session With the National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) assess the impairments due to ADHD in children and adolescents of both genders, (2) discuss the pharmacological treatments available for treating children and adults with ADHD, with emphasis on nonstimulant treatments, (3) identify the neuropsychological deficits of ADHD and address the heterogeneity of these deficits in terms of the genetic basis for ADHD, (4) describe the heritability of ADHD and the candidate genes that may possibly contribute to the symptoms of ADHD, and (5) distinguish the areas of the cortex that function differently in patients with ADHD.

No. 42A
PSYCHIATRIC AND FUNCTIONAL OUTCOME OF ADOLESCENT FEMALES WITH ADHD: A LARGE, CONTROLLED, FIVE-YEAR LONGITUDINAL FOLLOW-UP STUDY

Joseph Biederman, M.D., *Department of Psychiatry, Massachusetts General Hospital, 55 Fruit Street, Warren Building 705, Boston, MA 02114;* Stephen V. Faraone, Ph.D., Eric Mick, Sc.D.

SUMMARY:

Background: Previous follow-up studies showed that ADHD children growing up are at increased risk for comorbid conduct, mood, and anxiety disorders, as well as impairments in cognitive, social, family, and school functioning. However, this literature is almost exclusively based on studies of boys.

Methods: Using DSM-III- and DSM-IV-based structured diagnostic interviews and blind raters, the presenter's group examined psychiatric diagnoses at follow-up in adolescence and young adult years in a large sample of youths with and without ADHD of both genders. In addition, subjects were evaluated for cognitive, achievement, social, school, and family functioning.

Results: Analyses of follow-up findings revealed significant differences between ADHD subjects and control subjects in rates of disruptive behavior and mood, anxiety, and substance-use disorders, with these disorders increasing markedly from baseline to follow-up assessments. In addition, ADHD subjects had significantly more impaired cognitive, family, school, and psychosocial functioning than adolescent girls without ADHD.

Conclusions: These findings provide further support for the morbidity and dysfunction associated with ADHD in both sexes.

No. 42B
NONSTIMULANT TREATMENT OF ADULT ADHD

Thomas J. Spencer, M.D., *Department of Psychiatry, Mass General Hospital, 15 Parkman Street, WACC 7251, Boston, MA 02114*

SUMMARY:

Emerging data from randomized clinical trials document the tolerability, safety, and efficacy of nonstimulant drugs in the treatment of adults with ADHD. A variety of compounds with a common noradrenergic/dopaminergic activity have shown documented anti-ADHD activity, whereas those with predominately serotonergic properties appear not to be effective for ADHD. Randomized clinical trials of the tricyclic antidepressant desipramine and the atypical antidepressant bupropion support their efficacy in the treatment of adults with ADHD. Recently, the novel specific norepinephrine reuptake inhibitor atomoxetine has gained FDA approval for the treatment of ADHD in adults. Novel agents with cholinergic activity appear to be promising. Common adverse effects include minor increases in blood pressure and pulse that require monitoring. Despite these promising results, more research is needed to further document the short- and long-term safety and efficacy and the functional and neuropsychological outcomes of pharmacologic treatments for adults with ADHD.

No. 42C
NEUROPSYCHOLOGY OF ADHD: CLINICAL AND SCIENTIFIC IMPLICATIONS OF RECENT FINDINGS

Alysa E. Doyle, Ph.D., *Department of Psychiatry, Harvard Medical School, ACC-725 Parkman Street, Boston, MA 02114;* Stephen V. Faraone, Ph.D., Larry J. Seidman, Ph.D., Joseph Biederman, M.D.

SUMMARY:

A large literature has documented neuropsychological deficits in individuals with attention-deficit/hyperactivity disorder (ADHD) in aspects of executive and related functions associated with frontostriatal networks. Although the majority of these studies have examined preadolescent boys, recent data suggest similar impairments in females, adolescents, and adults with ADHD. Yet, despite these numerous studies, the core neuropsychological deficits in ADHD are still debated, most likely due to the substantial heterogeneity in neuropsychological performance across and within ADHD samples. The presenter reviews empirical evidence for this heterogeneity and dis-

cusses data illustrating the implications of these variable deficits in terms of functional impairment in individuals with ADHD. In addition, the implications of heterogeneity for the use of neurocognitive deficits as an endophenotype for ADHD are discussed. Specifically, using data from family studies of ADHD, the presenter addresses the familial overlap of neuropsychological phenotypes with ADHD symptom dimensions and the relevance of these findings to molecular genetic studies of ADHD.

No. 42D
HERITABILITY: NEW GENETIC FINDINGS IN ADHD

Pamela Sklar, M.D., *Mass General Hospital East, 149 13th Street, 10th Floor, Charlestown, MA 02129*

SUMMARY:

Attention-deficit/hyperactivity disorder (ADHD) is a common disorder of childhood associated with school failure, psychiatric comorbidity, and psychosocial disability. Most family studies demonstrate strong heritability for ADHD. The risk of ADHD among parents of children with ADHD is increased by between two- and eightfold, with a similarly elevated risk among the siblings. Twin studies and adoption studies likewise support strong heritability, with estimates of approximately 76%. Evidence for particular regions of the genome harboring susceptibility genes can be found in three recent genome scans.

Association studies are a complementary route for identifying risk genes for ADHD. Association studies have pointed to a number of biological candidate genes including DAT, DRD4, DRD5, SNAP-25, DRD3, MAOA, and 5HT1B. Review of the literature and meta-analysis support a role for several of these genes. Recent evidence for association between each of these genes and ADHD is reviewed. However, it is clear that in no case is variation at the gene comprehensively understood. Thus, it is not yet possible to determine the causal variant or understand the mechanism by which the gene produces increased risk. This will be an active area of research in the near future.

No. 42E
LOOKING AT THE ADHD BRAIN: NEUROIMAGING STUDIES IN ADHD

Larry J. Seidman, Ph.D., *Department of Psychiatry, Harvard Medical School, 25 Shattuck Street, Boston, MA 021115;* Eve M. Valera, Ph.D., Joseph Biederman, M.D., Thomas J. Spencer, M.D., Stephen V. Faraone, Ph.D., George Bush, M.D.

SUMMARY:

Although most of our current knowledge about attention-deficit/hyperactivity disorder (ADHD) developed from clinical observations and research with children, our understanding of the disorder in adults is growing rapidly. We are discovering that adults and children with ADHD share similar clinical features, comorbidities, neuropsychological deficits, and failures in major life domains (e.g., academics and work). It has become quite clear that in order to gain a full understanding of brain function and structure in ADHD, we must study the disorder from a lifespan perspective — integrating what we know about how it affects both adults and children. Cross-sectional structural MRI data suggest that brain dysfunctions are a central component of the childhood syndrome, and a growing functional MRI literature is suggesting the same for adults. The presenter reviews the current state of the literature pertaining to the structural and functional brain abnormalities that are found in children and adults with ADHD and presents new imaging data derived from an ongoing study of teenagers and adults with ADHD. This research incorporates measures of structural MRI, including general segmentation and cortical and cerebellar parcellation, as well as measures of working memory during functional MRI.

REFERENCES:

1. Faraone SV, Biederman J, Mick E, et al: A family study of psychiatric comorbidity in girls and boys with attention deficit hyperactivity disorder. Biol Psychiatry 2001; 50:586–592.
2. Spencer T, Biederman J, Wilens T: Nonstimulant treatment of adult attention deficit hyperactivity disorder. Psychiatr Clin North Am 2004; 27:373–383.
3. Doyle AE, Faraone SV, Seidman LJ, et al: Are endophenotypes based on measures of executive functions useful for molecular genetic studies of ADHD?, in preparation.
4. Seidman LJ, Valera E, Bush G: Brain function and structure in adults with attention-deficit/hyperactivity disorder. Psychiatr Clin North Am 2004; 27:323–347.

SYMPOSIUM 43—ASSOCIATIONS BETWEEN STRESS/ANXIETY AND PERSONALITY STYLES AND DISORDERS
Association for Research in Personality Disorders

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to demonstrate understanding of clinical and experimental relationships between anxiety/stress and personality/personality disorder.

No. 43A
A SELECTIVE OVERVIEW OF RELATIONSHIP OF ANXIETY AND PERSONALITY DISORDERS

James H. Reich, M.D., *Department of Psychiatry, Stanford Medical School, 2255 North Point Street, Unit 102, San Francisco, CA 94123*

SUMMARY:

Anxiety and personality disorder are frequently comorbid and interact with each other in symptom manifestations and in the treatment of symptoms. The presenter examines some of the ways they interact, first by reviewing data on the frequency of personality disorders in anxiety disorder populations. The continuity of some anxiety and personality symptoms is reviewed, with emphasis on avoidant personality disorder. The presenter discusses how state anxiety can affect the measurement of personality and reviews the effect of personality on outcome of Axis I disorders. Various models of the relationship between anxiety and personality disorders are discussed.

No. 43B
SCHEMA THERAPY FOR MALADAPTIVE PERSONALITY TRAITS INVOLVING ANXIETY

David Bernstein, *Department of Psychology, Maastricht University, DMKEP, PO Box 616, 6200 MD, Maastricht, Netherlands*

SUMMARY:

Research suggests that many patients with personality disorders are subject to anxiety, if not a DSM anxiety disorder. The presenter discusses an integrative form of cognitive therapy, Schema Therapy, which focuses on the amelioration of maladaptive traits and maladaptive coping mechanisms that are the hallmarks of personality disorders. Special emphasis is given to those schemas that are triggered

by or manifested by anxiety. In the Schema Therapy model, early maladaptive schemas (EMSs) are dimensional personality traits that develop in childhood due to temperament and early life experiences, are pervasive, and chronic. They are conceptualized as self-defeating patterns or themes, such as abandonment, defectiveness, and deprivation, which play out over the course of a lifetime. The presenter introduces the Schema Therapy model and therapeutic approach, illustrates the model with a clinical case, and discusses preliminary findings of a randomized clinical trial of Schema Therapy in relationship to anxiety. Schema Therapy is a promising treatment for maladaptive personality traits that may improve outcomes for a variety of challenging patient populations, including those with anxiety.

No. 44C
PERSONALITY AND STRESS IN THREE PHASES OF THE PHYSICIAN'S CAREER: A LONGITUDINAL NATIONWIDE STUDY

Per Vaglum, M.D., *Department of Basic Medicine, University of Oslo, Sognsvannsveien 9, P.O. Box 1111 Blindern, Oslo N-0317, Norway;* Reidar Tyssen, M.D., Oivind Ekeberg, M.D., Tore Gude, M.D., Erlend Hem, M.D., Jan Ole Rovik

SUMMARY:

Some personality types may better cope with medical stress than others. This hypothesis was explored in a nationwide prospective study of last-term medical students (N = 459) who were reexamined (1) at the end of internship, (2) in the middle of residency, and(3) in established jobs seven years later. Stress reactions were measured by the Job Stress Questionnaire (Cooper) and a five-item version of the Hopkins Symptom Checklist (SCL-5), and neuroticism (N), extroversion (E) and conscientiousness (C) with Torgersen's Character Inventory (BCI). By dividing the sample on each of the personality variables at the median, eight unique combinations or personality types were constructed: spectator, insecure, sceptic, brooder, hedonist, impulsive, entrepreneur, and complicated type. Compared with all other types and with adjustment for gender, the hedonist reported significantly lower *job stress* in all three career phases, and the entrepreneur in the two first. The brooder and the impulsive reported higher job stress in the two first phases, and the complicated only in internship. Concerning mental distress, the hedonist and the entrepreneur reported a lower and the brooder a higher level in all three phases, the complicated only in internship. Stress in the early medical career was best tolerated by the hedonistic (low N/low C/high E) and entrepreneur (Low N/high C/high E) types. Implications of the findings are discussed.

No. 43D
PANIC, RAGE, AND FAMILY DISCORD IN BPD

David M. Allen, M.D., *Department of Psychiatry, University of Tennessee, 135 North Pauline Street, 6th Floor, Memphis, TN 38105*

SUMMARY:

Panic disorder is reportedly highly comorbid with borderline personality disorder. Symptoms of panic disorder share many characteristics with the autonomic arousal seen in rage attacks, a common symptom of borderline personality disorder. Clinically, patients who describe rage or panic attacks may report that an episode starts with rage and turns into panic or vice versa. This co-occurence may be due to limbic system activity characteristic of fight-or-flight responses. The amygdala, anterior cingulate gyrus, and orbital frontal cortex play crucial roles in fight or flight, directly regulating the autonomic nervous system through the hippocampus and hypothalmic-pituitary axis. These same brain regions are also activated during social stimulus appraisal and social cognition. Evidence is emerging that specific synaptic pathways in the amygdyla that are laid down early in life as attachment patterns develop and that generate social fear responses are highly resistant to extinction. Clinical examples are given of rage and panic symptoms in adults with borderline personality disorder that are seemingly triggered by dysfunctional family interactions. A patient's sense of responsibility for family problems and for solving them, along with a feeling of helplessness to do so, may be a particularly potent trigger.

No. 43E
IS EMOTIONAL DYSCONTROL AND IMPULSIVITY RELATED TO SUICIDAL IDEATION IN BPD PATIENTS?

Navjot Chaudhary, B.S.C., *Department of ASR Suicide, Saint Michael's Hospital, 30 Bond Street, Shuter Wing, Room 2010, Toronto, ON M4Y 1J3, Canada;* Paul S. Links, M.D., Rahel Eynan, M.A., Aiala Barr, Ph.D.

SUMMARY:

The goal of this study was to provide greater insight into the role of impulsivity in suicidal ideation in borderline personality disorder patients. It was predicted that a form of emotional dyscontrol, as indicated by the autocorrelation between successive Visual Analogue Scale ratings of daily mood, would be related to other measures of impulsive behavior, and that emotional dyscontrol would be related to suicidal ideation. Emotional dyscontrol was assessed with Experience Sampling Methodology, which employs signaling devices to sample subjective experience at six randomized times daily. Impulsivity was assessed with the Barratt Impulsivity Scale (BIS) and the Buss-Durkee Hostility Inventory (BDHI). Suicidal ideation was measured with the Scale for Suicide Ideation. Analysis of data for 58 patients ranging in age from 19 to 49 years demonstrated that emotional dyscontrol was related to impulsivity in males, as there were correlations of –0.583 ($p<0.05$) with BIS cognitive and 0.585 ($p<0.05$) with BDHI indirect. The results indicate that impulsivity, but not emotional dyscontrol, is related to suicidal ideation, as suicidal ideation was significantly related to BDHI resentment by a correlation of 0.589 ($p<0.05$) in males and to BIS non-planning by a correlation of –0.297 ($p<0.05$) in females. The data weakly support the conclusion that emotional dyscontrol is related to impulsivity, but not to suicidal ideation.

No. 43F
STRESS, PERSONALITY DISORDERS, AND OPIOID RECEPTORS

Kenneth Silk, M.D., *Department of Psychiatry, University of Michigan, 1500 E Medical Center Dr, Box 0295, Ann Arbor, MI 48109-0295;* Jon-Kar Zubieta, M.D.

SUMMARY:

Because a substantial proportion of patients with personality disorders have positive dexamethasone suppression tests (DST), the role of stress in the symptoms of personality disorders has attracted attention. Transient psychotic as well as dissociative symptoms in borderline personality disorder have been attributed to excessive stress or anxiety. Reduction of anxiety can lessen some of these symptoms. Patients who self-mutilate describe cycles of a progressive build up of anxiety that culminates in the feeling of being overwhelmed (with psychological pain or depersonalization). Decreases in feeling overwhelmed can be achieved through self-mutilatory acts. However, the tension begins to build again, and a cycle of increased tension being relieved by self-mutilation followed by a subsequent building up of tension leading to another act of self-mutilation becomes established. This cycle has the rhythm of an

addiction. The presenter's group is examining involvement in these processes of the endogenous opioids, a neurotransmitter system that interfaces responses to stress, emotional regulation, and physical injury. Preliminary results from a positron emission tomography (PET) study of mu-opioid system activity during induced sadness suggest that some patients with personality disorders, particularly borderline personality disorder, overactivate mu-opioid neurotransmission. Further understanding of the behavioral correlates of this phenomenon will allow examination of whether it occurs because of a lower effectiveness of this system to suppress the pain experience or because there is a rewarding element to the activation of this circuit that may contribute to indulging in behaviors with the potential to mobilize larger amounts of endogenous opioids. Data from these PET studies are presented to test these hypotheses.

REFERENCES:

1. Reich J, Hofmann S: State personality disorder in social phobia. Ann Clin Psychiatry, in press.
2. Young J, Klosko J, Weishaar M: Schema Therapy: A Practitioner's Guide. New York, Guilford, 2003.
3. Allen DM: Psychotherapy with Borderline Patients: An Integrated Approach. Mahwah, NJ, Lawrence Erlbaum, 2003.
4. Zubieta JK, Smith YR, Bueller JA, et al: Regional mu opioid receptor regulation of sensory and affective dimensions of pain. Science 2001; 293:311–315.

SYMPOSIUM 44—PERINATAL DEPRESSION: PREVALENCE, SCREENING ACCURACY, AND INTERVENTION

EDUCATIONAL OBJECTIVES:

At the conclusion of the symposium, the participant should be able to identify the current science in the following areas of perinatal depression: (1) the incidence of depression (major/minor) during pregnancy and the postpartum period, (2) the accuracy of different screening tools, and (3) the effect of screening with subsequent intervention on outcome.

No. 44A
A SYSTEMATIC REVIEW OF THE EVIDENCE ON THE INCIDENCE AND PREVALENCE OF PERINATAL DEPRESSION

Norma I. Gavin, Ph.D., *RTI International, 3040 Cornwallis Road, Research Triangle, NC 27709-2194*

SUMMARY:

Objective: The presenter's group conducted this study to (1) clarify the incidence and prevalence of depression during pregnancy and the first postpartum year, (2) identify factors accounting for variation in the rates, and (3) compare the rates to those for similar-age women during nonchildbearing periods.

Methods: Electronic databases were systematically searched to identify studies meeting predetermined inclusion criteria, including use of a clinical criterion for diagnosing depression; the quality of included articles was reviewed and assessed; and statistical meta-analyses were conducted on estimates of the same type, diagnosis, and time period.

Results: Twenty-eight prospective studies and over 200 estimates of the incidence and prevalence of perinatal depression were found; only three studies included a nonpregnant comparison group. Considerable uncertainty remains in the combined estimates, which vary from 7% to 13% for major/minor depression and 1% to 7% for major depression, with peaks at two to three months postpartum. The prevalence of depression in the perinatal period does not differ significantly from that seen during other periods. A single study shows the rate of new episodes of major/minor depression to be three times higher than typical in the first month postpartum.

Conclusion: Larger studies of the incidence and prevalence of perinatal depression among the general population and vulnerable subpopulations using current diagnostic criteria are needed.

No. 44B
WHAT IS THE ACCURACY OF DIFFERENT SCREENING TOOLS FOR DETECTING DEPRESSION DURING THE PERINATAL PERIOD?

Bradley N. Gaynes, M.D., *Department of Psychiatry, University of North Carolina at Chapel Hill, CB #7160, School of Medicine, Chapel Hill, NC 27599-7160*

SUMMARY:

Objective: Prenatal and postpartum visits provide opportunities for depression screening. The presenter's group reviewed the evidence on perinatal depression screening accuracy.

Methods: The authors systematically reviewed MEDLINE, CINAHL, PsycINFO, Sociofile, and Cochrane databases to identify studies of the accuracy of perinatal depression screening instruments that met predefined criteria, including a validated depression diagnosis. The authors abstracted selected articles, assessed their quality, and synthesized the relevant data.

Results: More than 90 abstracts and hand-searched bibliographies of selected articles were reviewed. Twenty-three articles met selection criteria. Of 11 studies using an English screen, one assessed use during pregnancy, while 10 were postpartum studies. Depression was reported as major/minor depression, or major depression alone. Articles were of good internal validity but poor external validity. Estimates of sensitivity were imprecise, given the small number of depressed patients involved, ranging from 3% to 95% for major/minor depression and 35% to 100% for major depression alone. Variability in patients studied, screening tools and thresholds, reference standards, and screening time points all limit the quantitative synthesis of information.

Conclusions: Available evidence involves few depressed subjects and varying methods, limiting conclusions about accuracy of particular screens and preventing direct comparison of different screens. A larger sample size is required for a reasonably precise measure of test properties.

No. 44C
DOES PERINATAL SCREENING FOR DEPRESSIVE SYMPTOMS WITH SUBSEQUENT INTERVENTION LEAD TO IMPROVED OUTCOMES? A SYSTEMATIC REVIEW OF THE EVIDENCE

Samantha E. Meltzer-Brody, M.D., *Department of Psychiatry, University of North Carolina, Campus Box 7160, Chapel Hill, NC 27599*

SUMMARY:

Objective: Although effective treatments for perinatal depression are available, many women do not receive adequate screening or treatment of their depression. This study examines whether perinatal screening for depressive symptoms with subsequent intervention leads to improved outcomes.

Method: The presenter's group systematically reviewed electronic databases to identify randomized controlled or prospective cohort trials of screening and treatment methods for perinatal depression that met inclusion criteria, including a criterion standard diagnosis

of a depressive disorder. The authors abstracted selected articles, assessed the quality of evidence, and synthesized the data.

Results: More than 60 articles were reviewed, and 15 were selected for inclusion. Of the 15 included articles, four examined screening during pregnancy and 11 screened in the postpartum period. The types and frequency of screening and treatment interventions differed among the studies. Overall quality was fair to good, whereas generalizability was poor. However, there appears to be a variety of interventions that may be helpful in treating at-risk women with perinatal depression.

Conclusions: The available evidence does not directly address whether screening with subsequent intervention improves outcomes. Future studies would need similar screening measures, length and intensity of the intervention, and outcome measures so that the studies could be compared and synthesized.

REFERENCES:

1. Armstrong KL, Fraser JA, Dadds MR, et al: A randomized, controlled trial of nurse home visiting to vulnerable families with newborns. J Paediatr Child Health 1999; 35:237–244.
2. Kessler RC: Epidemiology of women and depression. J Affect Disord 2003; 74:5–13.
3. Murray D, Cox JL: Screening for depression during pregnancy with the Edinburgh Depression Scale (EPDS). J Reprod Infant Psychol 1990; 8:99–107.
4. O'Hara MW, Swain AM: Rates and risk of postpartum depression: a meta-analysis. Int Rev Psychiatry 1996; 8:37–54.
5. Brugha TS, Wheatley S, Taub NA, et al: Pragmatic randomized trial of antenatal intervention to prevent post-natal depression by reducing psychosocial risk factors. Psychol Med 2000; 30(6): 1273–1281.

SYMPOSIUM 45—THE LONG-TERM PSYCHOLOGICAL AFTERMATH OF 9/11-RELATED TRAUMATIC LOSS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant will have an increased awareness of the mental health toll of traumatic loss related to the attacks of September 11, 2001, and will understand the challenges of detecting and managing grief-related problems in the wake of mass violence disasters.

No. 45A
TRAUMATIC GRIEF AMONG 9/11 VICTIMS

Yuval Y. Neria, Ph.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 69, New York, NY 10032*

SUMMARY:

Objective: The presenter provides data on the risk of psychopathology three years after the September 11 attacks, including data on posttraumatic stress disorder, traumatic grief, and functional problems. The role of coping, social support, and the level of attachment to the deceased in the long-term course of illness are examined.

Method: Structural assessments were conducted approximately three years after the September 11 attacks, through an Internet, secured survey of 520 people who lost family members, friends, or co-workers during the terrorist attacks.

Results: The majority of the individuals who experienced loss tended to recover and to have relatively low levels of adjustment problems, but for a significant minority, the loss of intimate friends or family members is debilitating and accompanied by long-term functional impairment.

Conclusions: When people lose loved ones unexpectedly, in particular from acts of violence, they are at risk for complicated and chronic grief-related problems. The unpredictable loss due to malicious acts of violence during the September 11 attacks created a cascade of loss and stress in those who were affected.

No. 45B
TRAUMA, BEREAVEMENT, AND TRAUMATIC LOSS

George A. Bonanno, Ph.D., *Teachers College, Columbia University, 525 West 120th Street, Box 1218, New York, NY 10027*

SUMMARY:

This talk reviews research and theory on the unique type of loss and trauma reactions associated with traumatic loss. Responses to the death of a loved one or exposure to violent and life-threatening events (trauma) share many common features. Although reactions to these events, typified by grief and posttraumatic stress disorder (PTSD), respectively, are usually qualitatively distinct, the prototypical outcome trajectories following loss and trauma are similar. Many people and often the majority of those exposed to loss or potential trauma evidence a resilience trajectory of relatively low levels of psychological symptoms. Others exhibit a classic recovery trajectory characterized by elevated symptoms and distress for the first several months after the event and then a gradual return to baseline over the next several years. Relatively small subsets of people, usually 10% to 15%, evidence chronically elevated symptoms and distress lasting several years and often longer. Recent research has suggested, however, that the loss of a loved though violence (suicide, homicide, accident) is more likely to lead to chronic depression and PTSD than losses due to natural death. These findings thus suggest that individuals who lost loved ones in the September 11 attacks were particularly vulnerable for chronic symptom reactions.

No. 45C
A NATIONWIDE LONGITUDINAL STUDY OF RESPONSES TO THE 9/11 TERRORIST ATTACKS

Roxane C. Silver, Ph.D., *Department of Psychology & Social Behavior, University of California, Irvine, 100 Theory, Suite 110, Irvine, CA 92697-7085*

SUMMARY:

Since September 11, 2001, the presenter's group has conducted a longitudinal investigation of emotional, cognitive, and social responses to the terrorist attacks across the United States. Using an anonymous Web-based survey method, data have been collected on a national probability sample of adults seven times: at two weeks, and two, six, 12, 18, 24, and 36 months after September 11. Pre-September 11 mental and physical health histories are available on most of the respondents, and follow-up health data were collected at one, two, and three years after September 11. This presentation reports on the national mental and physical health consequences of the September 11 attacks, the time course of these effects, and the predictors of traumatic stress symptoms, distress, positive affect, and well-being over time. Several myths of adjustment to this trauma are considered, including the assumptions that direct exposure was a necessary precondition for high levels of acute and posttraumatic stress symptoms and that acute and posttraumatic stress symptoms were proportional to the degree of exposure, amount of loss, or proximity to the trauma (i.e., as "objective" trauma increased, so did distress). The implications of these findings for health care providers are discussed.

No. 45D
LOSS AND CONSEQUENCES AFTER MASS TRAUMA: EXAMPLES FROM THE 9/11 TERRORIST ATTACKS IN NEW YORK CITY

Sandro Galea, M.D., *CUES, New York Academy of Medicine, 1216 Fifth Avenue, New York, NY 10029*

SUMMARY:

Disasters are shared traumatic experiences that may have substantial consequences. Persons affected by disasters can suffer from both physical and mental pathology and have reduced psychosocial functioning in the aftermath of disasters. The presenter reports data showing that the prevalence of posttraumatic stress disorder and depression was high in New York City after the September 11, 2001, terrorist attacks and that there was a particularly high burden of psychopathology among persons who suffered material and personal losses during the attacks. In addition, persons who were directly affected by the attacks were more likely to report worsening psychosocial resources, lower perceived social capital, greater concern about subsequent potential disasters, and higher limitation in physical and psychological functioning in the first two years after the disaster. These data suggest that in the aftermath of disasters, persons in the general population, particularly those who have experienced disaster-related loss, may have both clinically important psychological symptom and a substantial change in their day-to-day functioning for years after the event; this finding has important public health and clinical implications. The presenter discusses the mechanisms that may underlie the development of psychological pathology and psychosocial limitation among persons who experience loss after a disaster.

No. 45E
9/11-RELATED TRAUMATIC LOSS AND ITS PSYCHOPATHOLOGY IN PRIMARY CARE PATIENTS IN NEW YORK CITY

Raz Gross, M.D., *Department of Epidemiology, Columbia University, 600 West 168th Street, Room 518, New York, NY 10032*

SUMMARY:

Background: Unpredictable loss due to malicious acts of violence creates a cascade of loss and stress in those who are affected. Despite the tremendous number of individuals who lost a loved one during the September 11 attacks, there has been little empirical examination of the types of psychopathology associated with traumatic loss related to the attacks.

Objective: To examine the relationship between loss due to the September 11 attacks and the risk of psychopathology seven to 16 months following the attacks.

Methods: Structured assessments were conducted in a systematic sample of 980 primary care patients at Columbia University Medical Center. Twenty-six percent (N = 258) reported that they knew someone who died in the September 11 attacks.

Results: After adjustment for family psychiatric history and traumatic exposures other than the September 11 attacks, loss due to the attacks was significantly related to PTSD (OR = 3.90, 95% CI = 2.06–7.37), major depressive disorder (OR = 1.59, 95% CI = 1.13–2.23), generalized anxiety disorder (OR = 2.67, 95% CI = 1.76–4.05), and mental-health related quality of life based on the SF-12 (OR = 3.53, 95% CI = 2.79–5.26).

Conclusion: Seven to 16 months after the September 11 attacks, persons who experienced traumatic loss are at increased risk for a range of mental health problems. Future research is needed to document the course and long-term consequences of unresolved traumatic loss reactions.

REFERENCES:

1. Kaltman S, Bonanno GA: Trauma and bereavement: examining the impact of sudden and violent deaths. J Anxiety Disord 2003; 17:131–147.
2. Silver RC, Holman EA, McIntosh DM, et al: Nationwide longitudinal study of psychological responses to September 11. JAMA 2002; 288:1235–1244.
3. Galea S, Vlahov D, Resnick H, et al: Trends in probable posttraumatic stress disorder in New York City after the September 11 terrorist attacks. Am J Epidemiol 2003; 158:514–524.
4. Neria Y, Litz BT: Bereavement by traumatic means: The complex synergy of trauma and grief. Journal of Loss and Trauma 2004; 9:73–87.

SYMPOSIUM 46—REHABILITATION OF THE MAD OR BAD: GLOBALLY
American Association for Psychosocial Rehabilitation and the World Psychiatric Association's Section on Rehabilitation

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to summarize different methods used by various countries in labeling and dealing with behavior generally regarded as symptomatic of mental illness or criminal behavior, due process, the right to treatment, and where and how rehabilitation is done.

No. 46A
MAD OR BAD? JAPAN

Naotaka Shinfuku, M.D., *International Health, Kobe University Medical School, Kobe 650-0017, Japan*

SUMMARY:

In Japan, criminals with the slightest indication of mental disease are usually sent to a psychiatric hospital, and most forensic mental patients are taken care of at mental hospitals. Japan has only 46,000 persons in prison, but 350,000 patients in psychiatric hospitals. In comparison, the United States has at present 2,000,000 in prison and 80,000 in psychiatric hospitals. It is estimated that 15% of the U.S. prison population (around 300,000) have mental problems. Japan and the United States have very different attitudes and social policies toward forensic mental patients. National mental health policy and mental health financing are important contributing factors to the differences. However, very interesting trends have been seen recently in both countries to balance judicial and psychiatric intervention toward forensic mental patients. In the United States, several initiatives to place forensic psychiatric patients in the community have started. In Japan, there are strong social pressures to criminalize forensic mental patients after several murder cases involving mental patients became major newspaper headlines. The presenter reviews aspects of social background as well as mental health policy in both countries and suggests ways to balance law and medicine in the management of forensic mental patients.

No. 46B
MAD OR BAD? UNITED STATES

Zebulon Taintor, M.D., *Department of Psychiatry, NYU School of Medicine, Nathan Kline Institute for Psychiatric Research, Orangeburg, NY 10962*

SUMMARY:

The United States experience with psychiatric hospitals has been one of growth and decline. The psychiatric hospitals that survive are tertiary-care facilities that offer specialized diagnostic and treatment services to patients who do not respond to treatment in general hospitals or elsewhere. Although deinstitutionalization occurred at the same time as a rapid rise in reported crime and great national concern about crime, mental illness was not seen as a cause of criminal behavior. Causes were of less interest than quick mapping of incidents, improved detection through digital identification of fingerprints and DNA analysis, and rapid arrests and prosecution. Criminal justice system throughput was increased, and more jails and prisons were built to house persons who were convicted. Although the prison population passed 2 million in 2003, there has been little public outcry, especially as crime is greatly reduced, arrests are down, and six states that led the prison population increase are now showing decreases. Studies consistently report that 15%–20% of the prison population has mental illness, and programs have been developed in prisons for treatment and rehabilitation. Although some of these programs are exemplary, most are dilute and second in priority to correction. Drug and mental health courts offer possibilities for preventing incarceration of mentally ill persons.

No. 46C
MAD OR BAD? HUNGARY

Ida Kosza, M.D., *Bela Galfi Hospital, 2013 Pomasz, Budapest PF 165, Hungary*

SUMMARY:

Hungary, like the rest of eastern Europe, has been through a lot, including a lot of government change. The relevant historical streams are (1) traditional Hungarian society and independence, with strong loyalty to the family, tribe, and nation; (2) partnership in the Austro-Hungarian Empire, with its tolerant inclusion of many diverse populations; (3) World War II, in which personal crime was eclipsed by the criminal behavior of nations; (4) a communist state dominated by the Soviet Union; and (5) the present, post-communist state in which economic questions have had top priority and power has shifted back and forth among different political parties. Each of these has left its mark on the criminal and mental health systems. Crime has waxed and waned in inverse proportion to police efficiency. Hungary is currently oriented to the European Union and is integrating many of its practices regarding due process and the rights of people with mental illness, especially the right to treatment. Yet old laws, even if repealed, often are followed, and societal traditions often reduce adversarial confrontations. A sense of being part of Europe has not replaced the sense of being a special nation. Hospitals and community mental health are more in transition than are prisons.

No. 46D
MAD OR BAD? PAKISTAN

Afzal Javed, M.D., *The Medical Center, Manor Court Avenue, Nuneaton CV115HX, United Kingdom*

SUMMARY:

Pakistan is a developing country with an overwhelmingly Muslim non-Arab population that developed some of the world's earliest cities. The relevant historical streams are (1) traditional tribal society, practices in which can vary considerably from place to place, emphasizing loyalty to the tribe and traditional practices; (2) development of independent small states that converted to Islam; (3) inclusion in the British Empire as part of India, where the emphasis was on tolerant inclusion of many diverse populations; (4) traumatic separation from India and continued membership in the Commonwealth; and (5) the present state, wedged between India and the developed countries versus Islamic fundamentalism and jihadism. Each of these has contributed to the criminal and mental health systems, but Islamic law (shariah) is presented as an encompassing alternative that will be implemented by certain political parties. This alternative has the virtue of simplicity and is attractive, despite its codification of the inferior status of women. Traditional systems do not recognize mental illness and mete out harsh punishments. There is a great need for the development of better psychiatric services, as well as more humane correctional services. Getting political support for improvements requires a growing economy, an educated population, and professional commitment.

No. 46E
MAD OR BAD? INTERNATIONAL EFFORTS

Humberto Martinez, M.D., *South Bronx Mental Health Council, 82 Eastbrook Drive, River Edge, MO 07661*

SUMMARY:

The presenter, as chair of the human rights committees of both the World and American Association for Psychosocial Rehabilitation, has worked with Mental Disability Rights International and other groups associated with the United Nations (UN), especially the Economic and Social Council and the Division of Public Information. United Nations Resolution 46/119, The Protection of Persons with Mental Illness and the Improvement of the Mental Health Care, was adopted on December 17, 1991. It is the most detailed, comprehensive statement about the rights of mentally ill persons internationally. It recognizes (1) the right to informed consent; (2) the right to protection from harm; (3) the right to be free from arbitrary or unnecessary isolation or physical restraint; (4) the right to live, work, and receive treatment within the community; (5) the need for recognition of the patient's cultural background to facilitate comprehensive reintegration into society; and (6) the right to live and be treated in the least restrictive environment possible. All UN agencies, led by the World Health Organization, are charged with implementation. The World Psychiatric Association has adopted the same principles. The presenter describes some country visits and efforts by international organizations, especially in psychiatric rehabilitation.

REFERENCES:

1. Beech H.: Hidden away: stigmatized, abandoned, often locked up, Asia's mentally ill are left to inhabit a special hell. TIMEAsia, Sept 6, 2004
2. Teplin LA, Abram KM, McClelland GM, et al: Psychiatric disorders in youth in juvenile detention. Arch Gen Psychiatry 2002; 59:1133–1143.
3. Zinkler M, Priebe S: Detention of the mentally ill in Europe: a review Acta Psychiatr Scand 2002; 106:3–8.
4. Steadman HJ (ed): Jail Diversion for the Mentally Ill: Breaking Through the Barriers. Washington, DC, US Department of Corrections, National Institute of Corrections, 2001.

SYMPOSIUM 47—NEW DEVELOPMENTS IN THE TREATMENT OF SOMATOFORM DISORDERS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be familiar with the use of cognitive/behavior therapy to treat somatization disorder and hypochondriasis, be aware of the most recent findings about the pharmacotherapy of somatoform disorders, be knowledge-

able about alternative and complementary medicine approaches, and be familiar with the treatment of somatization in children.

No. 47A
PHARMACOTHERAPY OF SOMATOFORM DISORDERS

Brian A. Fallon, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 69, New York, NY 10032*

SUMMARY:

Somatoform disorders, although common, are relatively neglected as a focus of pharmacologic research. Within the somatoform disorders, different pharmacologic strategies may be needed for the obsessional cluster of somatoform disorders (hypochondriasis and body dysmorphic disorder) versus the somatic/sensory cluster (somatization and pain disorders). The presenter reviews the published literature on the pharmacologic management of somatoform disorders. Using MEDLINE, all articles published between 1970 and 2004 on this topic were identified. Case reports and small series are supported by placebo-controlled studies indicating that SSRIs are effective in helping patients with hypochondriasis and body dysmorphic disorder. These studies also indicate that response is not dependent on degree of insight into the reason for one's fears or on the presence of a personality disorder. Controlled trials of treatment for somatization disorder have not been published, although one small series suggests that fluvoxamine may be helpful. Studies of specific pain syndromes have indicated a beneficial effect for a variety of psychiatric agents, including tricyclics, mixed serotonergic/noradrenergic agents, and anticonvulsants. Additional reports indicate that other agents, such as SAMe (S-adenosyl-methionine), may also be useful. Although the study of the pharmacotherapy of obsessional somatoform disorders has made strides in the last decade, insufficient research has been conducted on somatization syndromes, despite their prominence in primary care and despite evidence of beneficial pharmacologic effect in reducing many types of pain.

No. 47B
MANAGING COMMON SOMATIC PRESENTATIONS IN PRIMARY CARE: CULTURAL CONSIDERATIONS

Javier I. Escobar, M.D., *Department of Psychiatry, University of Medicine, New Jersey - RWJMS, 675 Hoes Lane, D-205, Piscataway, NJ 08854-5635;* Michael A. Gara, Ph.D., Angelica Diaz-Martinez, Psy.D., Lesley A. Allen, Ph.D., Alex Interian, Ph.D., Melissa Warman, Ph.D.

SUMMARY:

Medically unexplained physical symptoms are a frequent, frustrating, and costly presentation of mental disorders in primary care, because somatic concerns often assume a cardinal role leading to rejection of psychological labels and psychiatric referral. Recognition of these patients is essential, and new treatment developments adapted to primary care would have significant practical value. The presenter reports on a controlled, NIMH-funded study of cognitive behavior therapy (CBT) for patients with medically unexplained physical symptoms recruited at an urban, multiethnic clinic. These patients were randomly assigned to a CBT treatment group or to a "consultation letter" control group. CBT included 10 sessions targeting physical symptoms. Changes in somatic, mood, anxiety, and functional status were examined with traditional instruments. Interim analyses of data for the first 112 patients that completed the study show a significant effect of CBT on somatic symptom severity and functional outcomes, compared to the control group. For example, in the Clinical Global Impression ratings anchored for somatic symptoms, 65% of CBT-treated patients were rated as "much/very much improved," compared to only 28% of patients in the control group. This effect seems to be independent of any effect CBT may have on mood or anxiety symptoms. Latino patients had an excellent response to this intervention.

No. 47C
COGNITIVE-BEHAVIOR THERAPY FOR HYPOCHONDRIASIS: A RANDOMIZED, CONTROLLED INTERVENTION TRIAL

Arthur J. Barsky, M.D., *Department of Psychiatry, Brigham and Women's Hospital, 75 Frances Street, Boston, MA 02115;* David K. Ahern, Ph.D.

SUMMARY:

Hypochondriasis is a chronic, distressing, and disabling psychiatric disorder that is prevalent in ambulatory medical practice. Until recently, no specific treatment has been clearly demonstrated to be effective. The presenter's group conducted a randomized, controlled trial of a cognitive behavior therapy (CBT) specifically designed to target hypochondriacal assumptions, beliefs, expectations, and attitudes. A total of 187 patients exceeding a predetermined cutoff score on a hypochondriasis questionnaire were randomly assigned to receive six sessions of individual CBT accompanied by a consultation letter to the patient's primary care physician or to receive medical care-as-usual. They were assessed at the beginning of treatment and reassessed six and 12 months later. In an intent-to-treat analytic strategy, statistically and clinically significant treatment effects on hypochondriacal symptoms and role impairment were found at six- and 12-month follow-up. These beneficial effects persisted even after adjustment for generalized psychiatric distress at baseline. At 12-month follow-up, CBT patients had significantly lower levels of hypochondriacal symptoms, beliefs, and attitudes ($p < 0.001$) and health-related anxiety ($p = 0.009$). They also had significantly less impairment of social role functioning ($p = 0.05$) and intermediate activities of daily life ($p < 0.001$). In the CBT group, 56.5% of patients experienced a greater than 25% improvement in hypochondriacal symptoms, compared to 32.1% of the control group ($p = 0.001$). Hypochondriacal somatic symptoms were not significantly improved by treatment. This brief, individual CBT, developed specifically to alter hypochondriacal thinking and restructure hypochondriacal beliefs, appears to have significant, beneficial long-term effects on the symptoms of hypochondriasis.

No. 47D
TREATMENT OF UNEXPLAINED SOMATIC SYMPTOMS IN CHILDREN AND ADOLESCENTS

Joshua D. Lipsitz, Ph.D., *Department of Psychiatry, NYSPI Columbia University, 1051 Riverside Drive #69, New York, NY 10032;* Merav Gur, Ph.D., Daniel Kamins, B.A.

SUMMARY:

Medically unexplained somatic complaints account for about 5% of pediatric medical visits. These complaints most commonly take the form of pain syndromes, such as recurrent abdominal pain and headaches. Children and adolescents with frequent somatic complaints experience significant impairment in the form of school difficulties and social impairment; they report high levels of anxiety and depressive symptoms. Diagnostic studies indicate that pediatric somatic complaints often co-occur with psychiatric disorders, and they may also reflect an independent risk for later development of psychopathology.

Families of youngsters with somatic complaints seek care in non-psychiatric medical settings. Many families are reluctant to consider a treatment that focuses on the psychological aspects of the syndrome.

This reluctance presents a challenge for referral and treatment. A few studies have examined the efficacy of specific interventions for pediatric somatic syndromes. Findings to date indicate that cognitive behavior techniques may be beneficial. The presenter provides an overview of treatment research to date and discusses methodological limitations that should be addressed in future studies. Additional treatment considerations based on preliminary data from an ongoing study of children and adolescents with noncardiac chest pain are discussed. Current results highlight the need to carefully address psychiatric comorbidity, psychosocial stressors, cognitive features, and parents' influence in providing treatment for youngsters with unexplained somatic complaints.

No. 47E
INTEGRATIVE TREATMENT FOR FIBROMYALGIA/ CHRONIC FATIGUE SYNDROME

Richard P. Brown, M.D., *Department of Psychiatry, Columbia University, 86 Sherry Lane, Kingston, NY 12401;* Patricia L. Gerbarg, M.D.

SUMMARY:

There are different subgroups of fibromyalgia (FMS)/chronic fatigue (CFS) patients: some show extreme tenderness but no psychological factors, some have moderate tenderness and somewhat disturbed mood, and some have low tenderness and moderately disturbed mood. Conventional medicine has limited effectiveness for most FMS/CFS patients. Acupuncture, herbs, nutrients, exercise, yoga, and meditation are promising adjuncts. The presenter reviews literature and presents clinical experience with acupuncture, aerobic exercise, St. John's wort, *Rhodiola rosea,* magnesium, carnitine, DHEA, SAM-e, meditation, chi-kung, and yoga breathing with postures in this widespread, disabling, and perplexing condition. Suggestions for further research are offered.

REFERENCES:

1. Fallon BA: Pharmacotherapy of somatoform disorders. J Psychosom Res 2004; 56:455–460.
2. Mechanic D: Social psychological factors affecting the presentation of bodily complaints. New Engl J Med 1972; 286:1132–1139.
3. Barsky AJ, Ahern DK: Cognitive behavior therapy for hypochondriasis: a randomized controlled trial. JAMA 2004; 291:1464–1470.
4. Lipsitz JD, Masia-Warner C, Apfel H, et al: Anxiety and depressive symptoms and anxiety sensitivity in youngsters with noncardiac chest pain and benign heart murmurs. J Pediatr Psychol 2004; 29:607–612.
5. Brown RP, Gerbarg PG, Muskin PR: Alternative treatments in psychiatry, in Psychiatry, 2nd Edition. Edited by Tasman A, Kay J, Lieberman JA. London, John Wiley, 2003, pp. 449–485.

SYMPOSIUM 48—INPATIENT PSYCHIATRY: CRISIS AND RESPONSE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to demonstrate an ability to redesign purpose, function, staffing, and evaluation of an inpatient psychiatric setting, given current fiscal realities.

No. 48A
PUBLIC POLICY AND INPATIENT PSYCHIATRIC CARE

Anita S. Everett, M.D., *SAMHSA, 3563 Cattail Creek Drive, Glenwood, MD 21738*

SUMMARY:

The roles of both state and federal governments in the provision of inpatient psychiatric care have dramatically shifted in the last two decades. Once upon a time there was a clear delineation between public and private psychiatric systems of care. The missions of public and private systems were distinct. There were differences in target populations, treatment goals, social responsibility, and funding sources. The presenter reviews recent trends in federal and state policy regarding funding for and regulation of inpatient psychiatric care. The work and recommendations of the Acute Care Subcommittee of the President's New Freedom Commission on Mental Health are reviewed. Current public policy opportunities and options are presented and opportunities for input are solicited. This session provides useful information for all levels of participants and is intended to inspire psychiatrists to become well-informed advocates for compassionate public policy and the effective use of public resources for psychiatric treatment.

No. 48B
AN UPDATED MODEL FOR INPATIENT PSYCHIATRIC CARE

Ira D. Glick, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Suite 2122, Stanford, CA 94305-5723;* Grady Carter, M.D., Rajiv Tandon, M.D.

SUMMARY:

Recent drastic changes in the funding for inpatient hospitalization has created uncertainty about what can and cannot be done in a short hospital stay. A review of the literature reveals no model, guidelines, or controlled research since Sederer and Rothschild's classic text on acute care psychiatry written in 1997. From the literature, and from three different treatment settings, the presenter's group developed an updated model based on the new realities. The updated model for inpatient staff delineates (in stepwise fashion) (1) objectives, (2) how to assess the patient while protecting the patient from self-harm, (3) how to deliver both psychopharmacological and psychosocial treatment interventions, and (4) how to deliver discharge and posthospital planning for both patient and family. The presenter discusses the advantages and disadvantages of the model, as well as the need to view (for most patients who need hospitalization) acute inpatient intervention as one component—albeit a crucial one—of long-term (or lifetime) care in the community.

No. 48C
CRISIS RESIDENTIAL CARE FOR PATIENTS WITH SERIOUS MENTAL ILLNESS: OUTCOMES AND COST

Wayne S. Fenton, M.D., *National Institute of Mental Health/ DMDBA, 6001 Executive Boulevard, Bethesda, MD 20892-9617*

SUMMARY:

Crisis residential programs are designed to provide community-based alternatives to acute care for patients who would otherwise require hospitalization. The presenter reviews recent randomized controlled trials comparing crisis residential and hospital care for patients with serious mental illness who are willing to accept voluntary treatment. Randomized controlled trials of crisis residential care models developed in Connecticut and Maryland are described. For

both treatment settings, cost models estimate total episode and six-month cost from the perspective of state payers. Episode symptom reduction and days of community tenure achieved over the six-month postepisode period represent effectiveness. In both Maryland and Connecticut, patients treated in crisis residential programs and those treated in general hospitals did not differ significantly in episode symptom improvement or postepisode community days achieved. For both locations, crisis residential program cost was less than one-half of that for hospital care. Crisis residential programs are a cost-effective approach to providing acute care to patients with serious mental illness willing to accept voluntary treatment. Maintaining a humane infrastructure of care for patients with serious mental illness within a fixed budget requires an optimal mix of hospital, community-based crisis residential, and community support services.

No. 48D
A NATIONAL REFERRAL CENTER FOR TREATMENT-RESISTANT PATIENTS

Edward R. Shapiro, M.D., *Department of Admissions, Austen Riggs Center, 25 Main Street, P.O. Box 962, Stockbridge, MA 01262-0962*

SUMMARY:

Psychiatric inpatient treatment has been transformed in the last 15 years toward a focus on crisis intervention and stabilization. Definitive treatment is no longer a goal. However, the Austen Riggs Center, a national referral center for patients with treatment-resistant disorders, has flourished and grown during this period of draconian curtailment of resources for inpatient treatment and the closing of other long-term hospital and residential treatment facilities. This presentation focuses on the need for one or more national referral centers for patients with treatment-refractory disorders and describes criteria for selecting patients for such long-term hospital or residential treatment. These criteria include complex comorbidity including personality disorder, failed treatments of lesser intensity, and inability to sustain functioning between outpatient sessions without chronic crisis management. The presenter examines the need for complex engagement with these patients and their families around repeating maladaptive patterns in patients' lives and around resource limitations, focusing on the use of the patient's authority in taking charge of the treatment. Beginning data from Riggs follow-along research indicate significant improvement in this group with treatment-resistant disorders. The issue of whether elements of the interventions used in this setting are applicable to other less intensive settings is discussed.

No. 48E
TRENDS AND CHARACTERISTICS OF INPATIENT TREATMENT IN ROUTINE PSYCHIATRIC PRACTICE IN THE U.S.

Joshua E. Wilk, Ph.D., *APIRE, Department of Research, American Psychiatric Association, 1000 Wilson Boulevard, Arlington, VA 22209;* Joyce C. West, Ph.D., Darrel A. Regier, M.D.

SUMMARY:

Using data from the American Psychiatric Institute for Research and Education (APIRE), the presenter describes trends in and characteristics of inpatient psychiatric treatment in the United States. The percentage of patient visits to psychiatrists in hospitals and inpatient settings declined significantly from 1988 to 2002. Currently, only 18% of visits to psychiatrists are in an inpatient setting, with only 15% of psychiatrists identifying hospitals as their primary work setting. During this time, the treatments provided by psychiatrists also changed dramatically, with a shift away from psychotherapeutic interventions and toward more psychopharmacologic interventions and shorter visits. Findings that characterize the diagnostic and clinical characteristics of patients treated in inpatient settings versus those treated in outpatient settings are reviewed. Differences in treatment patterns for inpatients versus outpatients, diagnostic mix between these patient groups, and demographic differences between patient groups are discussed. The differences in financing of care for inpatient and outpatient services are analyzed by examining the source of payment for psychiatrists' services with these patient groups. Overall, patients are spending less time in inpatient treatment, and psychiatrists are spending less time working in hospital settings in general. Possible reasons for this shift, including the financing and management of care, are presented, as well as the effects of these changes on diagnostic mix, symptom severity, and patterns of treatment of inpatients.

REFERENCES:

1. New Freedom Commission on Mental Health, Subcommittee on Acute Care: Background Paper (DHHS Pub. No. SMA-04-3876). Rockville, MD, US Substance Abuse and Mental Health Services Administration, 2004.
2. Fenton WS, Hoch JS, Herrell JM, et al: Cost and cost effectiveness of hospital versus crisis residential care for patients with serious mental illness. Arch Gen Psychiatry 2002; 357-364.
3. Glick ID, Carter WG, Tandon R: A paradigm for treatment of inpatient psychiatric disorders: from asylum to intensive care. J Psychiatr Pract 2003; 9:1–5.
4. Duffy FF, West JC, Wilk J, et al.: Mental health practitioners and trainees; in Mental Health U.S., 2002, DHHS Pub No. (SMA) 3938. Rockville, ND, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2004.

SYMPOSIUM 49—ADVANCES AND INNOVATIONS IN ASSESSING DECISION-MAKING CAPACITY

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to identify the four major domains addressed by the MacArthur Competence Assessment Tools and the implications for research arising from their use.

No. 49A
EVALUATING DECISIONAL CAPACITY IN OLDER PATIENTS

Barton W. Palmer, Ph.D., *Department of Psychiatry, University of California San Diego, NC 0603, La Jolla, CA 92093;* Laura B. Dunn, M.D., Paul S. Appelbaum, M.D., Sunder Mudaliar, M.D., Robert Henry, M.D., Shanokh Golshan, Ph.D., Dilip V. Jeste, M.D.

SUMMARY:

The presenter reviews findings from a study that evaluated the degree to which patients with impaired decisional capacity (as measured with the MacArthur Competence Assessment Tool for Clinical Research [MacCAT-CR]) can be efficiently identified with three brief screening questions, and compared decisional capacity among three diagnostic groups of older patients commonly involved in clinical research trials. Participants were outpatients age ≥ 60 years with schizophrenia (N = 35), mild to moderate Alzheimer's disease (N = 30), or type 2 diabetes (N = 36) recruited through university-affiliated research centers as well as a research-active VA hospital clinic. Primary measures were total scores on a three-item decisional capacity questionnaire and MacCAT-CR subscale scores. Decisional capacity was highest among the diabetes patients and lowest among

the Alzheimer's disease patients, but there was also considerable heterogeneity within the three groups. Mini-Mental State Examination and three-item questionnaire scores were each significant predictors of MacCAT-CR scores. Decisional capacity varies widely even within diagnostic groups. Neither the presence nor absence of decisional capacity should be assumed based on diagnosis or advanced age. Ongoing efforts are needed to refine methods for efficiently identifying those potential participants at greatest risk of impaired capacity, for whom more thorough capacity evaluations and more intensive disclosure procedures may be warranted.

No. 49B
ERROR BEHAVIORS IN CAPACITY INTERVIEWS

Scott Y. Kim, M.D., *Department of Psychiatry, University of Michigan, 300 North Ingalls, 7C27, Ann Arbor, MI 48109;* Paul S. Appelbaum, M.D.

SUMMARY:

Persons with serious mental disorders such as schizophrenia, as a group, tend to have diminished abilities relevant to giving informed consent for research and for treatment. Most studies to date have documented the quantitative aspects of this phenomena. The presenter reviews findings from a qualitative analysis of the types and frequency of errors seen in 92 persons with schizophrenia, compared with those seen in 40 healthy comparison subjects. The results show that although, as expected, the healthy subjects made fewer errors, the types of errors made by patients and comparison subjects are quite similar. Errors associated with positive symptoms such as delusions, hallucinations, and gross disorganization tend to be relatively infrequent, even among persons with schizophrenia. The policy implications of the analysis are discussed.

No. 49C
DISTINGUISHING RESEARCH FROM CLINICAL CARE

Laura B. Dunn, M.D., *Department of Psychiatry, University of California at San Diego, 9500 Gilman Drive, 0603-R, La Jolla, CA 92093-0603*

SUMMARY:

For Symposium entitled, "Advanced and Innovations in Assessing Decisions-Making Capacity" Symposium Chair: Philip Candilis, M.D.

Objective: Concerns continue regarding research participants' abilities to discern important distinctions between clinical research and usual clinical care. Failure to appreciate these distinctions, termed the "therapeutic misconception" (TM), may call consent into questions. Yet, how to assess for the therapeutic misconception is unclear. Also unclear is whether patients with severe mental illnesses, such as schizophrenia, may be more vulnerable to these beliefs or their effects.

Method: We examined the prevalence of TM, as well as its demographic, clinical, and neurocognitive correlates, in 87 patients with schizophrenia or schizoaffective disorder. Our outcome measure was a brief instrument assessing TM regarding a hypothetical clinical trial.

Results: Almost one-third of the participants answered all six items correctly, while two-thirds were correlated with higher levels of TM. Degree of TM was also negatively associated with understanding, appreciation, and reasoning scores on the MacArthur Competence Assessment Tool—Clinical Research version. Degree of TM was not associated, however, with severity of psychopathology. The TM scale showed fair internal consistency.

Conclusions: Further work is needed to refine measures of the therapeutic misconception, and to find ways to address this persistent concern when enrolling participants in clinical trials. Educational techniques to help participants grasp these somewhat abstract concepts will be discussed.

No. 49D
CAPACITY FOR INFORMED CONSENT IN PATIENTS WITH SCHIZOPHRENIA

David J. Moser, Ph.D., *Department of Psychiatry, University of Iowa, Iowa City, IA 52242*

SUMMARY:

Most people with schizophrenia can provide informed consent for research, and those lacking this capacity can benefit from remediational interventions. However, important questions on this topic remain. For example, what are the best ways to enhance capacity for consent? Can enhancement of this capacity be accomplished relatively quickly? Does decisional capacity decline during medication-free schizophrenia research? The presenter describes a study in which a hypothetical research scenario and the MacCAT-CR were used to assess decisional capacity in 30 patients with schizophrenia, before and after a remediational intervention, and the patients' decisional capacity was compared to the performance of 30 control subjects. The decisional capacity in 13 patients before and after discontinuation of antipsychotic medication was also compared. Although participants with schizophrenia earned significantly lower baseline MacCAT-CR scores than the control subjects with regard to understanding and appreciation, they benefited from a brief intervention and were not different from the control subjects at follow-up. In the study on medication-free research, the results suggested that individuals going through a medication-free interval do not typically experience a major decline in decisional capacity. These findings suggest that even a relatively brief intervention can be useful in improving decisional capacity and that the large majority of patients with schizophrenia can make informed decisions regarding research participation.

REFERENCES:

1. Appelbaum PS, Grisso T: MacCAT-CR: MacArthur Competence Assessment Tool for Clinical Research. Sarasota, FL, Professional Resource Press, 2001.
2. Marson DC, Annis SM, McInturff B, et al: Error behaviors associated with loss of competency in Alzeheimer's disease. Neurology 1999; 53:1983–1992.
3. Lidz CW, Appelbaum PS: The therapeutic misconception: problems and solutions. Med Care 2002; 40(9 suppl):V55–63.
4. Carpenter WT Jr, Gold JM, Lahti AC, et al: Decisional capacity for informed consent in schizophrenia research. Arch Gen Psychiatry 2000; 57:540–542.

SYMPOSIUM 50—NOVEL RESEARCH TREATMENTS FOR EATING DISORDERS
Collaborative Session With the National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) describe pilot data on promising new treatments for anorexia nervosa, bulimia nervosa, and binge-eating disorder; and (2) demonstrate understanding of theoretical mechanisms that inform innovative treatments.

No. 50A
ATYPICAL ANTIPSYCHOTIC MEDICATION FOR ANOREXIA NERVOSA

Evelyn Attia, M.D., *Department of Psychiatry, NYS Psychiatric Institute-Columbia University, 1051 Riverside Drive, Unit 98, New York, NY 10032-2603;* Allan S. Kaplan, M.D., Laura Schroeder, B.A.

SUMMARY:

Anorexia nervosa is a serious mental illness with high morbidity and mortality rates and few evidence-based treatments. Case reports and one open trial have identified olanzapine as being helpful for weight restoration as well as psychological symptoms for some individuals with anorexia nervosa. The mechanism for this improvement is unknown. Groups that have attempted to study olanzapine more rigorously in this population have encountered resistance from individuals with anorexia, who are reluctant to take a medication that has been identified as causing weight gain as a side effect in some patients for whom it has generally been prescribed. To collect preliminary data about atypical antipsychotic medications, including their acceptability, tolerability, and general effectiveness, the presenter's group undertook a study in which outpatients with anorexia are randomly assigned to treatment with olanzapine or aripiprazole. Interventions aimed at enhancing medication compliance are included in this medication treatment protocol. The presenter discusses the research treatment protocol and results from 12 anorexia nervosa patients treated with these medications at the eating disorders research programs of Columbia University/New York State Psychiatric Institute and the University of Toronto, including data about weight, eating behavior, and associated psychological symptoms.

No. 50B
NEW MEDICATION TREATMENTS FOR BINGE-EATING DISORDER

Jose C. Appolinario, M.D., *Department of Psychiatry, University of Rio de Janeiro, Visconde de Piraja 550 CJ 2002, Rio De Janeiro, RJ 22410-001, Brazil*

SUMMARY:

Binge-eating disorder (BED) is characterized by episodes of uncontrolled consumption of large amounts of food (binge-eating) not being followed by inappropriate compensatory behaviors that characterize bulimia nervosa. Despite the fact that there is no established treatment for BED, medications are frequently part of a multimodal approach that also includes psychological and nutritional interventions. The last decade has witnessed the development of promising pharmacological treatments for BED. Several randomized placebo-controlled trials with different agents have been recently published. Overall, three classes of drugs have been studied in placebo-controlled trials in patients with BED. Antidepressants, particularly selective serotonin reuptake inhibitors, remain the best studied class of agents in this condition. More recently, the antiobesity agent sibutramine and the neurotherapeutic agent topiramate have also been shown effective in BED. This presentation provides an overview of the available information and future directions for the pharmacological treatment of BED. Recent data on the efficacy of new agents such as sibutramine and topiramate are discussed in more detail.

No. 50C
CD-ROM-BASED TREATMENT FOR BINGE-EATING DISORDER AND OBESITY

Cynthia M. Bulik, Ph.D., *Department of Psychiatry, University of North Carolina, 101 Manning Drive, First Floor, NSH CB7160, Chapel Hill, NC 27514-4220*

SUMMARY:

The Internet has rapidly become a primary source of health care information for patients. Successful Web-based programs exist for weight loss in individuals with type II diabetes, obsessive-compulsive disorder, anxiety, and depression and for general psychiatry. Cognitive behavior therapy (CBT) is effective in the treatment of eating disorders, yet poorly disseminated. The Internet is a potential mechanism for disseminating evidence-based treatment widely. The presenter's group developed a CD-ROM-based CBT program for the treatment of binge-eating disorder and obesity (POWER: Preventing Overweight with Exercise and Reasoning). The presenter describes the methods for converting an empirically tested manual-based therapy into CD-ROM and Web-based format and presents preliminary results of a pilot clinical trial comparing traditional group CBT for BED in overweight individuals to self-help CD-ROM treatment alone and a wait list control. Internet-based deliveries can be used alone in stepped care, as an adjunct to traditional therapy, or as part of a relapse prevention package. Web-based approaches offer additional advantages including (1) a convenient means to conduct dismantling studies, as topics can be delivered in modular format; (2) a means to deliver tailored interventions based on specific challenges or obstacles faced by individual patients; and (3) opportunities for ready interface including Web-based self-monitoring and live chat support.

No. 50D
HOW THE STUDY OF MECHANISM MAY INFORM TREATMENT OF BULIMIA NERVOSA

B. Timothy Walsh, M.D., *Department of Psychiatry, NY State Psychiatric Institute-Columbia University, 1051 Riverside Drive, Unit 98, New York, NY 10032-2603;* Michael J. Devlin, M.D., Gillian Boudreau, B.A.

SUMMARY:

In recent years, human and animal studies have begun to suggest pathophysiological mechanisms that may underlie the persistence of binge-eating in bulimia nervosa. One possible mechanism is a disturbance of upper gastrointestinal function, including slowed gastric emptying and diminished postprandial release of the satiety hormone cholecystokinin (CCK). This line of work suggests that agents that increase the rate of gastric emptying may be helpful in the treatment of bulimia.

A separate line of research suggests that binge-eating may be induced in animals and in several respects resembles the consumption of substances of abuse. Research in animals and humans suggests that the GABA-B agonist baclofen may reduce the craving for and the abuse of drugs of abuse such as cocaine. Recent studies of an animal model of binge-eating indicate that baclofen may reduce binge-eating without significantly affecting non-binge-eating. These data suggest that a trial of baclofen in bulimia is warranted. The presenter reviews possible pathophysiological mechanisms contributing to binge-eating in bulimia nervosa and novel pharmacological interventions based on these mechanisms.

No. 50E
D-CYCLOSERINE AND ANOREXIA NERVOSA: CLINICAL IMPLICATIONS OF TRANSLATIONAL RESEARCH

Joanna E. Steinglass, M.D., *Department of Psychiatry, New York State Psychiatric Institute, 1051 Riverside Drive, Unit 98, New York, NY 10032;* Robyn Sysko, M.S., Michael J. Devlin, M.D., Michael Strober, Ph.D., B. Timothy Walsh, M.D.

SUMMARY:

Fear and avoidance are characteristic features of anorexia nervosa, with "fear of gaining weight or becoming fat" listed among the DSM-IV diagnostic criteria for the disorder. Furthermore, anxiety symptoms and comorbidity with anxiety disorders are common among individuals with anorexia nervosa. To better understand the relationship between anorexia and fear, models of anxiety and fear from animal research can be applied to the study and treatment of anorexia. Specifically, translational research designs can be developed to study constructs that are well defined in animals, including fear conditioning and fear extinction. D-Cycloserine (DCS), a glutamate partial agonist at the *N*-methyl-D-aspartate (NMDA) receptor that appears to significantly enhance fear extinction, provides a method by which to investigate fear conditioning in humans. Previous research has found that in a laboratory setting, patients with anorexia nervosa, at low weight and after weight normalization, demonstrated extreme avoidance of a test meal, consuming one-fourth the amount of calories as healthy comparison subjects. The presenter briefly discusses animal data with implications for anorexia nervosa, including studies of fear extinction, and the potential for novel treatments based on preclinical data. In particular, the effect of DCS on cognitive processes in other disorders and the implications for anorexia nervosa are discussed. In addition, preliminary data are presented from a placebo-controlled study administering DCS in a laboratory setting to patients with anorexia nervosa in conjunction with exposure therapy in an attempt to ameliorate fear of caloric intake.

REFERENCES:

1. Powers PS, Santana CA, Bannon YS: Olanzapine in the treatment of anorexia nervosa: an open label trial. Int J Eat Disord 2002; 32:146–164.
2. Appolinario JC, Bacaltchuk J. Sichieri R, et al: A randomized, double-blind, placebo-controlled study of sibutramine in the treatment of binge-eating disorder. Arch Gen Psychiatry 2003; 60:1109–1116.
3. Myers TC, Swan-Kremeier L, Wonderlich S, et al: The use of alternative delivery systems and new technologies in the treatment of patients with eating disorders. Int J Eat Disord 2004; 36:123–143.
4. Klein DA, Walsh BT: Eating disorders: clinical features and pathophysiology. Physiol Behav 2004; 81:359–374.
5. Walker DL, Ressler KJ, Lu K-T, et al: Facilitation of conditioned fear extinction by systemic administration or intra-amygdala infusions of D-cycloserine as assessed with fear-potentiated startle in rats. Neurosci 2002; 22:2343–2351.

SYMPOSIUM 51—NEUROSCIENCE AND DYNAMIC PSYCHIATRY
American Academy of Psychoanalysis and Dynamic Psychiatry

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to demonstrate how neuroscience is relevant to the clinician; to understand the principles of functional neuroimaging, its use in the study of psychiatric disorders, and its potential for the integration of psychoanalysis and neuroscience; and to understand the neurobiologic foundation of psychotherapy and how psychotherapy changes the brain.

No. 51A
PSYCHOTHERAPY AND NEUROBIOLOGY

Richard M. Brockman, M.D., *Department of Psychiatry, Columbia University, 30 East End Avenue, New York, NY 10028*

SUMMARY:

In 1900, Freud wrote, "I shall entirely disregard the fact that the mental apparatus with which we are here concerned is also known to us in the form of an anatomical preparation, and I shall carefully avoid the temptation to determine psychical locality in any anatomical fashion." Freud made this statement after having made numerous unsuccessful attempts to "determine psychical locality." But despite his abandonment of further efforts to find the scientific ground for psychotherapy, he often referred back to the fact that he believed that one day such a ground would be found, a ground that would change the very structure and nature of psychotherapy as well as the hypotheses on which it was based. And thus he would later write in 1920, "Biology is truly a land of unlimited possibilities. We may expect it to give us the most surprising information, and we cannot guess what answers it will return in a few dozen years to the questions we have put to it. They may be of a kind which will blow away the whole of our artificial structure of hypotheses." Now, about seven dozen years from when Freud wrote those words, psychiatry is in a position to change the "very structure and nature of psychotherapy." As he had predicted, the field in a position to "blow away" some of the hypotheses on which psychotherapy has been based. This presentation reviews some of the underlying hypotheses—including repression, free association, the unconscious, primary process, transference—that have been blown away, modified, or validated by neurobiology.

No. 51B
CONTEMPORARY AFFECT THEORY AND CONTROVERSIES REGARDING DRIVE THEORY IN PSYCHOANALYSIS

Otto F. Kernberg, M.D., *Department of Psychiatry, New York Presbyterian Hospital, 21 Bloomingdale Road, White Plains, NY 10605-1504*

SUMMARY:

This presentation reviews contemporary affect theories in the light of findings from early development, neurobiological studies, and studies of affect communication in the clinical setting. The structural characteristics or modules of affect expression are related to the assumed structural characteristics of drives in psychoanalytic theory, and drive and affect theory are compared from a biological perspective regarding the role of instincts and motivation. Psychoanalytic object relation theory is proposed as an integrating frame that determines the developmental aspects of affects and integrates drive and affect theory in a comprehensive formulation of motivational systems.

No. 51C
IMAGING THE MIND-BRAIN INTERFACE BRIDGING THE PSYCHOANALYSIS-NEUROSCIENCE GAP

David A. Silbersweig, M.D., *Department of Psychiatry, Cornell Medical, 1300 York Avenue, Room F-1303, Box 140, New York, NY 10021*

SUMMARY:

Neuroscience is now mature enough to be able to address some of the important issues of interest to psychoanalysts. Functional neuroimaging, in particular, permits the noninvasive localization and characterization of patterns of brain activity during mental states and thus allows one to begin to bridge the gap between psychoanalysis and neuroscience. In this context, some relevant developments in behavioral neuroscience are outlined; general principles and recent advances in fMRI imaging are described; the uses and limitations of these approaches to examine the neural correlates of cognitive,

perceptual, affective, and behavioral processes are discussed; examples of functional neuroimaging studies across a range of psychiatric conditions — including borderline personality disorder, and focusing on fronto-limbic circuitry — are presented; and approaches that may enhance the emerging dialogue between psychoanalysts and neuroscientists are considered.

No. 51D
HOW NEUROSCIENCE CAN HELP THE CLINICIAN

Samuel Slipp, M.D., *Department of Psychiatry, NYU School of Medicine, 220 Chestnut Street, Englewood, NJ 07631*

SUMMARY:

Neuroscience can 1) vandate some theories in dynamic psychotherapy, 2) show how therapy changes the brain, and 3) check the effectiveness of different therapies. Freud's libido theory, based on Newtonian physics and linear thinking, could not be studied experimentally. He emphasized inner subjective experiences over external reality. Psychoanalysts now see these two as interacting. This interaction can be viewed as a feedback system that establishes homeostasis. Observational studies show that the dyadic attunement between mother and infant is internalized to form this representational system. There is evidence for external reinforcement of this feedback system. Transference and projective identification provide external perceptual or behavioral feedback. The presenter's subliminal stimulation experiments showed the importance of the current parental relationship in young adults, and his family research found specific forms of current family dynamics related to specific forms of psychopathology. Kandel discovered that repeated external input changed gene expression. The 21-year prospective study by Tienari noted that adopted children with the genotype developed schizophrenia only when reared in dysfunctional families. Therapy, conducted in a safe holding environment, provides the opportunity to work through past and present relationships, especially the current transference to the therapist, and to disrupt the vicious internalized feedback cycle to produce change in the brain and in behavior.

REFERENCES:

1. Kandel ER: A new intellectual framework for psychiatry. Am J Psychiatry 1998; 155:457–478.
2. Kernberg OF: New perspectives on drive theory, in Aggression in Personality Disorders and Perversions. New Haven, CT, University Press, 1992, pp. 3–20.
3. Epstein J, Isenberg N, Stern E, et al: Toward a neuroanatomical understanding of psychiatric illness: the role of functional imaging, in Defining Psychopathology in the 21st Century (DSM-V and Beyond). Edited by Helzer J, Hudziak J. Washington, DC, American Psychiatric Publishing, 2002, pp. 57–70.
4. Slipp S: The Technique and Practice of Object Relations Family Therapy. Northvale, NJ, Aronson, 1988.

SYMPOSIUM 52—DISTURBED FRONTO-LIMBIC BRAIN CIRCUITRY: HOW SPECIFIC IS IT FOR DIFFERENT PSYCHIATRIC DISORDERS?

EDUCATIONAL OBJECTIVES:

At the conclusion of the symposium, the participant should be able to demonstrate the neuroanatomy and functional connectivity of the frontal cortex and the limbic system and to explain its relevance for the divergent psychopathology of psychiatric disorders such as major depression, posttraumatic stress disorder, and borderline personality disorder.

No. 52A
FRONTO-LIMBIC BRAIN PATHOLOGY: EVIDENCE FROM ANIMAL RESEARCH

Gregory Quirk, Ph.D., *Department of Physiology, Ponce School of Medicine, P.O. Box 7004, Ponce 00732-7004, Puerto Rico*

SUMMARY:

Numerous disorders such as posttraumatic stress disorder, depression, and phobias are accompanied by exaggerated fear and anxiety. Having made great strides in understanding amygdala mechanisms of fear learning, scientists have recently focused on the systems that control the amygdala. The dominant experimental model for studying fear inhibition is extinction, where rats learn that a conditioned stimulus no longer predicts the occurrence of a footshock. Extinction does not erase fear memories but forms a new memory of safety that competes for control of behavior. The presenter reviews recent advances in the neural mechanism of extinction learning. Neurons in the infralimbic (IL) medial prefrontal cortex (mPFC) signal extinction memory and inhibit amygdala output. Electrical stimulation of IL turns off fear and strengthens extinction memory. Molecular mechanisms of extinction in the mPFC and amygdala are becoming understood. Chronic stress reduces the size of the dendrites of mPFC neurons and leads to increased fear. A realizable goal of extinction research is to develop physiological and pharmacological methods to strengthen extinction memory and facilitate extinction-based exposure therapies.

No. 52B
FRONTO-LIMBIC BRAIN PATHOLOGY IN PTSD

Eric Vermetten, M.D., *Department of Psychiatry, Rudolf Magnus Institute of Neurosciences, Heidelberglaan 100, Utrecht 3584 CX, Netherlands*

SUMMARY:

Intrusive recollections of a traumatic event, hyperarousal, and avoidance of clues associated with the trauma are hallmark symptoms of posttraumatic stress disorder (PTSD). A decade ago initial hypotheses were formulated that the functional neuroanatomy of traumatic stress involved a circuit of brain areas involved in both stress and memory function, including the hippocampus, amygdala, cingulate, medial prefrontal cortex, and dorsolateral prefrontal cortex. An abundance of studies used neuroimaging to investigate the way in which these brain areas are affected in PTSD. Studies with PET and fMRI demonstrated a hyperreactive amygdala to trauma-related stimuli. Exaggerated startle and flashbacks were found to be a failure of frontal regions to dampen the symptoms of arousal and distress that are mediated as reminders of the traumatic event. The model in PTSD that attributes the intrusive re-experiencing in PTSD to a failure of inhibitory processes over a fear-conditioned hyperresponsive limbic system has been supported by several studies. This research has supported the use of psychopharmacological agents that are targeted to affect limbic activation as well as decreased frontal lobe functions. In addition, the use of exposure therapies based on extinction are thought to find their basis in prefrontal cortex function.

No. 52C
PREFRONTAL AND LIMBIC PATHOLOGY IN BPD

Klaus Lieb, M.D., *Department of Psychiatry and Psychotherapy, University of Freiburg Medical School, Hauptstr. 5, Freiburg 79104, Germany*

SUMMARY:

Borderline personality disorder is characterized by a pervasive pattern of instability in affect regulation, impulse control, interper-

sonal relationships, and self-image. Clinical hallmarks of the disorder are emotional dysregulation, impulsive aggression, repeated self-injurious behavior, and chronic suicidality. Recent evidence indicates that a dual brain pathology affecting prefrontal areas and the limbic system may cause impulsivity and affective dysregulation. Brain imaging data have shown amygdalar hyperreactivity to emotional stimuli and dysfunctions in prefrontal areas, including lower metabolism and smaller volumes, which may cause insufficient inhibition of limbic responses. However, other brain areas are also affected, which may modulate limbic responses. Examples are the anterior cingulate cortex for pain processing and the hippocampus for memory of traumatic experiences. Interactions in this complex network may explain the broad spectrum of symptoms and may be a starting point for the development of specific therapeutic approaches for this severly ill patient group.

No. 52D
STRESS-INDUCED BRAIN STRUCTURAL PLASTICITY: WHAT DO ANIMAL MODELS TELL US?

Bruce S. McEwen, Ph.D., *Department of Neuroendocrinology, Rockefeller University, 1230 York Avenue, New York, NY 10021*

SUMMARY:

The hippocampal formation expresses high levels of adrenal steroid receptors and is a malleable brain structure that is important for certain types of learning and memory. It is also vulnerable to the effects of stress and trauma. The amygdala is an important target of stress and mediates physiological and behavioral responses associated with fear and strong emotions. The prefrontal cortex plays an important role in working memory and executive function and is also involved in extinction of learning. All three regions are targets of stress hormones, and stress is known to precipitate and exacerbate mood disorders. In long-term depressive illness, the hippocampus and prefrontal cortex undergo atrophy, whereas the amygdala is hyperactive in anxiety and mood disorders and may undergo a biphasic change in structure — increasing in size in acute depression and shrinking in long-term depression. In animal models of acute and chronic stress, neurons in the hippocampus and prefrontal cortex respond to repeated stress by showing atrophy that leads to memory impairment, whereas neurons in the amygdala show a growth response that leads to increased anxiety and aggression. Yet, these are not necessarily "damaged" and may be treatable with the right medications. The mechanisms that distinguish between protection and damage of brain cells from stress are discussed in this context.

No. 52E
NEURAL CIRCUITS IN TRAUMA SPECTRUM DISORDERS

J. Douglas Bremner, M.D., *Department of Psychiatry, Emory University, 1364 Clifton Road, Atlanta, GA 30322*

SUMMARY:

The past decade has seen an explosion in the application of neuroimaging sciences to posttraumatic stress disorder (PTSD) and other trauma-spectrum disorders such as depression and borderline personality disorder (BPD). In particular, neuroimaging, including PET and MRI technologies, has been useful in mapping out the neural circuitry of trauma-related disorders. PET studies used symptom provocation to assess neural correlates of trauma-related symptoms. Studies have outlined a circuit that has also been implicated in stress responses and memory, including the prefrontal cortex, cingulate, hippocampus, amygdala, and other connected brain regions. Volumetric MRI studies showed smaller hippocampal volume in PTSD and BPD, as well as in women with depression with (but not without) early abuse. Hippocampal volume increased and memory deficits reversed after treatment with antidepressants in PTSD. Although baseline cortisol was low, symptom provocation and cognitive stress challenge led to an exaggerated cortisol response to PTSD.

REFERENCES:

1. Santini E, Ge H, Ren K, et al: Consolidation of fear extinction requires protein synthesis in the medial prefrontal cortex. J Neurosci 2004; 24:5704–5710.
2. Bremner JD: Does Stress Damage the Brain? Understanding Trauma-Related Disorders From a Mind-Body Perspective. New York, WW Norton, 2002.
3. Quirk GJ, Gehlert DR: Inhibition of the amygdala: key to pathological states? Ann NY Acad Sci 2003; 985:263–272.
4. Lieb K, Zanarini MC, Schmahl C, et al: Borderline personality disorder. Lancet 2004; 364:453–461.

SYMPOSIUM 53—INCREASES IN OPIOID ANALGESIC ABUSE: CONCERNS AND STRATEGIES
National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to demonstrate knowledge of (1) the increases in opioid misuse, (2) the role of the Internet in these increases, (3) best practices for prescribing and monitoring opioids for chronic pain conditions, and (4) best practices for treating persons with addiction to opioid medications.

No. 53A
INCREASES IN OPIOID ANALGESIC USE, MISUSE, AND ADDICTION

Wilson M. Compton III, M.D., *NIH/NIDA, 6001 Executive Blvd MSC5153, Bethesda, MD 20892-9589*

SUMMARY:

Misuse of and addiction to prescription opioid analgesics have emerged as major public health issues. In 2002, 4.7% (i.e., 11.0 million) U.S. household residents over age 12 misused an opioid medication, and one agent, Vicodin®, was misused by 10.5% of high school seniors in 2003. Furthermore, approximately 1.5 million U.S. residents are estimated to have had prescription opioid abuse or dependence in 2002. These high rates appear to reflect, in part, prescribing practices. For example, from 1994 to 2001, prescriptions for oxycodone increased 2.10-fold from approximately 11,742 to 26,513. Hydrocodone prescriptions increased 2.26-fold from approximately 39,218 to 82,213. During this same time from 1994 to 2001, mentions of these agents in hospital emergency departments (ED) increased 2.31-fold from 4,069 to 18,409 for oxycodone and 4.52-fold from 9,320 to 21,567 for hydrocodone. For both agents, especially for oxycodone, increases in ED mentions, which are indicators of associated health problems, have been greater than increases in the number of prescriptions. Psychiatrists need to be aware of these increasing problems so they can intervene in the appropriate identification, treatment, and referral of patients with opioid analgesic misuse and addiction.

No. 53B
THE AVAILABILITY OF OPIOID MEDICATIONS OVER THE INTERNET WITHOUT A PRESCRIPTION

Robert F. Forman, Ph.D., *Department of Psychiatry, University of Pennsylvania-TRI, 600 Public Ledger Building, Philadelphia, PA 19106*

SUMMARY:

Three national drug use monitoring studies have reported increases in the use of opioid-containing medications such as oxycodone and hydrocodone, particularly among young people. One contributing factor may be the emergence of "no prescription Web sites" (NPWs) (Forman 2003), that is, Web sites that offer to sell prescription opioids without a prescription. Since March 2003 the presenter has conducted systematic Internet studies using a variety opioid search terms, including "Vicodin," "hydrocodone," "no prescription codeine," "no prescription Vicodin," "Oxycontin," and "codeine." The proportion of Web sites offering to sell opioid-containing medications without a prescription was determined in each search by querying Google. Considering a sample of 1,200 links examined over an 18-month period, 55% offered to sell opioid-containing medications without a prescription; when only the first 20 links are considered, the proportion of NPWs increased to 62%. In addition to discussing these data, the presenter provides examples of NPWs, as well as a 3-minute video-documentary of a 13-year-old suburban girl making online purchases of opioid medications without a prescription. Plans for future monitoring studies and the implications of the emergence of NPWs are discussed.

No. 53C
MANAGING CHRONIC PAIN IN THE PATIENT WITH COMORBID SUBSTANCE ABUSE

Nathaniel P. Katz, M.D., *Inflexxion, Inc., 320 Needham St, Ste 100, Newton, MA 02464*

SUMMARY:

Chronic pain and substance abuse are conditions that commonly co-occur and create a variety of both conceptual and practical issues in clinical care. The prevalence of chronic pain among U.S. adults is estimated to be in the 20 to 30 million range, and of substance abuse in the 10% to 15% range. The prevalence of chronic pain among patients with substance abuse ranges from 25% to 60%, and the prevalence of substance abuse among patients with chronic pain from 3% to 50%, depending on populations and methods. Managing patients with both problems is challenging, and there are few tested principles and methods. Due to the complexity of these patients, psychiatrists are often involved in their care. The management of chronic pain, particularly as involves the use of long-term opioid therapy, is discussed to help psychiatrists maximize benefits and minimize harm resulting from the use of these medications in this challenging population.

No. 53D
TREATMENT OF PRESCRIPTION ANALGESIC ABUSE

Herbert D. Kleber, M.D., *Department of Substance Abuse, Columbia University, 1051 Riverside Drive, Unit 66, New York, NY 10032*

SUMMARY:

Prescription opioid abusers are a rapidly growing group. Treatment assessments need to include an initial evaluation as to whether there is significant pain. Although the agonist methadone decreases opiate use by cross-tolerance and improves psychosocial outcome, high rates of concurrent alcohol and cocaine abuse, need for frequent clinic visits, and major difficulty in withdrawal are issues. Also, many prescription abusers are unwillingly to attend methadone clinics. The antagonist naltrexone, while blocking opiate use and decreasing alcohol abuse, has low rates of acceptance and high dropout rates but may be more useful in this population, who are often employed and have more family support, as long as pain is not an issue. The partial agonist buprenorphine has some of the advantages of methadone but in addition has easier withdrawal, a ceiling effect on respiratory depression, protection against diversion because of the combination with naloxone, and the possibility of office-based prescribing. This option opens the possibility of mainstreaming addiction treatment and attracting individuals who have not sought help. New approaches to opiate detoxification, a common initial request, include lofexidine; rapid detoxification, especially using buprenorphine and naltrexone; and the use of NMDA antagonists. The presenter discusses office-based possibilities for treatment.

REFERENCES:

1. Zacny J, Bigelow G, Compton P, et al: College on Problems of Drug Dependence taskforce on prescription opioid non-medical use and abuse: position statement. Drug Alcohol Depend 2003; 69:215–232.
2. Forman RF: Availability of opioids on the Internet (letter). JAMA 2003; 290:889.
3. Katz NP, Shelburne S, Beach M, et al: Behavioral monitoring and urine toxicology testing in patients receiving long-term opioid therapy. Anesth Analg 2003; 97:1097–1102.
4. Kleber HD: Pharmacologic treatments for heroin and cocaine dependence. Am J Addict 2003; 12(suppl 2):S5–S18.

SYMPOSIUM 54—PSYCHIATRY AND THE PHARMACEUTICAL INDUSTRY: WHERE IS THE BOUNDARY?

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to appreciate the effectiveness of the pharmaceutical industry in shaping psychiatric education and practice and to discuss some responses to this influence.

No. 54A
PHARMACEUTICAL PROMOTIONS: EFFECTS ON THE PRACTICE OF PSYCHIATRY

Amy C. Brodkey, M.D., *Department of Psychiatry, University of Pennsylvania, 644 West Ellet Street, Philadelphia, PA 19119-3427*

SUMMARY:

The pharmaceutical industry's U.S. marketing budget exceeded 30%–35% of total revenues, or approximately $21 billion, in 2002. This figure far surpasses outlays for both research and development and drug production. By far the largest share goes to promotional activities to physicians, in the form of detailing, gifts, speakers, journals, sampling, and other forms of promotion. A substantial literature demonstrates that, despite many physicians' protestations to the contrary, their opinions and prescribing practices are greatly influenced by such promotion. In addition, studies demonstrate bias and inaccuracy in industry-sponsored advertising, detailing, promotional materials, continuing medical education seminars, published symposia, and sponsored research. The ethical conflicts inherent in accepting gifts from drug companies, existing guidelines, studies on the public's perceptions of this relationship, and harms to the public, the profession, and trainees are examined. The presenter also analyzes how industry has been able to manufacture expert consensus and

has helped to redefine the scope of the psychiatric profession. The presenter suggests ways to establish a firmer barrier between commercial and professional aspects of psychiatry to safeguard the profession and our patients.

No. 54B
ACADEMIC MEDICINE, MEDICAL EDUCATION, AND THE PHARMACEUTICAL INDUSTRY

Frederick S. Sierles, M.D., *Department of Psychiatry, Rosalind Franklin University, 3333 Green Bay Road, North Chicago, IL 60064*

SUMMARY:

The once clear boundary between academic medicine and industry has become increasingly blurred. As other sources of research and education funding have waned, the pharmaceutical industry has become more prominent in academic medicine. The Bayh-Dole Act allowed universities to patent NIH-sponsored discoveries and then to grant exclusive licenses to drug companies. Previously, taxpayer-financed research was in the public domain. Medical schools, medical centers, and many faculty members began viewing themselves as partners of industry. Drug company gifts and sponsored events permeate the educational landscape of residents and students. The overwhelming majority of trainees meet with detailers and receive gifts from them, attend sponsored events, read sponsored studies in journals, and are taught by faculty who receive industry funds. This is a serious problem, because the vast majority of evidence is that virtually every type of interaction between drug companies and trainees presents information favoring the sponsored product. The presenter reviews the literature on (1) trainees' exposures to and attitudes about drug company marketing, (2) pro-industry bias in medical school-drug company research agreements, research results and publication, journal articles, clinical guidelines, and other drug company-academic interactions, and (3) interventions that have been shown to modestly affect trainee attitudes and behavior. The presenter provides suggestions for addressing these problems.

No. 54C
THE PHARMACEUTICAL INDUSTRY, PSYCHIATRY, AND THE PUBLIC INTEREST

Robert M. Factor, M.D., *University of Wisconsin, 625 West Washington Avenue, Madison, WI 53703-2637*

SUMMARY:

Over the past several years, there has been increasing discussion about the influence of the pharmaceutical industry on the practice of medicine in general and of psychiatry in particular. Prescription drug costs have risen faster than the rate of inflation, and medications for psychiatric indications represent nearly half of outpatient drug expenses, especially in the public sector. In psychiatry, new-generation antipsychotic and antidepressant drugs have replaced many older medications. Antiepileptic drugs are being used with greater frequency as mood stabilizers. Newer benzodiazepines have replaced older ones. In many cases, the newer drugs offer the promise of greater efficacy and fewer side effects. These newer drugs are also significantly more expensive than the drugs they have replaced. Almost all of them are on patent. The presenter discusses several important questions about drug costs, the role of industry lobbying, legislation providing Medicare coverage beginning in 2006 for prescription drugs, and special benefits from legislation in the areas of technology transfer and patent protection. He also presents some actions psychiatrists can take to improve their ability to give quality care and to improve the practice of medicine in relation to the pharmaceutical industry.

No. 54D
DANCING WITH PORCUPINES: DILEMMAS FACED BY SPEAKERS FOR THE PHARMACEUTICAL INDUSTRY

Diana M. Koziupa, M.D., *Pennsylvania Foundation, 807 Lawn Avenue, Sellersville, PA 18960*

SUMMARY:

Industry-sponsored educational activities have an enormous influence on the prescribing practices of physicians. The presenter discusses the issues that industry-sponsored speakers face when providing educational experiences for clinicians, both for CME credit and not for credit. A large number of educational activities are funded by the pharmaceutical industry, ranging from lectures to roundtable discussions, on subjects directly or indirectly related to their products. The presenter addresses some dilemmas that speakers face when providing these educational experiences, including the overt and covert influence of the sponsors to promote their specific product, and highlights ways that speakers can ensure that they provide balanced, objective educational experiences, including appropriate discussion of positive and negative research, description of off-label or investigational usage, and discussion of other pharmaceutical products.

REFERENCES:

1. Wazana A: Physicians and the pharmaceutical industry: is a gift ever just a gift? JAMA 2000; 283:373–380.
2. Bekelman JE, Li Y, Gross CP: Scope and impact of financial conflicts of interest in biomedical research. JAMA 2003; 289:454–465.
3. Angel M: The Truth About the Drug Companies: How They Deceive Us and What to do About It. New York, Random House, 2004.
4. Collier J, Iheanocho I: The pharmaceutical industry as informant. Lancet 2002; 360:1405–1409.

SYMPOSIUM 55—AUTISM: A COMMON, SEVERE, TREATABLE, AND NEGLECTED PSYCHIATRIC ILLNESS
Collaborative Session With the National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be knowledgeable about the incidence, etiology, public health issues, neuroscience findings, and psychopharmacologic treatments associated with autism spectrum disorders.

No. 55A
A COMPREHENSIVE REVIEW OF MAJOR RESEARCH FINDINGS IN AUTISM FROM THE PAST DECADE

Eric B. London, M.D., *Department of Psychiatry, UMDNJ, 178 South Street, Suite 1, Freehold, NJ 07728*

SUMMARY:

Autism is a lifelong psychiatric disorder that can be diagnosed in the second year of life. Despite being nearly as common as schizophrenia (recent CDC estimates place the prevalence at 1 per 166 in the population) and of comparable morbidity, autism receives a fraction of the attention from the field of psychiatry as do other illnesses such as schizophrenia. Along with a tenfold increase in prevalence estimates and a 20-fold increase in NIH autism research

funding over the past decade, there have been advances in autism research that could be informative to many other psychiatric disorders. This presentation reviews many of these new findings, including findings in epidemiology, etiology, neuroscience, and diagnosis. Nonpharmacologic aspects of clinical care are also discussed. Autism has been at the center of public health controversies, including its putative association with vaccinations. A clear review of the evidence-based research relevant to these important clinical issues is offered to attendees, enabling an understanding of these sometimes confusing issues.

No. 55B
BIOLOGY OF SOCIAL BEHAVIOR FROM MICE TO MONKEYS

James T. Winslow, Ph.D., *IRP, NIMH, 9000 Rockville Pike, NIHAC Building 110, Bethesda, MD 20892*

SUMMARY:

Autism is a complex, heterogeneous developmental disorder characterized by impairments in social cognition and social attachment and by compulsive behavior. The presenter reviews evidence from rodent and nonhuman primate studies that the neuropeptides oxytocin and vasopressin have a unique role in the normal expression of species typical social behavior and social cognition. The presenter's group and others have hypothesized that an abnormality in oxytocin or vasopressin neurotransmission may account for social deficits in autism. Mutations in the various peptide, peptide receptor, or lineage-specific developmental genes could lead to altered oxytocin or vasopressin neurotransmission. Gene-targeting studies that alter expression of either the peptides or their receptors in the mouse brain also support the autism hypothesis. Recent findings suggest that autism may be associated with a mutation or variation in one of the posttranslational processing enzymes for oxytocin, which could result in reduced oxytocin availability. Animal models provide critically important access to the neural control of normal social behavior and have provided valuable insights into the potential etiologies of psychiatric disorders of social behavior. The studies presented here provide a strong argument for a role of oxytocin and arginine vasopressin in the regulation of specific, relevant social behaviors and therefore should be considered in research investigating the genetic, cellular, and neural substrates of autism.

No. 55C
FMRI STUDIES OF SOCIAL PERCEPTION AND SOCIAL COGNITION IN AUTISTIC DISORDER

Robert T. Schultz, Ph.D., *Child Study Center, Yale University, 230 South Frontage Road, P0207900, New Haven, CT 06520*

SUMMARY:

Individuals with autism spectrum disorders (ASDs) show deficits in the perception of person identity from faces and the perception of internal states from dynamic facial displays. The ability to recognize and remember people by their face may be fundamental for effective interpersonal relationships. Consistent evidence is emerging to show that persons with ASDs have abnormal brain activations during face discrimination and related social perceptual tasks. The presenter reviews new fMRI data showing that persons with an ASD have reduced activation during face perception tasks in several brain nodes, including the fusiform face area (FFA). Moreover, degree of FFA hypoactivation is highly correlated with degree of social impairment, and can discriminate subtypes of autism spectrum disorders. A three-part model to explain the observed underactivity of the FFA is presented. The model focuses on the roles of salience/attention, perceptual expertise, and social knowledge in influencing observed FFA activity. Pilot data are presented on the malleability of the FFA and related social brain areas with a systematic, computerized face training intervention program. This experimental approach is important to test claims for a causal role of the FFA and related social nodes in ASDs.

No. 55D
TARGETED TREATMENTS FOR THE REPETITIVE BEHAVIOR DOMAIN IN AUTISM

Eric Hollander, M.D., *Department of Psychiatry, Mount Sinai School of Medicine, One Gustave L. Levy Place, Box 1230, New York, NY 10029;* Stacey Wasserman, M.D., Evdokia Anagnostou, M.D., Ann Phillips, Ph.D., Karen Zagursky, B.A., Bill Chaplin, Ph.D., Sherie L. Novotny, M.D.

SUMMARY:

Autism is characterized by impairments in three core symptom domains: social deficits; speech/language deficits; and narrow, restricted interests/repetitive behaviors. The repetitive behavior domain in autism may be divided into the higher order repetitive behaviors to reduce anxiety and the lower order perseverative/self-stimulatory behaviors to regulate arousal level. This symptom domain occurs at higher rates in the siblings and parents of autistic probands with greater repetitive behaviors versus those with fewer OCD-like symptoms. Abnormalities of 5-HT function on ligand-based imaging and pharmacological challenges suggest involvement of the serotonin system in mediating this specific symptom domain in autism. Targeted treatments with low-dose selective serotonin reuptake inhibitors (liquid fluoxetine, liquid citalopram), anticonvulsants (valproate, levetiracetam), and atypical antipsychotics (risperidone, olanzapine) for repetitive behaviors in autism are highlighted.

No. 55E
ATYPICAL ANTIPSYCHOTICS IN CHILDREN WITH PERVASIVE DEVELOPMENTAL DISORDERS

Lawrence Scahill, Ph.D., *Child Study Center, Yale University, 230 South Frontage Road, PO BOX 207900, New Haven, CT 06520-7900*

SUMMARY:

Objective: To establish the rational use of atypical antipsychotic medications in the treatment of children and adolescents with autism and pervasive developmental disorders (PDD).

Methods: Selective literature review that includes results from clinical trials and practice guidelines provide the basis for treatment recommendations.

Results: Recent findings support the use of risperidone for the treatment of aggression, tantrums, and self-injury in children with PDD. The other atypical antipsychotics have not been as well studied in this population, but preliminary findings are emerging. Neurological side effects are uncommon, but weight gain and metabolic abnormalities have been observed. Results from recent clinical trials also provide information on the clinical application of symptom severity ratings.

Conclusion: The atypical antipsychotics are emerging as useful treatments for aggression, tantrums, and self-injury in children and adolescents with PDD. Compared with the traditional antipsychotics, the atypical antipsychotics are less likely to cause neurological side effects, but weight gain and metabolic and endocrine dysregulation are important concerns. Practice guidelines emphasize monitoring diet, weight, blood glucose, triglycerides, and symptom severity to ensure safe and effective treatment. Research assessment methods may be relevant for clinical practice in order to monitor target symptoms for pharmacological intervention.

REFERENCES:

1. Charman T: The prevalence of autism spectrum disorders: recent evidence and future challenges. Eur Child Adolesc Psychiatry 2002; 11:249–256.
2. Young LJ, Pitkow LJ, Ferguson JN: Neuropeptides and social behavior animal models relevant to autism. Mol Psychiatry 2002; (suppl 2):S38–39.
3. Grelotti DJ, Gauthier I, Schultz RT: Social interest and the development of cortical face specialization: what autism teaches us about face processing. Dev Psychobiol 2002; 40:213–225.
4. Hollander E, Phillips AT, Yeh C-C: Targeted treatments for symptom domains in child and adolescent autism. Lancet 2003; 362:732–734.
5. Research Units on Pediatric Psychopharmacology (RUPP) Autism Network: Risperidone in children with autism for serious behavioral problems. N Engl J Med 2002; 347:314–321.

WEDNESDAY MAY 25, 2005

SYMPOSIUM 56—SOVIET/RUSSIAN PSYCHIATRY: 15-YEAR EVOLUTION, DAVID LOZOVSKY MEMORIAL
APA Council on Global Psychiatry

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the history of the 1989 investigation of the abuse of psychiatry in the Soviet Union and the subsequent legal and service reforms in current Russian psychiatry.

No. 56A
ENDING SOVIET ABUSE OF PSYCHIATRY

Richard Schifter, *6907 Crail Drive, Bethesda, MD 20817*

SUMMARY:

To maintain its totalitarian system, the Soviet Union adopted a criminal code that contained provisions repressing freedom of expression and religion. Normally these repressive laws were enforced through criminal prosecutions. In some cases, however, the Soviet secret police followed a different route: it arranged for offenders to be committed to institutions for the mentally ill by having two psychiatrists certify that a person who had violated the criminal code by engaging in "anti-Soviet agitation and propaganda" or by organizing unauthorized religious services suffered from a mental illness called "sluggish schizophrenia."

During the 1980s the international human rights movement and the United States government increasingly called attention to this abuse of psychiatry. Once the United States and the Soviet Union entered into a dialogue on human rights issues, abuse of psychiatry was high on the U.S. agenda. In 1987 the Soviets ended any new commitments of political or religious dissidents. The remaining question was whether persons theretofore committed had been released. It was a subject of U.S./Soviet human rights talks throughout 1988 and led Foreign Minister Shevardnadze to invite U.S. psychiatrists to visit the Soviet Union to check it out. After extensive negotiations, the invitation was accepted, and an APA-sponsored delegation visited the Soviet Union in early 1989. Its findings helped bring about the release of the remaining improperly committed dissidents.

No. 56B
ASSESSING SOVIET PSYCHIATRY: VISIT OF THE 1989 U.S. DELEGATION

Loren H. Roth, M.D., *Department of Psychiatry, University of Pittsburgh, Forbes Tower 11016, 200 Lothrup Street, Pittsburgh, PA 15213*

SUMMARY:

While in the Soviet Union in 1989, the 26-person U.S. delegation examined 27 patients, both hospitalized and released, whose psychiatric treatment was alledged to have taken place for political reasons. The delegation included four psychiatrists who were native Russian speakers. Patient examinations were conducted in Russian. Salient records were reviewed, and families were interviewed where possible. Soviet psychiatrists also interviewed the patients in the presence of the U.S. psychiatrists. The legal process involved in hospitalizing these persons was reviewed, as well as forensic practices generally. Structured psychiatric examinations (SCID-PD, IPDE, DSM-III-R Checklist) were conducted to assure a proper scientific approach. This presentation summarizes the Soviet psychiatric practices, the evaluation process, and the results and recommendations of the delegation. The examining team did not believe a mental diagnosis was warranted for five of 15 hospitalized persons and for the great majority of the released patients. The visit of the U.S. delegation reopened dialogue among Soviet and U.S. psychiatrists after a long period of "silence" and mutual distrust during the 1970s and 1980s. David Lozovsky, a Russian-American psychiatrist in whose honor this symposium is conducted, was instrumental in the success of the visit and subsequent follow-up by both "sides."

No. 56C
UNRAVELING SOVIET PSYCHIATRY: CHANGES IN 15 YEARS

Richard Bonnie, J.D., *University of Virginia School of Law, 580 Massie Road, Charlottesville, VA 22901*

SUMMARY:

The presenters describe the deficiencies of Soviet mental health law and criminal procedure identified by the U.S. delegation in 1989 and summarize the legal changes that have occurred over the past 15 years in Russia and the other countries of the former They also highlight the continuing weaknesses in the legal structure.

No. 56D
REFORM OF RUSSIAN PSYCHIATRY: PROBLEMS AND PROSPECTS

Svetlana Polubinskaya, Ph.D., *Institute of State and Law, Russian Academy of Sciences, Znamenka st. 10, Moscow 119992, U.S.S.R*

SUMMARY:

The presenter describes the deficiencies of Soviet mental health law and criminal procedure identified by the U.S. delegation in 1989 and summarizes the legal changes that have occured over the past 15 years in Russia and the other countries of the former U.S.S.R. The continuing weaknesses in the legal structure are highlighted.

No. 56E
DISASTER PSYCHIATRY IN RUSSIA: EXAMPLE OF THE BESLAN TRAGEDY

Zurab Kekelidze, M.D., *Department of Emergency, Serbsky, Moscow, U.S.S.R.*

SUMMARY:

This presentation will describe the development of disaster-related psychiatric services in Russia with specific application to the Beslan school hostage tragedy. It will review the types of interventions and treatments that were administrated during and after the crisis, as well as the after-effects and their application to all disaster scenarios.

No. 56F
REFORMING RUSSIAN PSYCHIATRY: ROLE OF RUSSIAN-AMERICAN COLLABORATION

Valery N. Krasnov, M.D., *Moscow Research Inst. of Psych., 2 Poteshnaya, Moscow*

SUMMARY:

Seventy percent to 80% of 20th-century Soviet psychiatry turned out to be misused for political purposes and was exposed to strict but mostly fair critisicm from American and Western European psychiatrists and lawyers. Reforms in psychiatry became possible only during the period of *perestroika.* At the end of the 1980s, a group of American psychiatrists visited a number of Soviet Union psychiatric institutions, and this event became a dramatic culmination in the difficult process of starting reforms. It was a painful process, but it led to the creation of the law of psychiatric care in Russia. Development of new forms of psychiatric care was complicated not only by economic difficulties but by the necessity to renew the concept of psychiatry as well. New branches of psychiatry received powerful backing from Russian-American cooperation, especially in disaster psychiatry and depression treatment in primary care settings. David Lozovsky and Darrel A. Regier offered invaluable help in this area. Thanks to cooperation, Russian psychiatrists not only gain new experience but also take part in the discussion of new ethical, legal, organizational, and theoretical problems related to the development of contemporary psychiatry.

REFERENCES:

1. Roth LH, Regler DA, Reshetov Y, et al: Report of the US delegation to assess recent changes in Soviet psychiatry Schizophr Bull 198; 15(suppl): 1–88.
2. Bloch S, Reddaway P: Russia's Political Hospitals: The Abuse of Psychiatry in the Soviet Union. London, Victor Gollancz, 1977.
3. Bonnie RJ, Polubinskaya S: Unraveling Soviet psychiatry. San Diego Law Review 1999; 10:279–298.
4. United States–Russia Health Commission, 1994–2000. Moscow, 2000.

SYMPOSIUM 57—THE NIMH CLINICAL ANTIPSYCHOTIC TRIAL OF INTERVENTION EFFECTIVENESS FOR ALZHEIMER'S DISEASE (CATIE-AD): FIRST OUTCOMES
Collaborative Session With the National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant should be able to gain knowledge of outcomes of antipsychotic treatment of dementia patients with agitation or psychosis, assess the extent to which these outcomes inform and can be translated to clinical practice, have increased knowledge of the public health implications.

No. 57A
AN OVERVIEW OF MAIN OUTCOMES IN CATIE-AD

Pierre N. Tariot, M.D., *Department of Psychiatry, University of Rochester, Monroe Hospital, 435 East Henrietta Road, Rochester, NY 14620*

SUMMARY:

This presentation will provide an overview of the efficacy-related outcomes in CATIE. The trial was designed to address the following questions (1) Are atypicals more effective than placebo? and (2) What are the relative merits of atypical antipsychotics in treating patients with AD and psychosis and/or agitation/aggression? Symptomatic outcome measures included the CGIC, BPRS and NPI. Clinical responses based on global assessment, changes in frequency or severity of signs and symptoms, maintenance of medications, and other clinically significant endpoints such as time to hospitalization, time to nursing home placement, and death will be discussed. Intervening variables such as variation in clinical practices among physicians, non-responders, and patient acceptability will be presented as well. CATIE AD outcomes will be synthesized into treatment recommendations for real-world patients.

No. 57B
AD: SAFETY AND TOLERABILITY OF ANTIPSYCHOTICS AND CITALOPRAM

Saleem Ismail, M.D., *Department of Psychiatry, University of Rochester, 435 East Henrietta Road, Rochester, NY 14620*

SUMMARY:

This presentation reports the relative safety of the atypical antipsychotics (risperidone, olanzapine, and quetiapine) used in CATIE, and of citalopram. The following safety data will be reviewed: (1) treatment-emergent effects, particularly those of concern in elderly patients such as CVAEs, falls, syncope, fractures, anorexia, and weight changes, and (2) Serious adverse events and deaths, particularly those associated with the medication. Medical comorbidity, medical burden, and treatment compliance will also be reported. Current safety concerns regarding atypical antipsychotics including CVAEs and metabolic disorders will be addressed. In sum, the presentation will allow the audience to reconcile the safety data on atypical antipsychotics with efficacy data.

No. 57C
QUALITY OF LIFE OF PATIENT AND CAREGIVER: CAREGIVER-RATED ASSESSMENTS AND OUTCOMES

Peter V. Rabins, M.D., *Department of Psychiatry, Johns Hopkins University, Meyer 279, 600 North Wolfe St, Baltimore, MD 21287*

SUMMARY:

The CATIE trial enrolled patients with considerable behavioral symptomatology that makes caregiving more challenging. The presentation will provide an overview of outcomes on caregiver-rated assessments. This includes the Alzheimer disease-related quality of life (ADRQL), the Neuropsychiatric Inventory. Caregiver distress, depression, burden, caregiver activity, and level of care as a result of patients' behavior also will be presented. These outcomes are crucial in establishing effectiveness of treatments, i.e., the impact of treatment on the quality of life of the patients and of those who cared for them.

No. 57D
CATIE-AD: ECONOMIC UTILIZATION

Robert A. Rosenheck, M.D., *NEPEC, VA Northeast Program Evaluation Center, 950 Campbell Avenue, Building 8, Unit 182, West Haven, CT 06516*

SUMMARY:

This is a presentation of costs, cost effectiveness, service utilization, and health utilities of atypical antipsychotics. Two policy questions central to CATIE are whether the expenditure on these agents is justified by (1) the savings the medication generates in other health care or non-health care costs and/or (2) the improvements the agents yield in the well being of patients, their families, and/or their communities. Factors that will be discussed are services utilization, direct and indirect costs, cost-benefit, cost effectiveness, and quality-adjusted life years.

REFERENCES:

1. Schneider LS, Tariot PN, Lyketsos CG, Dagerman KS, Davis KL, Davis S, Hsiao JK, Jeste DV, Katz IR, Olin JT, Pollock BG, Rabins PV, Rosenheck BA, Small BG, Lebowitz B, Lieberman JA: National Institute of Mental Health-Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE): Alzheimer's disease trial methodology. American Journal of Geriatric Psychiatry 2001; 9(4):346-360.
2. Schneider LS, Katz IR, Park S, Napolitano J, Martinez RA, Azen SP: Psychosis of Alzheimer's disease: validity and response to risperidone. American Journal of Geriatric Psychiatry 2003; 11(4):414-425.
3. Rabins PV, Kasper J, Black BB, Patrick DL: Concepts and methods in the development of the ADRQL: an instrument for assessing health-related quality of life in persons with Alzheimer's disease. J Mental Health & Aging 1999; 5:33-48. [Reprinted in Assessing Quality of Life in Alzheimer's Disease, SM Albert, RG Logsdon, Eds. New York: Springer Publishing Company, 2000].

SYMPOSIUM 58—DIAGNOSTIC AND TREATMENT IMPLICATIONS OF A NEW MODEL OF PERSONALITY DISORDERS
Collaborative Session With the National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the significance of new research findings for the reconceptualization, diagnosis, and treatment of personality disorders.

No. 58A
COURSE OF SYMPTOMS AND IMPAIRMENTS IN PATIENTS WITH PERSONALITY DISORDERS

Andrew E. Skodol II, M.D., *Department of Psychiatry, New York State Psychiatric Institute, 1051 Riverside Drive, Box 129, New York, NY 10032;* M. Tracie Shea, Ph.D., Carlos M. Grilo, Ph.D., Robert L. Stout, Ph.D., John G. Gunderson, M.D., Maria E. Pagano, Ph.D., Thomas H. McGlashan, M.D.

SUMMARY:

The purpose of this presentation is to illustrate an apparent disjunction between the courses of symptoms and of associated functional impairments over time in patients with personality disorders. Patients with schizotypal (STPD), borderline (BPD), avoidant (AVPD), or obsessive-compulsive (OCPD) personality disorders, or with major depressive disorder (MDD) and no PD, were assessed with semi-structured interviews six times over four years for the presence of traits or behaviors meeting the criteria for each PD and for impairment in occupational, social, recreational, and global functioning. Only a small proportion of PD patients (4% to 20%, by group) remained at or above diagnostic threshold every month of the follow up. Although the probability of remitting was significantly higher for the MDD group, a majority of PD patients also remitted (STPD=47%, BPD=53%, AVPD=56%, OCPD=66% for 12 consecutive months of meeting two or fewer criteria). In contrast, impairment in functioning was more stable. For example, only 5% of patients with STPD, 10% with BPD, 18% with AVPD, and 28% with OCPD had 12 consecutive months with a GAFS score >70. These results suggest that functional aspects of PDs are more stable and fundamental than the symptomatic manifestations, and would need to be addressed in successful treatment.

No. 58B
ASSOCIATION OF COURSE CHANGES IN PERSONALITY DISORDERS AND AXIS I DISORDERS

M. Tracie Shea, Ph.D., *Department of Psychiatry, Brown University-Butler Hospital, 700 Butler Drive, Duncan Building, Box G-BH, Providence, RI 02906;* Robert L. Stout, Ph.D., Carlos M. Grilo, Ph.D., John G. Gunderson, M.D., Andrew E. Skodol II, M.D., Shirley Yen, Ph.D., Leslie C. Morey, Ph.D.

SUMMARY:

Background: Associations among personality disorders (PDs) and Axis I disorders have been widely studied using varied approaches, with relevance to classification, etiology, and treatment of these disorders. Relatively few studies have examined how changes in course of PDs and Axis I disorders are related over time. This presentation will address associations between changes in the course of schizotypal (STPD), borderline (BPD), avoidant (AVPD), and obsessive-compulsive (OCPD) PDs and changes in the course of co-occuring Axis I disorders.

Method: Following baseline diagnoses using semi-structured interviews, follow-along assessments at six, 12, 24, 36, and 48 months provided monthly ratings of individual criteria for the four PDs, and weekly ratings of the diagnostic status of co-occurring Axis I disorders. The prediction of change in PDs following change in Axis I disorders, and vice versa, is examined using proportional hazards regression with time-varying covariates.

Results: Findings to date have demonstrated significant course associations for BPD (with major depressive disorder and posttraumatic stress disorder) and for AVPD (with social phobia and obsessive-compulsive disorder) in prediction of remission. Remissions in STPD and OCPD were largely independent of Axis I disorder course. This presentation will extend the examination of course change associations to worsening, or relapse of PDs and Axis I disorders.

Conclusions: The findings suggest that the nature of the relationship between PDs and Axis I disorders varies for different PDs.

No. 58C
A HYBRID MODEL OF PERSONALITY DISORDERS: TRAITS AND SYMPTOMATIC BEHAVIORS

Charles A. Sanislow, Ph.D., *Department of Psychiatry, Yale University School of Medicine, 301 Cedar Street, P O Box 208098, New Haven, CT 06520-8098;* Carlos M. Grilo, Ph.D., John G. Gunderson, M.D., Leslie C. Morey, Ph.D., M. Tracie Shea, Ph.D., Andrew E. Skodol II, M.D., Thomas H. McGlashan, M.D.

SUMMARY:

Background: Personality disorders (PDs) can be decomposed into more stable trait-like features and less stable symptomatic behaviors. This conceptualization can help to explain seemingly high remission rates in naturalistic studies including the CLPS.

Method: Using a longitudinal follow-along study of a large sample of PD-diagnosed patients, we examined the course and stability of symptomatic behaviors and personality traits.

Results: Improvements are not always associated with comparable functional improvement; trait-like criteria remain stable while symptom-like criteria do not; changes in personality traits precede PD remission, but not the reverse. Collectively, these findings suggest a hybrid model of PDs: stable personality traits that are pathologically skewed (affective dysregulation in BPD and shyness in AVPD), and dysfunctional behaviors that reflect pathologic traits (self-cutting to modulate affect, avoiding social situations because of shyness). This hybrid model, separately grouping DSM-IV criteria that are longitudinally stable and those criteria that fluctuate, will be presented.

Conclusions: Traits are more enduring, perhaps more proximal to genetics. Symptomatic behaviors are more intermittently expressed and probably linked to situational stress. An integrated view of these two aspects of personality can clarify treatment targets and improve cross sectional diagnosis by clarifying the stable and non-stable components of PD.

No. 58D
COMPARATIVE VALIDITY OF THREE ALTERNATIVE PERSONALITY DISORDER MODELS

Leslie C. Morey, Ph.D., *Department of Psychology, Texas A & M University, College Station, TX 77843-4235*

SUMMARY:

This study examined antecedent, concurrent, and predictive (two- and four-year) markers of construct validity for three models of personality disorders (the five-factor (FFM), SNAP, and DSM-IV-TR, Axis II) in a sample of personality disordered (n = 571) and depressed (n = 97) patients from the Collaborative Study of Personality Disorders (CLPS). All models demonstrated temporal stability and were able to predict a wide variety of theoretically relevant variables over time. Trait models (NEO-PI-R, SNAP) demonstrated greater stability than the DSM-IV-TR. Dimensional models, including a dimensional characterization of DSM-IV-TR (i.e., symptom count), consistently outperformed the commonly used categorical diagnosis. A model composed of 30 FFM facets did not appear to add significant explanatory power to the model composed of five factors. Overall, the SNAP model consistently demonstrated larger coefficients of determination than both a dimensional characterization of the DSM-IV-TR and NEO-PI-R facets in predicting external markers of construct validity. In addition, the SNAP was able to predict the residuals of the FFM and DSM-IV-TR in predicting criteria, but the FFM and DSM-IV-TR were, for the most part, unable to predict variance associated with marker variables unexplained by the SNAP.

No. 58E
IMPLICATIONS FOR RESEARCH ON TREATMENT OF BPD FROM THE CLPS

John G. Gunderson, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont, MA 02478-9106*

SUMMARY:

Implications that derive from finding there is much more instability and likelihood of lasting remissions in BPD than has been believed include: (1) short-term interventions that reduce chronic stress should be developed; (2) RCTs are essential in evaluating effectiveness, (3) psychopharm trials should not primarily focus on comorbid Axis I conditions; and test the effects of discontinuance.

Other implications that derive from finding that social/functional impairment is more persistent than psychopathology include: social rehabilitative and skill-building treatments need more emphasis, and tests of treatment efficacy must include functional measures.

REFERENCES:

1. Grilo CM, Shea MT, Sanislow CA, Skodol AE, Gunderson JG, Stout RL, Pagano ME, Yen S, Morey LC, Zanarini MC, McGlashan TH: Two-year stability and change in schizotypal, borderline, avoidant and obsessive-compulsive personality disorders. J Consult Clin Psychol, in press.
2. Shea MT, Stout RL, Yen S, Pagano ME, Skodol AE, Morey LC, Gunderson JG, McGlashan TH, Grilo CM, Sanislow CA, Bender DS, Zanarini MC: Associations in the course of personality disorders and axis I disorders over time. Journal of Abnormal Psychology, in press.
3. McGlasban TH, Grilo CM, Sanislow, CA, Ralevski E, Morey LC, Gunderson JG, Skodol AE, Shea MT, Zanarini MC, Bender DS, Stout RL, Yen S, Pagano ME: Two-year prevalence and stability of individual criteria for schizotypal, borderline, avoidant, and obsessive-compulsive personality disorders. Am J Psychiatry, in press.
4. Gunderson JG, Shea MT, Skodol AE, McGlashan TH, Morey LC et al: The Collaborative Longitudinal Personality Disorders Study: Development, aims, design, and sample characteristics. Journal of Personality Disorders 2000; 14, 300-315.
5. Gunderson JG, Bender D, Sanislow C, Yen S, Bame Rettew J, Dolan-Sewell R, Dyck I, Morey L, McGlashan TH, Shea MT, Skodol AE: Plausibility and possible determinants of sudden "remissions" in borderline patients. Psychiatry 2003; 66:111-119.

SYMPOSIUM 59—ADVANCES IN PREVENTION: SCIENCE AND CLINICAL STRATEGIES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to identify the distinctions between primary, secondary, and tertiary prevention and learn examples of each being applied currently to major psychiatric disorders.

No. 59A
EARLY RECOGNITION AND TREATMENT OF PSYCHOSIS: INITIAL FINDINGS AND PROSPECTS

Thomas H. McGlashan, M.D., *Department of Psychiatry, Yale University, 301 Cedar Street, New Haven, CT 06519;* Per Vaglum, M.D., Ingrid Melle, M.D., Scott W. Woods, M.D., Diana O. Perkins, M.D., Jean M. Addington, Ph.D., Robert B. Zipursky, M.D.

SUMMARY:

Because all current treatments of the schizophrenic psychoses are merely palliative, prevention strategies are being explored. Schizophrenia develops in phases: premorbid, prodromal, and first-episode psychotic. Prevention strategies focus on reducing duration of untreated psychosis (DUP) in the post-onset, first-episode phase and introducing antipsychotic treatment in the pre-onset (prodromal) phase. Both aim to treat active symptoms and to prevent course progression. The nature of the prevention aim depends upon the phase of disorder, i.e., redncing DUP in the post-onset phase hopefully will

provide tertiary prevention by reducing severity and chronicity of established disorder, and treating prodromal symptoms before onset hopefully will provide secondary prevention by delaying the onset of disorder (reducing prevalence) or primary prevention by averting onset altogether (reducing incidence).

Recent prevention research in both phases will be reviewed, highlighting two studies of which the presenter is principal investigator. The first is located in Scandinavia (Norway and Denmark) and aims to reduce DUP through education about psychosis coupled with early detection teams. The second is located in North America (New Haven, Chapel Hill, Toronto, Calgary) and aims to test whether an atypical antipsychotic can prevent or delay onset in prodromally symptomatic persons at high risk for becoming psychotic in the near future. Initial findings will be presented and their implications for future prevention treatment and research will be discussed.

No. 59B
NEED FOR EARLY INTERVENTION TRIALS IN PREPUBERTAL BIPOLAR DISORDER

Robert M. Post, *Department of Biological Psychiatry, National Institute of Mental Health, 10 Center Drive MSC 1272, Bethesda, MD 20892-1272*

SUMMARY:

There is great need for early intervention studies in the bipolar prodrome in childhood, and particularly prepubertal onset bipolar illness because of its morbidity and diagnostic and treatment complexities and ambiguities.

We suggest the utility of randomized, open, parallel-group studies among several options in order to assess their relative tolerability and effectiveness in children (4 to 12 years of age) with prodromal symptoms or full diagnosis. When severe irritability/dyscontrol symptoms are accompanied by sleep disturbance and periods of mood elevation, there is a very high likelihood of a subsequent bipolar diagnosis. Another practical approach could involve children at very high risk based on a bilineal family history of affective disorders with one parent being bipolar. Since these children are at a 70% risk of an affective illness diagnosis, it would be ethically appropriate to design a randomized, comparative study at the first appearance of pjrodromal symptoms associated with dysfunction.

Given the young age of the potential subjects involved, attentio to the safety tolerability of the drugs being tested is paramount in the study design. Such studies would not only yield much needed information about affective therapies, but also whether early intervention could prevent the development of full-blown bipolar illness.

No. 59C
PREVENTION OF DEPRESSION IN CHILDHOOD: REVIEW AND IMPLICATIONS

William R. Beardslee, M.D., *Department of Psychiatry, Harvard Medical School, 27 Shepard Street, Cambridge, MA 02138*

SUMMARY:

Over the past two decades, important new advances in conceptual frameworks for understanding how to prevent depression in children and adolescents and a series of promising empirical approaches have evolved. At a conceptual level, the understanding is based on the fact that large public health risk factors such as exposure to violence, social isolation, and poverty play an important role in the causation of depression in some families, while extensive family history does in others. At the empirical level, group approaches for grade school students manifesting symptoms, school and clinic based, cognitive-behavioral preventions, and family-based health approaches, have all shown considerable merit. The conceptual framework and specific approaches will be reviewed and the larger implications, both for clinical practice and for public health prevention, will be explored.

No. 59D
PREVENTING SECONDARY SUBSTANCE-USE DISORDERS

Wilson M. Compton III, M.D., *NIH/NIDA, 6001 Executive Blvd MSC5153, Bethesda, MD 20892-9589*

SUMMARY:

Psychiatric disorders are much more common than expected among persons with substance-use disorders and substance-use disorders are more common among those with psychiatric illness (e.g. Reigier 1990; Armstrong 2002). Further, from retrospective and longitudinal studies, it is clear that certain psychiatric conditions are much more likely to appear before the onset of substance-use disorders (e.g. Compton 2000; Brook 2002). In particular, there is an increase in substance-use disorders among those with pre-existing childhood externalizing disorders. Secondary substance-use disorders among those with such externalizing disorders, especially conduct and antisocial syndromes, is nearly ubiquitous. But does effective intervention for the earlier (i.e. primary) disorder prevent or delay onset of the substance-use disorder? A recent review of the evidence for the effects on substance use outcomes of treatment of pre-existing childhood disorders demonstrates positive associations for treatment of disruptive behavior disorders and ADHD with decreased subsequent substance-use disorders (Farmer et al, 2002). Specifically, longitudinal prevention studies demonstrate that interventions designed to reduce disruptive behavior in children can reduce or delay subsequent onset of substance use. Future work will need to emphasize whether specific clinical treatment interventions have a similar impact as the broad, universal prevention interventions.

No. 59E
PUTTING GENETICS TO WORK FOR PREVENTIVE INTERVENTIONS

David Reiss, M.D., *Department of Medicine, George Washington University Medical Center, 2300 K Street, N.W., Washington, DC 20037*

SUMMARY:

Recent data suggest that adverse genetic factors are much less likely to lead to psychopathology when a child grows up in a favorable social environment. These studies of gene-environment interaction provide valuable clues to preventing a range of psychiatric disorders.

Current data suggest three strategies for using these genetic data to inform the design and execution of prevention trials: genotyping to identify children at risk, understanding genetic influences on sensitivity to the environment, and clarifying heritable mechanisms by which children evoke negative reactions from parents, sibs, and peers. Genetically-informed randomized, controlled clinical trials, such as those that can be conducted with adopted children, can verify that interventions developed from genetic data actually interrupt genetic mechanisms of transmitting illnesses from parents to children.

REFERENCES:

1. Melle I, Larsen TK, Haahr U, Friis S, Johannessen JO, Opjordsmoen S, Simonsen E, Rund BR, Vaglum P, McGlashan TH: Reducing the duration of untreated first-episode psychosis. Archives of General Psychiatry 2004; 61:143-150.
2. The National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention Development

and Deployment: Blueprint for Change: Research on Child and Adolescent Mental Health. Washington, D.C., 2001.
3. Farmer EM, Compton SN, Burns BJ, Robertson E: Review of the evidence base for treatment of childhood psychopathology: externalizing disorders. Journal of Consulting and Clinical Psychology 2002; 70(6):1267-1302.
4. Reiss D, Neiderhiser J, Hetherington EM, Plomin R: The Relationship Code: Deciphering Genetic and Social Patterns in Adolescent Development. Cambridge, MA, Harvard University Press, 2000.

SYMPOSIUM 60—WITHDRAWN

SYMPOSIUM 61—THE BIOPSYCHOSOCIAL CONSEQUENCES OF PATHOLOGICAL GAMBLING

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant will become familiar with the biological, psychological, and social consequences of pathological gambling. Of particular importance will be recognizing how pathological gambling might trigger or exacerbate medical and psychiatric conditions in high-risk groups.

No. 61A
THE MEDICAL CONSEQUENCES OF PATHOLOGICAL GAMBLING

Timothy W. Fong, M.D., *Department of Psychiatry, UCLA Neuropsychiatric Institute, 760 Westwood Ave. Room C9-440, Los Angeles, CA 90024*

SUMMARY:

Pathological gambling is classified as an impulse-control disorder and much has been written on its psychological and social consequences. Medical consequences of pathological gambling tend to be overlooked by mental health researchers and treatment providers but is a critical issue. This presentation will summarize the existing research that describes the medical consequences of pathological gambling. Given the high-risk nature of gambling and the multiples stressors (financial, social, legal, psychological) that can occur with this disorder, it follows that there would be elevated rates of stress-related medical problems. Pathological gamblers may be at elevated risk for cardiovascular disease, peptic ulcer disease, and hypertension. There are other under-recognized medical consequences of pathological gambling that can dramatically influence the disorder itself, including sleep deprivation, prolongation of sedentary behaviors, increased exposure to smoking and alcohol, and chronically elevated levels of stress hormone. Finally, there have been case reports of iatrogenically caused pathological gamblers through dopamine agonists. The importance of identifying and modifying these medical conditions that can co-exist with pathological gambling is critical as part of a multidisciplinary approach to treatment of behavioral addictions.

No. 61B
PROBLEM GAMBLING: PSYCHOSOCIAL PROBLEMS IN SPECIAL POPULATIONS AND TREATMENTS

Nancy M. Petry, Ph.D., *Department of Psychiatry, University of Connecticut Health Center, 263 Farmington Avenue, MC-3944, Farmington, CT 06030-3944*

SUMMARY:

This presentation will describe results from recent studies evaluating the prevalence and correlates of problem and pathological gambling in special populations including older adults, substance abusers, and patients in medical settings that serve the underprivileged. Results from recent treatment trials that employed cognitive-behavioral and brief interventions will also be discussed.

No. 61C
THE IMPACT OF PATHOLOGICAL GAMBLING ON THE FAMILY

Donald W. Black, M.D., *Department of Psychiatry, University of Iowa, Psychiatry Research MEB, Iowa City, IA 52442*

SUMMARY:

The problem of pathological gambling has become a major health concern, particularly as it has become more widespread. Though relatively under-researched, the impact of both problem and pathological gambling on families and marriages has been well document in the United States and elsewhere. In this presentation, the damaging social effects of problem pathological gambling on families and children are reviewed, including its impact on marriages, friendship patterns, child rearing practices, and domestic violence. Recommendations are made to incorporate this knowledge into the treatment of persons with problem and pathological gambling.

No. 61D
PATHOLOGICAL GAMBLING AND THE LAW

Jon E. Grant, M.D., *Department of Psychiatry, Brown Medical School, 345 Blackstone Boulevard, Providence, RI 02906*

SUMMARY:

Pathological gambling (PG) is a relatively common and often disabling disorder. Although complicated, an association between crime and PG is well-established. The prevalence of criminal activity among pathological gamblers has been estimated to be as high as 80%. Illegal behaviors may include writing bad checks or engaging in embezzlement, larceny, tax fraud, or prostitution. Although a relationship exists between criminality and gambling, a causal nature is still unclear. Does the addictive nature of PG represent an important criminogenic factor? What is the role of antisocial personality disorder? This presentation will review the forensic features of PG, including its relationship to antisocial personality disorder, substance use, and illegal sexual behavior. The presentation will review important legal case law on the status of PG and other addictions as defenses to criminal behavior and will offer practical advice on what clinicians and patients with PG need to know about the criminal justice system.

REFERENCES:

1. Goudriaan AE, Oosterlaan J, et al: Pathological gambling: a comprehensive review of biobehavioral findings. Neurosci Biobehav Rev 2004; 28(2):123-41.
2. Petry NM: Psychiatric symptoms in problem gambling and non-problem gambling substance abusers. Am J Adict 2000; 9(2):163-71.
3. Darbyshire P, Oster C, et al: Children of parent(s) who have a gambling problem: a review of the literature and commentary on research approaches. Health Soc Care Community 2001; 9(4):185-93.
4. Potenza MN, Steinberg MA, McLaughlin SD, Rounsaville BJ, O'Malley SS: Illegal behaviors in problem gambling: analysis of data from a gambling helpline. J Am Acad Psychiatry Law 2000; 28:389-403.

SYMPOSIUM 62—PSYCHOANALYSIS AND PSYCHOSOMATIC ILLNESS: A MODERN MIND-BODY PERSPECTIVE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should (1) understand the psychoanalytic view that mental events, e.g., emotional conflicts, and deficits in social relatedness, contribute to somatic illness, (2) recognize how mental events affect the brain, resulting in somatic disturbance, (3) use this mind-body approach in the treatment of conditions, such as eating disorders and irritable bowel syndrome.

No. 62A
THE THERAPEUTIC CONSULTATION OF PATIENTS WITH PSYCHOSOMATIC SYMPTOMS

Milton Viederman, M.D., *Weill Cornell Medical College, 170 East 77th Street, Apartment 1F, New York, NY 10021-4873*

SUMMARY:

This paper will elaborate methods of active intervention during the consultation process using dynamic principles for therapeutic effect. The goal of such an approach is to relieve distress by rapidly engaging the patient emotionally. In so doing, the consultant can establish a bond with the patient. He may thereby convey to the patient that the patient has been "noticed," and, reciprocally, the consultant may become a "presence" in the patient's world.

Observations and resultant inferences about the patient's concerns, conflicts, personality, and life history are formulated and presented to him to clarify meanings that make the patient's experience comprehensible. This may fascilitate the process of self-revelation and reflection and permit a co-construction with the patient of a perspective on his life experience and current problems.

Several examples with different patients in their contexts will be offered.

No. 62B
PSYCHOANALYSIS AND PSYCHOSOMATIC PROCESSES IN THE BRAIN AND MIND

Ronald W. Levin, M.D., *4033 East Madison Street, Seattle, WA 98112-3117*

SUMMARY:

Psychosomatic processes are linked to the reciprocating, regulating relationship between each individual's mind and body/brain. As a result, patients often communicate one transference verbally and another somatically. Integrating these two, often noncongruent, responses makes treatment complex. But it also offers opportunities for the therapist to conceptualize nonverbal early experience and intervene in a manner that has impact at psycho-physiologic levels. In this discussion, I will briefly describe two cases, the difficulties they presented, and the gains they made.

No. 62C
PSYCHOANALYTIC TREATMENT OF A PATIENT WITH IRRITABLE BOWEL SYNDROME

Beth J. Seelig, M.D., *Department of Psychiatry, Emory University Psychoanalytic Institute, 2004 Ridgewood Dr. NE, #300, Atlanta, GA 30322*

SUMMARY:

This psychoanalytic case study illustrates ways in which individual and family dynamics and difficulty with affects, particularly anger and sadness, can contribute to somatic illness such as irritable bowel syndrome. The patient suffered from irritable bowel syndrome and anxiety as well as mild-to-moderate depression. She had longstanding difficulties in interpersonal relationships, particularly with men, and entered psychoanalysis hoping to change her maladaptive relationship pattern. She regarded her physical symptoms as purely a medical problem and did not expect that psychoanalysis could help ameliorate them. Analytic work, which included careful attention to the way in which her life experiences were partially encoded as somatic schemata, gradually resulted in erosion of the artificial dichotomy she had maintained between her mind and body and symptom improvement ensued. In the process of learning to pay attention to her bodily sensations in a new way, recognizing them as affective representation, her capacity for self-reflection and symbolization increased. The treatment resulted in lasting significant improvement in the patient's anxiety and depressive symptoms and irritable bowel symptoms as well as in her relationships.

No. 62D
THE DEVELOPMENTAL LINE OF HUMAN FEEDING: COVARIANT ROOTS OF PSYCHOPATHOLOGY AND NEUROBIOLOGICAL DYSREGULATION IN EATING DISORDERS

Barton J. Blinder, M.D., *Department of Psychiatry, University of California, Irvine, 400 Newport Center Drive, Suite 706, Newport Beach, CA 92660-7608*

SUMMARY:

The achievement of competence in appetite regulation, food selection, and consummatory behavior depends critically on relational processes of attachment, attunement, reciprocity, homeostasis, and separation individuation covering critical developmental phases. These operate to stabilize and modulate neurobiologic processes which, when disrupted, may lead to disordered eating (rumination, bulimic behavior, restriction/neophobia). Separation distress has been associated with rumination and bulimia related to opiod modulation; object loss has been associated with binge eating and rumination; stress and abuse trauma has been associated with restrictive eating and hyperphagia.

Adaptation/disadaptation at critical neural domains (neural circuits/chemical systems; for instance opiods, DA, 5-HT, peptides) may play a significant role in linking eating behavior to affective modulation, anxiety, and cognitive processes related to changing environmental contexts.

Neurobiology and psychopathology are intimately linked in the spectrum of disordered eating throughout the life cycle.

REFERENCES:

1. Taylor GJ: Psychoanalysis and psychosomatics: a new synthesis. J of the Amer Academy of Psychoanalysis 1992; 20:251-275.
2. Viederman M: The psychodynamic life narrative: a psychotherapeutic intervention useful in crisis situations. Psychiatry 1983; 48:236-246.
3. Bucci W: Symptoms and symbols: a multiple code theory of somatization. Psychoanalytic Inq 1997; 17:151-172.
4. Blinder BJ, Chaitin B, Goldstein R: The Eating Disorders: Medical and Psychological Bases of Diagnosis and Treatment. New York, 1988.

SYMPOSIUM 63—THE DOCTOR'S DILEMMA: MANAGING PEDIATRIC CHRONIC UNEXPLAINED SYMPTOMS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to use the biopsychosocial model to differentiate and manage organic and non-organic factors in pediatric chronic unexplained medical symptoms with the family as therapeutic allies. The model can be applied to chronic unexplained medical symptoms without significant organic pathology or within the context of fibromyalgia, oncology, and chronic pain conditions.

No. 63A
SHIFTING THE FOCUS: FAMILY-ORIENTED REHABILITATION FOR CHRONIC UNEXPLAINED MEDICAL SYMPTOMS

Rose Geist, M.D., *Department of Psychiatry, Hospital for Sick Children, 555 University Avenue, Toronto, ON M5G 1X8, Canada;* Louis Peltz, M.D., Caroline Ho, Ph.D., Hasmig Halajian, C.Y.C.

SUMMARY:

This interactive workshop focuses on an innovative treatment model for pediatric unexplained medical symptoms (UMS). Case studies from the practices of the participants as well as the presenters will be used to discuss the principles and practice of a rehabilitative, family-oriented treatment program that focuses on enhancing patient functioning, rather than on symptoms, and on the appropriate use of selective serotonin reuptake inhibitors.

Pediatric UMS present a diagnostic and management challenge to family doctors, pediatricians, and psychiatrists. Typically, families believe that the symptoms are soley due to an organic cause, despite lack of significant organic findings. They often resist considering suggestions that psychosocial factors may be contributing to the development or perpetuation of UMS. Consequently, health care utilization is increased (i.e., multiple diagnostic investigations, repeated office and emergency department visits, and prolonged medical stays.)

The medical psychiatry program, division of child psychiatry, at the University of Toronto, has developed an approach to manage these problems. The families are treatment allies who assist in enhancing patient functioning (sleep, school attendance, social interaction). Attention to the symptoms is actively discouraged. The family is taught coping strategies for enhanced functioning. The presenters represent both a tetiary pediatric academic center as well as a community-based pediatric hospital.

No. 63B
BACK TO THE LAND OF THE LIVING: DEALING WITH CHRONIC FATIGUE SYNDROME/ FIBROMYALGIA

Arlette M. LeFebvre, M.D., *Department of Psychiatry, Hospital for Sick Children, 555 University Avenue, Toronto, ON M5G 1X8, Canada*

SUMMARY:

Chronic fatigue syndrome (CFS) and primary juvenile fibromyalgia syndrome (PJFS) are illnesses with similar symptoms than those with CFS, but both groups experience fatigue, headache, depression, concentration difficulty, blurred vision, and joint pain.

Of the variety of treatments used in the management of these conditions in adults, graded exercise therapy (GET) and cognitive-behavioral therapy (CBT) are the only two with demonstrated effectiveness.

In the division of rheumatology of the Hospital for Sick Children in Toronto, two to four new cases of CFS and PJFS are diagnosed a week and treated by a multidisciplinary team approach: children and adolescents with recent onset of symptoms, with a combination of outpatient graded exercise therapy and cognitive-behavioral therapy, with selective use of psychopharmacology, and youngsters who have missed six months or more of school, with a six- to eight- inpatient admission to the affiliated Bloorview McMillan Children's Hospital. The psychiatric component of this approach is outlined here.

No. 63C
MAKING IT THROUGH TREATMENT: THE ROLE OF MEDICAL PSYCHIATRY IN ONCOLOGY

Claire M. De Souza, M.D., *Department of Psychiatry, Hospital for Sick Children, 555 University Avenue, Toronto, ON M5G 1X8*

SUMMARY:

Unexplained medical symptoms are common in children suffering from anxiety and depression. Higher rates of anxiety and depression exist in the pediatric oncology population. As such, deciding on the etiology of the somatic complaint in a child with cancer can be difficult. Resolving this etiological dilemma is possible by viewing the somatic complaint as having biological, psychological, and social precursors as well as avenues for intervention. Doing so also ensures a collaborative multidisciplinary team approach involving medical and psychosocial disciplines, thereby helping to reduce the stigma associated with the latter group. Although there are more data in the adult cancer population to support psychopharmacological and psychotherapeutic interventions, there is some evidence in the pediatric population for cognitive-behavioral therapy (CBT), distraction, imagery, and parent support. A variety of approaches are incorporated, tailored to the needs of the patient and family, with the overarching goal of improving quality of life, decreasing distress, and improving coping skills. Intervention begins with the assessment to establish a therapeutic alliance and facilitate expression of distress by reviewing the patient's life story, including the impact of cancer. Subsequent interventions may include CBT, psychoeducation, distraction, relaxation training, and support. Illustrative cases will be discussed.

No. 63D
MASTERING PAIN: TAKING BACK YOUR LIFE

Michael M. Jeavons, M.D., *Department of Psychiatry, Hospital for Sick Children, 555 University Avenue, Toronto, ON M5G 1X8, Canada*

SUMMARY:

Chronic pain serves as a paradigm for any chronic medical symptom that can dominate a child's life and its treatment should involve addressing the psychological component as well as the physical.

Dr. Jeavons will include a brief case presentation and describe an approach to help children to manage their pain by reducing its severity and also by reducing its effect on their lives. These goals are achieved in the context of a multidisciplinary pain management clinic (Hospital for Sick Children, Toronto) and utilize an approach involving narrative, behavioral, and cognitive-behavioral techniques.

REFERENCES:

1. Bursch B, Wolco G, Zeltzer L: Clinical assessment and management of chronic pain and pain-associated disability syndrome. Developmental and Behavioral Pediatrics 1998; 19(1):45-53.

2. Breau LM, McGrath PJ, Ju LH: Review of juvenile primary fibromyalgia and chronic fatigue syndrome. Journal of Developmental and Behavioral Pediatrics 1999; 20(4):278-88.
3. Bearison DJ, RK Mulhern (eds.): Pediatric psychooncology: Psychological Perspectives on Children with Cancer, 1994.
4. Leo RJ: Concise Guide to Pain Management for Psychiatrists. American Psychiatric Publishing Inc., 2003.

SYMPOSIUM 64—EMERGING FRONTIER OF PSYCHIATRY: JUVENILE JUSTICE
APA Corresponding Committee on Juvenile Justice Issues

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium; the participant should demonstrate knowledge in issues relevant to mental competency pertinent to youth, on using a specialized mental health court for children and youth, prevalence of mental disorders in juvenile justice, elements of screening and assessment of youth in detention, and informed consent pertinent to use of psychotropic agents in incarcerated youth.

No. 64A
PREVALENCE OF MENTAL HEALTH SYMPTOMS AND DISORDERS AMONG JUVENILE OFFENDERS

Joseph J. Cocozza, Ph.D., *Policy Research Associates, Inc., 345 Delaware Avenue, Delmar, NY 12054;* Sarah McLean, Ph.D., Kathleen Skowyra, B.A.

SUMMARY:

In recent years, awareness of the large numbers of juveniles with mental disorders involved in the juvenile justice system has increased. Prevalence studies suggest that the rates of disorders among detained juveniles far exceed the rates of disorders among community samples. While there has been significant improvement during the past few years in the quality of research examining rates of mental disorders among justice-involved youth, there remain major gaps in the literature. Prevalence studies typically have focused only on a single level of care like detention, in a single site, and frequently have employed unstandardized instruments. Through funding from the Office of Juvenile Justice and Delinquency Prevention, the National Center for Mental Health and Juvenile Justice has undertaken a comprehensive study that addresses these gaps. This paper presents findings from this multi-site study, which was conducted in three states, across three levels of care (secure, detention, and community-based facilities), and using standardized instruments (MAYSI-2 and V-DISC) to identify both symptoms and psychiatric disorders. Data will be presented that also examine differences in types of disorders by race, gender, and age. Implications of the findings for policy and practice will be discussed.

No. 64B
AACAP PRACTICE PARAMETER FOR THE ASSESSMENT AND TREATMENT OF YOUTH IN JUVENILE DETENTION AND CORRECTIONAL FACILITIES

Joseph V. Penn, M.D., *Brown University, Psychiatry and Human Behavi, RI Training School, 300 New London Avenue, Cranston, RI 02920;* Christopher R. Thomas, M.D.

SUMMARY:

Over the past decade the number of youth held in juvenile correctional facilities in the United States has grown considerably. Up to 75% of these youth have a diagnosable mental disorder according to some estimates, but many do not have adequate mental health services. In addition, psychiatrists providing treatment for these youth face a myriad of challenges and pitfalls: potential role conflicts; confidentiality issues; working with families, social services, law enforcement, and courts; negative perceptions of "delinquents;" and the complex, multiple needs of these youth. In response to the lack of standards and guidance in addressing these problems, the American Academy of Child and Adolescent Psychiatry developed a practice parameter concerning mental health services for youth held in correctional facilities. The parameter set forth 14 specific recommendations on the organization and delivery of mental health care, including initial evaluation, ongoing monitoring of mental health problems, assessment of violent or suicidal youth, and use of psychotropic medications. Particular attention focused on the difficulties encountered in treatment planning and implementation for these youth. The research on which the recommendations are based, the process of creating the parameter, and the implications for policy and practice will be reviewed. The parameter will serve as a guide to individual practitioners as well as a model for policy makers and leaders.

No. 64C
ISSUES OF INFORMED CONSENT RELEVANT TO THE USE OF PSYCHOTROPIC MEDICATION IN JUVENILE DETENTION

Lawrence V. Tucker, M.D., *Department of Psychiatry, UCLA Neuropsychiatric Institute & Hospital, 760 Westwood Plaza, Room C8-222, Los Angeles, CA 90024;* William Arroyo, M.D.

SUMMARY:

The need for mental health treatment for youth in detention in juvenile facilities was a focus of a U.S. House of Representatives hearing held in July, 2004. One of the findings was that 347 juvenile detention facilities across the country "hold youths who do not need to be in detention as they wait for mental health services outside of the juvenile justice system," namely, in their communities. Despite this challenge, many detention facilities do provide mental health services, including psychotropic medication, to incarcerated youth. The legal authority to give informed consent for the use of psychotropic medication by children in the general community belongs to the legal guardian(s) of a child, usually the birth parents. However, the authority to give consent for youth who are incarcerated varies among states and within a state may vary among jurisdictions; juvenile court judges, parents, and others may have the authority. The implementation of applicable regulations also varies. A new challenge for psychiatrists who work in detention facilities who must acquire informed consent is grappling with the recently released scientific data relevant to SSRIs and suicidal behavior. Suicidal behavior among youth while in detention is more prevalent than in the general community.

No. 64D
MENTAL HEALTH COURT FOR CHILDREN IN LOS ANGELES

David T. Feinberg, M.D., *UCLA Neuropsychiatric Institute, 300 UCLA Medical Plaza #1234, Los Angeles, CA 90095*

SUMMARY:

The Juvenile Mental Health Court of the Los Angeles Superior Court was founded in 2001 to be a comprehensive, judicially monitored program of individualized mental health treatment and rehabili-

tation services for juveniles offenders who suffer from diagnosed mental disorders and/or developmental disabilities. The primary focus of this court is the assessment and treatment of eligible juveniles, and the monitoring of the juvenile's subsequent mental health treatment plan. This is the only full-time juvenile mental court in the country. This session is intended for any child/adolescent mental health practitioner with an interest in the interface between the juvenile justice system and clinical care. Specific case examples will be discussed so that participants will be able to better understand how this unique program works.

No. 64E
THE MACARTHUR JUVENILE COMPETENCE STUDY: RESULTS AND IMPLICATIONS FOR LAW AND PRACTICE

Thomas Grisso, Ph.D., *Department of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, MA 01655*

SUMMARY:

The issue of adolescents' capacities as trial defendants has become important in light of recent recognition of the right of juveniles to be competent in juvenile delinquency proceedings. Abilities associated with adjudicative competence were assessed among 927 adolescents in juvenile detention facilities and community settings. Adolescents' abilities were compared with those of 466 young adults in jails and in the community. Participants at four locations across the United States completed a standardized measure of abilities relevant for competence to stand trial (the MacArthur Competence Assessment Tool-Criminal Adjudication) as well as a new procedure for assessing psychosocial influences on legal decisions often required of defendants (MacArthur Judgment Evaluation). Youths aged 15 and younger performed more poorly than did young adults, with a greater proportion manifesting a level of impairment consistent with that of persons found incompetent to stand trial. Adolescents tended to make choices (e.g., about plea agreements) that reflected compliance with authority, as well as influences of psychosocial immaturity. Implications of these results for policy and practice are discussed.

REFERENCES:

1. Cocozza J, Skowyra K: Youth with mental disorders: issues and emerging responses. Office of Juvenile Justice and Delinquency Prevention Journal 2000; 7(1).
2. Penn JV, Thomas CR, AACAP Work Group on Quality Issues: Practice Parameter for the Assessment and Treatment of Youth in Juvenile Detention and Correctional Facilities, in press, 2004.
3. Deprato DK, Hammer JH: Assessment and treatment of juvenile offenders, in Principles and Practice of Child and Adolescent Forensic Psychiatry. Edited by Schetky DH, Benedek EP. Washington, DC: American Psychiatric Publishing Inc, 2002.
4. Arrendondo DE, Kumli K, Soto L, Colin E, Ornellas J, Davilla RJ, Edwards L, Hyman EM: Juvenile mental health court: rationale and protocols. Juvenile and Family Court Journal, 2001.
5. Grisso T, Steinberg L, Woolard J, Cauffman E, Scott E, Graham S, Lexcen F, Reppucci N, Schwartz R: Juveniles' competence to stand trial: a comparison of adolescents' and adults' capacities as trial defendants. Law and Human Behavior 2003; 27:333-363.

SYMPOSIUM 65—NEUROSCIENCE FOR THE PSYCHIATRIST, PART 2
Collaborative Session With the National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should learn about genetic and genomic strategies used in the study of psychiatric disorders, appreciate the importance of placing findings from these studies in the context of neural circuits, and integrating multiple levels of analysis in order to gain understanding of the pathophysiology of these disorders.

No. 65A
STRATEGIES FOR INVESTIGATING THE GENETICS OF PSYCHIATRIC DISORDERS

Margit Burmeister, Ph.D., *Department of Mental Health, University of Michigan, 205 Zima Pitcher Place, Ann Arbor, MI 48105*

SUMMARY:

Genes clearly play a role in major psychiatric disorders. However, these disorders are complex: any genetic variant alone is neither necessary nor sufficient for the disorder. To identify predisposing genes, two major approaches have been used: linkage analysis, which searches for the chromosomal locations of predisposing genes, and hypothesis-driven association studies that test genetic variants in specific candidate genes. Recently, whole genome candidate gene studies have become a possibility. These, however, rely on the assumption that common psychiatric disorders are caused by common genetic variants. If they are caused by a large number of individually rare genetic variants, these approaches will fail.

Another open question is how to best define a psychiatric disorder for genetic studies: If depression was the extreme end of a spectrum, quantitative measures of mood and anxiety would be a better approach than diagnostic categories. On the other hand, genetic heterogeneity may be reduced by focus on unique subtypes, e.g. bipolar disorder with psychosis. Last, many psychiatric disorders have significant known and unknown environmental risk factors. Only very recently have studies started to incorporate the effects of both genetic and environmental risk factors into the analysis. One example is how genetic variation in the serotonin transporter interacts with stressful life events in increasing risk for depression.

No. 65B
TRANSCRIPTOME PROFILING OF BRAIN TISSUE: IMPLICATIONS FOR SCHIZOPHRENIA RESEARCH

Karoly Mirnics, M.D., *Department of Psychiatry, University of Pittsburgh, W1655 Biomed Sci Tower, Pittsburgh, PA 15261*

SUMMARY:

Functional genomic studies of the human brain create unique challenges: the source of the RNA is postmortem material and the magnitude of the expression changes is modest. Furthermore, the genetic diversity and the transcriptome-shaping events during life create a unique brain gene expression profile for each human being. Large-scale analysis of gene expression in postmortem brain using microarray technology has the potential to elucidate molecular changes that occur in disease states. A number of exciting microarray studies are being performed on postmortem tissue originating from subjects with Alzheimer's disease, multiple sclerosis, Rett syndrome, autism, major depression, and especially schizophrenia. Recent transcriptome analyses of the prefrontal cortex identified a number of common expression changes that may be a hallmark of schizophrenia. These findings argue that at the transcriptome level schizophrenia is characterized by multiple and diverse phenotypes, which may be related to altered synaptic release, deficiencies in glutamate/GABA transmission, changed metabolism, and impaired myelination. In the near future, systematically obtained transcriptome data will serve as a rich foundation for the search for susceptibility genes and development of animal models that mimic the molecular aspects of the psychiatric diseases.

No. 65C
GENE EXPRESSION ABNORMALITIES IN SCHIZOPHRENIA: WHAT DO THEY MEAN?

David A. Lewis, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, W1650 BST, Pittsburgh, PA 15213-2593*

SUMMARY:

Gene expression studies of the prefrontal cortex from subjects with schizophrenia, such as those described in Dr. Mirnics presentation, have consistently demonstrated alterations in the expression of genes that encode for proteins involved in inhibitory GABAergic neurotransmission. However, given the multiple types and different functional roles of cortical GABA neurons, understanding the pathophysiological significance and therapeutic implications of these gene expression alterations requires knowledge of which GABA neuron subtypes, and the circuits that they form, are affected in schizophrenia. Thus, this presentation will illustrate the importance of placing gene expression findings in the context of neural circuits by reviewing convergent data indicating that a specific subpopulation of prefrontal cortical GABA neurons exhibit altered gene expression in schizophrenia, that the resulting disturbances in the associated circuits may contribute to certain cognitive abnormalities in schizophrenia, and that the selective localization of several neurotransmitter subtypes in these circuits reveal novel targets for the pharmacotherapy of schizophrenia.

No. 65D
FROM PHENOTYPE TO GENOTYPE AND BACK: HOW TO PUT IT ALL TOGETHER

Mayada Akil, M.D., *National Institute of Mental Health, 6001 Executive Boulevard, Room 8211, Bethesda, MD 20852-9667*

SUMMARY:

Although there is strong evidence for a genetic basis for many psychiatric disorders, it is likely that they arise from complex gene-gene and gene-environment interactions. The recent completion of the Human Genome Project, the increased sophistication of genetic studies of complex disorders, and the technical advances in genomic methods, such as gene arrays, have resulted in an explosion of genetic findings in psychiatric disorders. These findings are thought to hold great promise for identifying molecules and circuits involved in these disorders and providing targets for the development of novel therapeutics. But what do these findings really mean? How do genes confer susceptibility for psychiatric disorders? How can we understand their role at different levels of analysis from molecules to cells to circuits to systems? Finally, and perhaps most importantly, how do these genes relate to observable phenomena in our patients (phenotypes)? This presentation will illustrate the use of genetics in understanding the pathophysiology of psychiatric disorders at multiple levels of analysis and will describe the limitations and strengths of these approaches.

REFERENCES:

1. Burmeister M: Basic concepts in the study of diseases with complex genetics Biol Psychiatry 1999; 45(5):522-32.
2. Mirnics K, Pevsner J: Progress in the use of microarray technology to study the neurobiology of disease. Nat Neurosci 2004; 7(5):439-9.
3. Lewis DA, Volk DW, Hashimoto T: Selective alterations in prefrontal cortical GABA neurotransmission in schizophrenia: A novel target for the treatment of working memory dysfunction. Psychopharmacology 2004; 174:143-150.
4. Akil M, Kolachana BS, Rothmond DA, Hyde TM, Weinberger DR, Klienman JE: Catechol o-methyltransperase genotype and dopamine regulation in the human brain. J Neurosci 2003; 23(6):2008-2013.

SYMPOSIUM 66—THE MAKING OF A COMPETENT PSYCHOTHERAPIST: ADDRESSING THE NEW RRC GUIDELINES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to enumerate the essential elements of a good psychotherapist, the tools available for assessing competence and models of training and evaluation.

No. 66A
THE MAKING OF A COMPETENT PSYCHOTHERAPIST: DEVELOPING THE PROGRAM

Priyanthy Weerasekera, M.D., *Department of Psychiatry ,McMaster University, 301 James Street South F439, Hamilton, ON L8P 3B6, Canada*

SUMMARY:

The Accreditation Council has mandated that psychiatric training programs must demonstrate resident competency in five different forms of psychotherapy: brief, supportive, psychodynamic, cognitive-behavioral, and combined psychotherapy and psychopharmacology. This mandate has challenged training directors to develop new psychotherapy curricula so that competency in a variety of therapies is ensured. Several issues will have to be considered as programs are developed, including conceptual issues such as the definition of therapies and practical issues such as how to determine competence. Educators who have developed, implemented, and maintained empirically oriented, competency-based psychotherapy programs may offer some guidance in how to develop such programs that could graduate "competent therapists."

This paper will present the McMaster University Psychotherapy Program, a portable competency-based training program that has been in operation for almost ten years. This program offers residents training in several forms of psychotherapy including supportive, cognitive-behavioral (CBT), psychodynamic, interpersonal (IPT), family, couple, and group therapies. Training follows the use of manuals, audio and videotapes, and a structured evaluation process using therapist competency rating scales. The focus of this program is to graduate residents with *beginning skills* in a variety of therapies, rather than aiming for proficiency in any one.

No. 66B
COMBINING A COMMON FACTORS APPROACH WITH SPECIFIC PSYCHOTHERAPIES

John Manring, M.D., *SUNY Upstate Medical University, Department of Psychiatry, 750 East Adams Street, Syracuse, NY 13210*

SUMMARY:

A trainee reads books, observes experts, practices psychotherapy with a few patients, and is carefully supervised. Is the trainee now demonstrably competent in psychotherapy? Although mandated by the Residency Review Committee, there is no generally accepted model for training a competent psychotherapist and no accepted method to define or certify competence. Which aspects of specific therapies are essential for them to be effective? Is it sufficient to

master common factors or is mastery of the specific therapies necessary? The Syracuse model is presented, which incorporates both common factors and some of the specific psychotherapies, and describes how to teach and test them. Currently available tool kits to evaluate competence are presented and their pertinence to psychotherapy assessed.

No. 66C
FUTURE DIRECTIONS: SIMULATION-BASED TRAINING AND EVALUATION

Usha G. Satish, Ph.D., *Department of Psychiatry, SUNY Upstate Medical University, 750 East Adams Street, Syracuse, NY 13210*

SUMMARY:

With today's rapid advances in knowledge and faster development of new technologies, physicians are expected to be competent in a large variety of skills and techniques. In addition, there are simultaneous challenges to reduce costs and errors in medicine. The demands for competency require not only technical competence but also excellence in "process" variables of decision making such as flexibility, response style, communication; integration of knowledge, and breadth of approach. The SMS (Strategic Management Simulations) technology has been used extensively to test and train decision-making skills in persons occupying professional and leadership positions worldwide. The SMS can be used to predict, assess, and train psychiatric residents' competency in decision making. Data obtained on several cohorts of psychiatric residents across different PGY levels explores and identifies an array of underlying skills required for competencies in general and psychodynamic psychotherapies, psychopharmacology, and brief and crisis interventions. Examples of skills assessed include the ability to link present and past, identify and respond appropriately and flexibly to patient (psychodynamic psychotherapy); ability to rapidly establish therapeutic alliance, identification of precipitating events, establishment of goals, obtain collateral information (brief and crisis intervention), integration of variables (biological and psychological) (psychopharmacology and psychotherapy). Simulations can contribute to effective training in these areas without putting patients at risk.

REFERENCES:

1. Weerasekera P, Antony MA, Bieling P, et al: Competency assessment in the McMaster psychotherapy program. Academic Psychiatry 2003; 27:166-173.
2. Manring J, Beitman BD, Dewan MJ: Evaluating competence in psychotherapy. Academic Psychiatry 2003; 27:136-144.
3. Satish U, Streufert S: The value of a cognitive simulation in medicine: toward optimizing performance of healthcare personnel. Quality and Safety in Healthcare 2002; 11:163-167.
4. Streufert S, Satish U: Strategies management simulations: from psychology research to medical practice. Observer 2003; 16(9):54.

SYMPOSIUM 67—VIOLENCE FROM CRADLE TO GRAVE: BATTERING, STALKING, CHILD ABUSE, AND ELDER ABUSE
APA Committee on Family Violence and Abuse

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize risk factors for abuse across the age spectrum; assess abuse as it presents with and without psychiatric comorbidity in children, adults, and elders; and understand management of abuse and the need for specialist referral.

No. 67A
DOMESTIC VIOLENCE, TRAUMA, AND MENTAL HEALTH: CRITICAL ISSUES FOR CLINICAL PRACTICE

Carole L. Warshaw, M.D., *John M. Stroger Hospital, 3428 North Janssen, Chicago, IL 60657*

SUMMARY:

There is a growing body of research indicating that domestic violence can have serious mental health consequences for both adult victims and for children who witness the abuse. Survivors experience higher rates of depression, PTSD, substance abuse, and suicide attempts, and report significantly poorer mental health status than those who have not been abused. Significant numbers of individuals seen in a range of mental health settings either currently are or have been abused by an intimate partner. Many have also experienced multiple forms of abuse throughout their lives, placing them at greater risk for developing trauma-related symptoms and affecting their ability to achieve safety and stability. Stigma associated with mental illness increases vulnerability to domestic violence and exposure to other forms of victimization and/or discrimination make interventions for domestic violence more complex. This presentation will provide overview of current research on domestic violence and a framework for addressing these concerns. It will also describe practical recommendations for responding to domestic violence in psychiatric settings and to the more complex issues that arise in attending to mental health and advocacy needs. Specifically, it will address issues of assessment, intervention, treatment, and community collaboration in a variety of clinical and cultural contexts.

No. 67B
STALKING: CAUSES, CONSEQUENCES, AND THERAPEUTIC CONSIDERATIONS

Gail E. Robinson, M.D., *Department of Psychiatry, Toronto General Hospital, 200 Elizabeth Street, 8EN-231, Toronto, ON M5G 2C4, Canada;* Karen M. Abrams, M.D.

SUMMARY:

Stalking is a serious offense perpetrated by disturbed offenders. It can cause major mental health consequences that are often poorly understood by society. The majority of victims are female. Up to one in 20 women will be stalked during her lifetime. The offenders are usually men who have been in a failed relationship with the victim. Victims may experience anxiety, depression, guilt, helplessness, and symptoms of posttraumatic stress disorder. Victims also suffer from a lack of understanding by family, friends, society, police, and the legal system, all of whom may minimize the behavior of not enforce laws. Victims may also blame themselves for the stalker's behavior. Therapists must be aware of many counter-transference issues including fear of taking on the case, an increased sense of vulnerability, defensiveness, and over-protectiveness. This symposium will present overviews of the causes and consequences of stalking, stalking laws, and the problems victims may have with the legal system. Treatment issues for both victims and perpetrators will be discussed.

No. 67C
THE ROLE OF THE MOTHER-DAUGHTER DYAD IN RESPONSE TO CHILD ABUSE

Osvaldo Gaytan, Jr., M.D., *Department of Psychiatry, Emory University, 614 Lincoln Court Ave, Atlanta, GA 30329*

SUMMARY:

One out of eight women may experience sexual abuse in their lifetimes with nearly 60% occurring before age 18. Although there is good evidence that exposure to physical or sexual abuse early in life can lead to increased risk for development and persistence of psychiatric disorders such as major depression and posttraumatic stress disorder (PTSD), it is not clear which subset of abused individuals will go on to develop these disorders. Studies of sexually abused children and adolescents found that less than half of these children displayed psychiatric symptoms at the initial time of assessment. However, these children may remain predisposed to develop a wide array of mental and physical symptoms, as well as long-term alterations in stress hormones later in life. A few studies have suggested that certain factors, especially greater levels of parental support, can serve as protective factors in the development of psychiatric symptoms following sexual abuse. We will concentrate on exploring the mother-daughter dyad and how psychopathology in the mother, level of attachment in the dyad, and exposure to chronic abuse/trauma plays a strong role in predicting outcome in these children. Importance of involving mothers and family members in therapy and treatment plans will be discussed.

No. 67D
ELDER ABUSE AND NEGLECT

F. M. Baker, M.D., *Lower Shore Clinic, 505 East Main Street, Salisbury, MD 21804-5020*

SUMMARY:

In the United States, the reported prevalence of abuse of persons age 63 and older is reported as 32 per 1,000 persons age 65. Elder abuse may be physical, emotional, psychological, financial, or sexual. Elderly neglect may be self-neglect by the elderly person or neglect by the primary caregiver who fails to provide adequate care, food, or shelter. Abandonment refers to the desertion or willful forsaking of an older person by the elder's caregiver. Whether at a physician's visit, an inpatient hospitalization, or in a skilled care setting, it is important for the mental health professional to be vigilant about assessing an elder and the elder's caregiver for characteristics that may suggest an at-risk situation. Persons age 80 and older are at increased risk for abuse or neglect. Caregiver characteristics have been identified as the stronger predictor of abuse, particularly alcohol abuse. The identification of elder abuse is made difficult because the elderly victim may be concerned about further abuse, fearful of losing the caregiver upon whom the elder depends, and may be concerned about pressing charges against a family member. This presentation will summarize the existing literature concerning at-risk situations, characteristics of elder and caregiver that increase the risk for elder abuse, and will present a specific model for the assessment and management of elder abuse and neglect.

REFERENCES:

1. Warshaw C, Gugenheim AM, Moroney G, Barnes H: Fragmented services, unmet needs: building collaboration between the mental health and domestic violence communities. Health Affairs September/October 2003:230-234.
2. Abrams KM, Robinson GE: Stalking Part 1: An Overview of the Problem. 1998; 43:473-476.
3. Burton D, Foy D, Bwanausi C, Johnson J, Moore L: The relationship between traumatic exposure, family dysfunction, and posttraumatic stress symptoms in male juvenile offenders. Journal of Traumatic Stress 1994; 7:83-93.
4. Rudolph MN, Hughes DH: Emergency assessments of domestic violence, sexual dangerousness, and elder and child abuse. Psychiatric Services 2001; 52(3): 281,282,306.

SYMPOSIUM 68—SEQUENCED TREATMENT ALGORITHMS FOR RESISTANT OCD: AN INTERNATIONAL APPROACH
Collaborative Session With the National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to treat resistant OCD patients with efficient and well-tolerated treatment strategies.

No. 68A
ODDS OF RESPONSE IN OCD TO SWITCHING SRIS, INCREASING SRI DOSE OR TREATMENT TIME

Lorrin M. Koran, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, OCD Clinic #2363, Stanford, CA 94305*

SUMMARY:

Expert consensus guidelines estimate that patients unresponsive to one SRI have about a 40% chance of responding to a second SRI and abut a 10% chance to a third (The Expert Consensus Panel for Obsessive-Compulsive Disorder, 1997). This presentation reviews available data on response rates after switching SRIs and compares this with data regarding SRI dose escalation or longer treatment at constant dose. The presentation also explores potential reasons for an individual's different responses to different SRIs.

Among the data reviewed are studies reporting a 20% response after switching among SRIs, a 20% response after switching from clomipramine to fluoxetine, a 33% response to a switch after sertraline, a 33% to 40% response after switching to clomipramine, and a 56% response after switching from venlafaxine to paroxetine. Response rates to high dose versus low (effective) doses of fluoxetine, sertraline, and citalopram are discussed. The results of continuing double-blind on sertraline versus doubling the dose for a second 12 weeks are presented.

Discussion of potential reasons for differences in an individual's response to different SRIs will include: non-adherence, differences in the effectiveness of particular drugs, drug plasma concentrations, pharmacogenetic factors, symptom subtypes, and comorbid conditions.

No. 68B
SWITCHING FROM SSRIS TO SNRIS IN RESISTANT OCD

Eric Hollander, M.D., *Department of Psychiatry, Mount Sinai School of Medicine, One Gustave L. Levy Place, Box 1230, New York, NY 10029;* Stacey Wasserman, M.D., Andrea Allen, Ph.D., Alicia J. Kaplan, M.D., Sallie J. Hadley, M.D., Bryann Baker, M.D., Suah Kim, B.A.

SUMMARY:

Forty percent to 60% of OCD patients remain treatment resistant after a 12-week trial of SSRIs in OCD. One treatment option for nonresponders is switch from the SSRI to a SNRI (serotonin-norepinephrine reuptake inhibitor). This presentation will review the weight of the evidence for and against switching to the SNRIs clomipramine and venlafaxine from metaanalytic studies and open and controlled trials in SSRI nonresponders. Practical suggestions for switch-over, including dosing, cross-titration, and side-effect issues are discussed. This will be discussed in light of the evidence for other algorithms

in resistant OCD, and for specific OCD subtypes and comorbid conditions.

No. 68C
REVIEWING THE ROLE OF ANTIPSYCHOTIC AGENTS IN OCD

Naomi Fineberg, M.A., *Department of Psychiatry, QEII Hospital, Howlands, Welnyn Garden City AL7 4HQ, United Kingdom;* Tim M. Gale, Ph.D., Thanusha Sivakumaran, B.S.C.

SUMMARY:

Objective: Although most OCD patients experience substantial improvements with serotonin reuptake inhibitors (SRIs), for many the treatment response is incomplete. Recently, there has been considerable interest in combining antipsychotics with SRIs. This paper presents a review of the evidence for antipsychotics in the treatment of OCD.

Method: This was a systematic review of 24 papers reporting on antipsychotic monotherapy and SRI augmentation in OCD.

Results: No positive studies of antipsychotic monotherapy meet today's standards, and OCD is not recognized to respond to these drugs individually. Investigation of traditional antipsychotic agents such as haloperidol, given in low doses in combination with an SRI, showed efficacy with some evidence that patients with comorbid tics and schizotypal disorders responded better. Second-generation antipsychotics, modulating serotonin and dopamine neurotransmission, have been the subject of randomized, controlled investigation and appear to be better tolerated.

Conclusion: The mechanism by which atypical antipsychotics exert antiobessional activity remains speculative. Differential blockade and activation of 5-HT 2A and non 5-HT 2A receptors or frontal dopamine activation have been proposed. Further investigation of selective serotonin or dopamine antagonists, such as mirtazepine or amisulpride, will be valuable.

No. 68D
LONG-TERM EFFICACY OF INTRAVENOUS AND ORAL-LABEL CITALOPRAM IN RESISTANT OCD

Stefano Pallanti, M.D., *Inst. Neuroscienze, Viale Ugo Bassi 1, Firenze, Italy;* Leonardo Quercioli, M.D.

SUMMARY:

Objective: Intravenous citalopram (CIT) has been demonstrated safe and rapidly effective in treatment-resistant OCD patients. The primary aim of this study is to investigate long-term outcome of resistant OCD treated with CIT. The secondary aim was to determinate if subjects who underwent intravenous (i.v.) administration of CIT in the first three week of treatment had a better long-term outcome.

Method: In an open-label protocol, 70 resistant patients with primary diagnosis of OCD were considered, who were assigned to 21-days i.v. CIT protocol followed by drug oral continuation (n=35), or to oral CIT protocol (n=35). All the subjects were assessed with SCID, Y-BOCS, CCI-I (primary improvement measures), up to 24 months after CIT treatment started.

Results: At the end of the trial (24th month) 32/70 (45.7%) were still under CIT treatment, and 29/70 (41.4%) reported significant amelioration of the symptomatology. More compliancers at the end of the trial were found among patients who had initial i.v. CIT (18/35) compared with subjects who started on oral treatment (14/35). Patients who had initial i.v. CIT showed better outcome after 24 months, expressed as primary measures (YBOCS p<.01; CGI-I p<.01) and as percentage of responders (17/35, 48.6% vs. 12/35, 34.3%)

Conclusions: Citalopram appeared to be effective in long-term relapse prevention in about 40% of OCD resistant subjects who began CIT as antiobsessive treatment 24 months before. Furthermore, the initial i.v. administration of CIT appeared also more effective in reducing the risk of relapse.

REFERENCES:

1. Denys D, Hiubert B, van Megen H, et al: A score for predicting response to pharmacotherapy in obsessive-compulsive disorder. Int Clin Psychopharmacol 2003; 18: 315-322.
2. Hollander E, Friedberg J, Wasserman S, Allen A, Birnbaum M, Koran LM: Venlafaxine in treatment-resistant obsessive-compulsive disorder. J Clin Psychiatry 2003; 64: 546-550. Erratum in: J Clin Psychiatry 2003; 64: 972.
3. McDougle CJ, Epperson CN, Pelton GH, Wayslink S, Price LH: A double-blind, placebo-controlled study of risperidone addition in serotonin reuptake inhibitor-refractory obsessive compulsive disorder. Archives of General Psychiatry 2000; 57:794-801.
4. Pallanti S, Quercioll L, Koran LM: Citalopram intravenous infusion in resistant obsessive-compulsive disorder: an open trial. J Clin Psychiatry 2002; 63(9):796-801.

SYMPOSIUM 69—ADVANCES AND ISSUES IN PSYCHODYNAMIC PSYCHOTHERAPY

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to appreciate the recent developments in and challenges to treating patients with psychodynamic psychotherapy.

No. 69A
EVIDENCE-BASED PSYCHODYNAMIC PSYCHOTHERAPY

Jerald Kay, M.D., *Department of Psychiatry, Wright State University, P.O: Box 927, Rosary Hall, Dayton, OH 45401*

SUMMARY:

Psychodynamic theory provides the modern clinician with a comprehensive system for understanding personality development, the meaningfulness of human conflict and emotional pain, and mutative factors with the doctor-patient relationship. The practice of psychodynamic psychotherapy, however, is currently under scutiny. There is a widely held belief that psychodynamic treatments lack evidence-based support. The purpose of this presentation is to provide an overview of the effectiveness of psychodynamic psychotherapy in the treatment of both axis I and axis II disorders including mood, anxiety, and personality disorders. Potential mechanisms for the usefulness of psychodynamic psychotherapy in light of advances in the understanding of the neuro-biology of psychotherapy and attachment will also be discussed.

No. 69B
DYNAMIC PSYCHOTHERAPY OF PERSONALITY DISORDERS

Glen O. Gabbard, M.D., *Department of Psychiatry, Baylor College of Medicine, 6655 Travis, Suite 500, Houston, TX 77030*

SUMMARY:

Major advances have occurred in psychodynamic thinking regarding the treatment of personality disorders in recent years. From a psychodynamic perspective, personality can be considered as com-

prising five fundamental components: (1) a biological temperament, (2) a characteristic set of defense mechanisms, (3) a specific constellation of internal object relationships, (4) a sense of self, and (5) a cognitive style. Proposed mechanisms of action of dynamic psychotherapy for personality disorders will be discussed. Recent empirical research has included randomized, controlled trials demonstrating the efficacy of this treatment modality for Axis II conditions. A promising feature of this research is an extended release component, suggesting that the therapeutic dialogue is internalized and continued following termination of the treatment.

No. 69C
PSYCHODYNAMIC PSYCHOTHERAPY IN THE TREATMENT OF PANIC DISORDER

Barbara L. Milrod, M.D., *Department of Psychiatry, NY Presbyterian Hospital, 525 East 68th Street, Box 240, New York, NY 10022*

SUMMARY:

Psychodynamic psychotherapy is the most widely practiced form of psychotherapy in this country, yet empirical studies demonstrating whether or not it has utility for the treatment of specific psychiatric disorders are sparse. Patients with panic disorder constitute on population who may benefit from psychodynamic treatment. Panic disorder is a serious public health problem and can be chronic and debilitating with high rates of medical and psychiatric utilization of services. Several forms of therapy, including medication monotherapy and cognitive-behavioral therapies, have shown efficacy in short-term treatment studies of panic disorder, but long-term outcome data from these interventions are inconclusive. Approximately half of patients, at best, treated for panic disorder achieve full recovery. These factors necessitate study of other treatment interventions such as psychodynamic psychotherapy. In addition, many patients do not tolerate or refuse medication and some have difficulty in complying with behavioral treatment. This presentation will report on preliminary results of a manualized psychodynamic psychotherapy for treatment that shows considerable promise as a nonpharmacological treatment for patients with highly symptomatic panic disorder with a broad range of comorbidities.

No. 69D
THE ROLE OF PSYCHOTHERAPEUTIC TECHNIQUES IN PHARMACOTHERAPY

Allan Tasman, M.D., *Department of Psychiatry, University of Louisville, 500 S Preston St/Building A Room 210, Louisville, KY 40292-0001*

SUMMARY:

Emerging evidence suggests that adherence to medication prescriptions is strongly influenced by the context of the doctor-patient relationship that exists during pharmacologic treatment. This appears to be true for all psychiatric disorders, especially schizophrenia, where the symptoms of the illness present special difficulties in maintaining the therapeutic alliance. A positive relationship appears to have a beneficial effect on response to medication through a number of factors, including improved compliance and the opportunity to discuss side effects and target symptoms. For example, even when the primary therapeutic intervention is psychopharmacologic, the psychiatrist must be aware of a number of factors within the process of treatment, including transference and countertransference reactions. Specific attributions regarding the psychiatrist's motivation in prescribing medication, as well as meanings attributed to the medication itself, are important variables. Further, there is increasing evidence that integrated pharmacotherapy, and psychosocial and psychotherapeutic treatments produce the optimum outcomes, especially in severe illnesses such as schizophrenia. In recent years, collaborative treatment, in which psychotherapy and medications are prescribed by two different clinicians, has emerged as a major approach to treatment. Economic factors and managed care delivery systems have been a significant influence in this regard. When two clinicians are simultaneously involved, process and relationship issues are much more complex. Attention to a variety of components of these triangular therapeutic relationships will maximize treatment effectiveness.

No. 69E
UNIQUE CONTRIBUTIONS OF PSYCHODYNAMIC PSYCHOTHERAPY TO RESIDENCY TRAINING

David A. Goldberg, M.D., *Department of Psychiatry, California Pacific Medical Center, 329 Summit Drive, Corte Madera, CA 94925*

SUMMARY:

Psychodynamic psychotherapy is a core competency for all U.S. psychiatric residents. This presentation will articulate the specific knowledge, skills, and attitudes learned from training in psychodynamic psychotherapy and the ways in which they uniquely contribute to both the practice of psychotherapy and to the general clinical practice of psychiatry.

The applications to psychotherapy will include specifics of boundaries, the frame, active listening, a dynamic focus, managing transference and resistance, self reflection, and the supportive-expressive continuum. Broader specific applications of the model to general practice will include a conceptual framework for understanding the person, the role of inner conflict in symptom expression and compliance, treating patients with character disorders and psychosis, and medication management.

REFERENCES:

1. Kay J, Kay R: Individual psychoanalytic psychotherapy, in Psychiatry 2nd ed, Therapeutics. Edited by Tasman A, Kay J, Lieberman JA. London, John R Wiley and Sons, 2003, pp 1-18.
2. Gabbard GO: Psychodynamic Psychiatry in Clinical Practice, Fourth Edition. Arlington, VA, American Psychiatric Publishing, 2005.
3. Milrod B, Fusch F, Leon A, et al: A pilot, open trial for brief psychodynamic psychotherapy for panic disorder. J Psychotherapy Practice and Research 2001; 10; 239-245.
4. Tasman A, Riba M, Silk K: The Doctor-Patient Relationship in Pharmacotherapy: Improving Treatment Effectiveness. Guilford Press, New York, 2000.
5. Goldberg D: Structuring training goals for psychodynamic psychotherapy. J Psychother Prac Research 1998; 7:10-22.

SYMPOSIUM 70—THE USE OF NEUROSCIENCE TO UNDERSTAND MEDICATION TREATMENT

EDUCATIONAL OBJECTIVES:

The participant in this symposium will better understand current efforts to translate neuroscience into bedside approaches utilizing brain imaging, neuropsychology, and genomics.

No. 70A
IMAGING ANTIPSYCHOTICS: FROM BENCH TO BEDSIDE

Shitij Kapur, M.D., *Department of Research, University of Toronto, 33 Russell Street, Toronto, ON M55 251, Canada*

SUMMARY:

For nearly a century antipsychotics have been used in animals as well as humans. Over this time much has been learned about their mechanism of action — and with the advent of neuroimaging it has become possible to relate their actions in animal models to their actions in humans. This talk will review the contributions of imaging in uniting the findings in animal models and clinical studies and the value of "receptor occupancy" studies in understanding antipsychotics. The talk will first explain the concept of receptor occupancy and show how for most antipsychotics — haloperidol, olanzapine, risperidone, and ziprasidone — response is achieved when 60%-70% D_2 receptors are blocked and much higher blockade (>80%) leads to motor side effects. Exceptions to these rules will be addressed. The talk will then illustrate how the concept of occupancy unites seemingly unrelated findings at the "bench" to their "bedside" counterparts. Finally, it will be shown how this bench-to-bedside knowledge can be used to inform clinical practice (eg, why some atypicals give rise to prolactin elevation; why some cause high levels of dopamine blockade yet produce no motor side-effects).

No. 70B
MRI IN ASSESSING DRUG RESPONSE

Kelvin Lim, M.D., *University of Minnesota, 2450 Riverside Avenue, Minneapolis, MN 55454*

SUMMARY:

Magnetic resonance (MR) is a very flexible imaging modality. While most people are familiar with the exquisite anatomical detail that MR can provide, MR can also provide information about brain microstructure organization, metabolism, perfusion, and neurotransmitter turnover. As early CT studies explored the possibility of predicting antipsychotic medication response, some investigators have utilized structural MRI to investigate correlates of medicine response. Assessment of such studies reveals possible usefulness at the early stages of schizophrenia. Perhaps more interesting have been developments of MRI spectroscopy that allow for in vivo measurement of the neurotransmitter glutamate. With this technology has come the ability to assess the impact on this important brain chemical. Techniques in our lab have also been developed to measure glutamate dynamics in the living brain. As glutamate may play an important role in psychiatric disease, these developments may refine our understanding of medication action. This presentation will review how MRI has been used to study treatment response and how emerging methods might be applied in the future.

No. 70C
POPULATION PHARMACOKINETIC APPROACHES IN NEUROPHARMACOLOGY RESEARCH

Angela Birnbaum, M.D., *Department of Pharmacy, University of Minnesota, 516 Delaware Street, S.E., Minneapolis, MN 55455*

SUMMARY:

This presentation will introduce a general description of population pharmacokinetics, using nonlinear, mixed-effects modeling (NONMEM). This modeling tool can be used as a tool to aid in the forecasting of drug response. Different types of data and modeling will be presented, including the types of variables that can be incorporated into a model.

Examples from research involving valproic acid will be presented to illustrate how this approach can be used in the clinical setting. The value of in vitro microsomal analyses in predicting drug-drug interaction can be coupled with NONMEM to help in the selection of variables that are significant determinant of drug disposition. Other examples will include analyses of generic data from individuals. In particular, several P450 isoenzymes will be discussed, including several single nucleotide polymorphisms (SNPs) of 2C9, 2C19, 3A5 that are considered to be polymorphic, in particular in racial/ethnic groups. These polymorphisms are important in determining drug pharmacokinetics. Finally, pharmacokinetic and pharmacodynamic modeling of CNS pharmacologic responses in animal models will be introduced.

No. 70D
COGNITIVE NEUROSCIENCE AND NEW SCHIZOPHRENIA TREATMENTS

Robert W. Buchanan, M.D., *Department of Psychiatry, Maryland Psychiatric Research, PO Box 21247, Baltimore, MD 21228-5567*

SUMMARY:

Deficits on cognitive and electrophysiological measures are considered core features of schizophrenia for several reasons: they start before onset of clinical symptoms, are stable across changes of clinical state, correlate poorly with clinical symptoms, and are detectable in unaffected first-degree relatives. These cognitive deficits reflect risk to illness, and so appear to be valuable phenotypes in genetic studies of schizophrenia. Because they are considered to be closer to the genome than clinical symptoms of schizophrenia, they are referred to as endophenotypes. Identification of the genes that underlie certain cognitive and psychophysiological risk indicators will eventually provide rational neurochemical targets for drug intervention.

The cognitive deficits of schizophrenia are determinants and correlates of functional outcome, so they are logical treatment targets. However, there is currently no drug approved for the treatment of cognitive deficits in schizophrenia. A recent NIMH initiative (MATRICS) is designed to focus the resources of industry on this neglected clinical target. This initiative reflects a shift from solely targeting clinical symptoms to also improving cognitive deficits in schizophrenia. Among the innovative pharmacological treatments being tested for cognition are novel drugs that act on cholinergic, glutamatergic, serotonergic, and dopaminergic systems.

No. 70E
PET IMAGING OF TREATMENT-RESISTANT DEPRESSION

Sohail A. Sheikh, M.D., *Department of Psychiatry, VA Medical Center, 4301 Valley View Road, Suite 7, Edina, MN 55424;* Jose Pardo, M.D., Joseph Lee, M.S., Matthew Hagen, Farouk S. Abuzzahab, Sr., M.D., David E. Adson, M.D., Barry Rittberg, M.D.

SUMMARY:

Many depressed patients fail to improve with standard antidepressant treatment. Various brain imaging studies on depression have shown divergence in results, possibly due to the heterogeneous causes. Limited literature in this area identifies pregenual anterior cingulate as the marker for antidepressant (fluoxetine) response (Mayberg et al). A recent study by Kimbrell et al; 2002 identifies reduced metabolism in prefrontal cortex, amygdala, insula, and temporoparietal cortex and increased metabolism in cerebellum, and brain stem in patients with treatment resistant depression (trD). We compared the metabolic differences between medicated and unmedicated trD patients. We consider trD patients the most homogenous group as they respond minimally to the daily changes in the environment.

Fifteen normals, ten unmedicated, and eight medicated trD patients were recruited. Both trD groups were compared against age-matched normals. SCID, MMSE, AIMS, and physical exam were performed on all patients and normals. Patients also received $HAMD_{25}$, and

HAMA. Current substance abuse or dependence was excluded. FDG PET scans were obtained under eyes closed resting state.

Unmedicated trD patients showed increased metabolism in thalamus, cerebellum, precuneus, and inferior frontal gyrus; and decreased metabolism in superior, middle, and inferior temporal gyrii, fusiform gyrus, cuneus, and lingual gyrus. Medicated trD patients showed increased metabolism in precuneus and cerebellum; and decreased metabolism in inferior frontal gyrus, middle frontal gyrus, inferior temporal, anterior cingulate, subgenual cingulate, and lingual gyrus. Both trD patients showed increased metabolism in cerebellum and precuneus and reduced metabolism in inferior temporal, and lingual gyrus.

REFERENCES:

1. Kapur S, Sridhar N, et al: The newer antipsychotics: underlying mechanisms and the new clinical realities. Curr Opin Psychiatry 2004; 17:115-121.
2. Terpstra M, Lim KO, Vaughn JT, et al: Reduced anterior cingulate glutathione in schizophrenia. Biol Psychiatry 2004; 55(suppl 8):168S-169S.
3. Birnbaum AK, Hardie NA, Leppik IE, et al: Variability of multiple total phenytoin serum concentrations in elderly nursing home residents. Neurology 2003; 60:555-559.
4. Hyman SE, Fenton WS: What are the right targets for psychopharmacology? Science 2003; 299:350-351.
5. Mayberg HS: Limbic-cortical dysregulation: a proposed model of depression. J Neuropsychiatry Clin Neurosci 1997; 9:471-481.

SYMPOSIUM 71—PEDIATRIC BIPOLAR DISORDER: PHENOMENOLOGY AND NEW TREATMENT OPTIONS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, each participant will have better understanding of the state of the art in etiologic research, differential diagnosis, comorbidity, and treatment of bipolar disorder in children.

No. 71A
MOLECULAR GENETICS OF PEDIATRIC BIPOLAR DISORDER

Stephen V. Faraone, Ph.D., *Center for Neuropsychiatric Genetics, SUNY Upstate Medical University, 750 East Adams Street, Syracuse, NY 13210*

SUMMARY:

Family, twin, and adoption studies consistently show bipolar disorder to be a highly heritable condition. We review the genetic literature about early-onset bipolar disorder from two perspectives. This review shows substantial evidence that early-onset bipolar disorder is more highly heritable than later-onset bipolar disorder and that onset in childhood confers a greater risk to relatives than onset in adolescence. We present a genome-wide scan of the age at onset of bipolar disorder from a sample of 538 people in 97 families with bipolar disorder. The age at onset of bipolar disorder had significant heritability (40%, p=.004). We found LOD scores greater than 2.5 for markers DLS1292, GATA31B, and GATA153 on chromosomes 12, 14, and 15, respectively. In addition, because early-onset bipolar disorder is known to show substantial comorbidity with attention deficit/hyperactivity disorder and conduct disorder, we review the literature on this topic and show how it supports the idea that early-onset bipolar disorder with these comorbidities may be a genetic subtype. We assess the validity of this subtype using family-based, haplotype-block association studies of the following genes: BDNF, SNAP25, SLC6A3, DRD5, and HTR1B.

No. 71B
REVISITING THE DIAGNOSTIC UTILITY OF IRRITABILITY IN PEDIATRIC BIPOLAR DISORDER

Eric Mick, Sc.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 725, Boston, MA 02114*

SUMMARY:

Objective: The goal of this report is to discriminate low frustration tolerance from explosive irritability in ADHD children with and without bipolar disorder.

Methods: Measures of irritability were extracted from individual items of diagnostic interviews for and examined in ADHD boys and girls (N=274).

Results: Thirty (11%) of the ADHD subjects met criteria for bipolar disorder and 63 (23%) met criteria for major depressive episode. Mild forms of irritability associated with frustration intolerance were quite common, even in the sample of ADHD children with no mood disorder (59% were easily annoyed and 47% often lost their temper). Explosive irritability as measured in the mania module of the KSADS-E was the least common symptom of irritability endorsed (8% of the non-mood-disordered ADHD subjects). There was weak agreement between the measures of milder irritability or feelings of anger and the severe rages drawn from the mania module (kappa values of 0.13-0.35).

Conclusion: The prevalence of irritability ranged widely depending upon the putative degree of severity associated with the symptom. Thus, it appears that severity and other qualifiers of irritability may be important in understanding the role that this symptom plays in the diagnosis of pediatric bipolar disorder.

No. 71C
EXAMINING THE ASSOCIATION BETWEEN PEDIATRIC BIPOLAR DISORDER AND ANXIETY DISORDERS IN PSYCHIATRICALLY-REFERRED CHILDREN AND ADOLESCENTS

Theresa L. Harpold, M.D., *Pediatric Psychopharmacology Research Unit, Massachusetts General Hospital, 185 Alewife Brook Parkway, Suite 2000, Cambridge, MA 02138;* Joseph Biederman, M.D., Anne Kwon, M.S., Jennifer Gilbert, M.S., Julia Wood, B.A., Laura Smith, B.A.

SUMMARY:

Objective: An emerging literature has documented important associations between bipolar disorder (BPD) and anxiety disorders (ANX) in youth. This study examined the moderating effects of anxiety disorders and bipolar disorder on each other.

Methods: Subjects were 1,845 consecutively referred youth with (N=301) and without (1,361) a DSM-III-R/DSM-IV diagnosis of bipolar disorders on structured interview.

Results: Of the 301 youth with BPD, 227 (75%) met criteria for a comorbid anxiety disorder (BPD+ANX) and 74 did not (BPD). All anxiety diagnoses were significantly over-represented among BPD subjects compared with non-BPD controls. The presence of anxiety comorbidity increased the risk for psychosis and impaired psychoeducational functioning among BPD youth.

Conclusions: A bi-directional moderating effect between bipolar disorder and anxiety disorders was identified in which bipolar disorder increased significantly the risk for anxiety disorders and comorbid anxiety increased the morbidity of bipolar disorder.

No. 71D
NEUROPSYCHOLOGICAL DEFICITS IN CHILDREN WITH BIPOLAR DISORDER

Timothy E. Wilens, M.D., *Department of Child Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC 725, Boston, MA 02114;* Alysa E. Doyle, Ph.D.

SUMMARY:

Although there are no published studies on the neuropsychological profile of juveniles with bipolar disorder, the limited data on adults with the disorder suggest deficits in attention, aspects of verbal memory, and executive functions. Given that these functions play a large role in successful self-regulation, it is likely that findings will extend to youth with this condition. If such deficits are indeed found, a further question to address is whether they are due to the high comorbidity of juvenile bipolar disorder with ADHD. To investigate these issues, we compared the neuropsychological functions of 57 youth with bipolar disorder with 46 controls on a battery of clinical neuropsychological measures of executive functions. The battery included the WISC-III Freedom From Distractibility Index, the Stroop, the Wisconsin Card Sorting Test, the Rey Osterreith Complex Figure, an auditory continuous performance test and a measure of verbal learning. Bipolar youth were impaired on all measures, and findings remained significant even after controlling for ADHD. These findings suggest that deficits in executive functions, vigilance, and verbal learning are associated with juvenile bipolar disorder and that this association is not simply due to comorbid ADHD.

No. 71E
COMPARATIVE EFFICACY OF ATYPICAL ANTIPSYCHOTICS FOR PEDIATRIC BIPOLAR DISORDER

Joseph Biederman, M.D., *Department of Psychiatry, Massachusetts General Hospital, 55 Fruit Street, Warren Building 705, Boston, MA 02114*

SUMMARY:

Objective: The objective of this study was to assess the relative impact of atypical antipsychotics in pediatric bipolar disorder.

Methods: This was a randomized, open-label, eight-week study of monotherapy with an atypical neuroleptic (olanzapine (N=19), quetiapine (N=19), risperidone (N=42), and ziprasidone (N=21)) in the treatment of youth with mania.

Results: One-hundred one subjects were enrolled in the study. They were 10.2±2.7 years of age and predominantly male (67%). 71% of subjects completed the study with no differences in rate of dropout between the medication arms (p=0.7). There were significant reductions in symptoms for each treatment arm that were not statistically significantly different (F(3,96)=2.2, p=0.09). However, clinical ratings on the CGI indicate that the effect was strongest for risperidone (75% much or very much improved) followed by ziprasidone (57%), quetiapine (56%), and olanzapine (50%). Olanzapine was associated with marked increase in weight (4.9±2.1 kg increased) that was statistically significantly greater than the weight gain for risperidone (2.2±2.1kg), quetiapine (1.4±1.6kg), and ziprasidone (0.6±2.1kg).

Conclusions: This study suggests that atypical antipsychotics reduce manic symptomatology in children and adolescents with bipolar disorder and that this effect may be strongest for risperidone. Future placebo-controlled, double-blind studies of these compounds are warranted in this population.

REFERENCES:

1. Faraone SV, Glatt S, Tsuang MT: The genetics of pediatric onset bipolar disorder. Biological Psychiatry 2003; 53:970-977.
2. Mick E, Biederman J, Faraone SV, Murray K, Wozniak J: Defining a developmental subtype of bipolar disorder in a sample of non-referred adults by age-at-onset. Journal of Child and Adolescent Psychopharmacology 2004; 13:453-462.
3. Chen Y, Dilsaver S: Comorbidity of panic disorder in bipolar illness: evidence from the epidemiologic catchment area survey. American Journal of Psychiatry 1995; 152(2):280-282.
4. Biederman J, Mick E, Faraone SV, Spencer T, Wilens TE, Wozniak J: Current concepts in the validity, diagnosis, and treatment of pediatric bipolar disorder. Int J Neuropsychopharmacol 2003; 6(3):293-300.

SYMPOSIUM 72—EMOTION REGULATION IN BPD

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be educated about (1) various methods of assessing affective dysregulation, (2) the interaction of affective dysregulation and non-suicidal self-injurious behavior, (3) the utility of ambulatory assessment for evaluating treatment outcome, and (4) the neurofunctional correlates of affective dysregulation and their improvement due to treatment.

No. 72A
AUTONOMIC REACTIVITY AND BORDERLINE FEATURES AMONG INTIMATE PARTNER ABUSERS

Julia C. Babcock, Ph.D., *Department of Psychology, University of Houston, 126 Heyne Bldg, Houston, TX 77204*

SUMMARY:

Many experts now believe that pervasive problems in affective regulation constitute the central area of dysfunction in borderline personality disorder (BPD). However, data supporting this theory are inconclusive. This symposium presents studies supporting affective dysregulation in BPD, as well as studies going far beyond a basic assessment. Julia Babcock presents data on studies investigating the correlation between autonomic reactivity and borderline features among intimate partner abusers. Stacy ShawWelch presents data on emotional responses to parasuicide imagery in BPD patients. In this study non-suicidal self-injurious behavior is negatively reinforced by immediate reductions of negative emotions. Ulrich Ebner-Priemer employed a 24-hour ambulatory monitoring approach to investigate affective dysregulation in the natural environment of BPD patients. This methodology allows calculating affective instability using multiple assessment points. Tom Lynch investigated Linehan's Biosocial Theory supporting the concepts of emotion vulnerability (emotion sensitivity, emotion reactivity) and problems with regulation (delayed return to baseline). Sabine Herpertz investigated neurofunctional correlates of affective dysregulation and their improvement due to an inpatient treatment program. Preliminary data indicate that psychotherapy is associated with stronger activations in brain areas which are linked to cognitive control. In summary, all presentations support affective dysregulation in BPD and point to innovative aspects of assessment.

No. 72B
EMOTIONAL RESPONSE TO PARASUICIDE IMAGERY IN BPD

Stacy Shaw-Welch, Ph.D., *Department of Psychiatry, Emory University, 910 Ladson Ct., Decatur, GA 30033*

SUMMARY:

Objective: Parasuicide is especially prevalent in borderline personality disorder (BPD). One promising theory of parasuicide is Linehan's Integrative Emotion Regulation theory, which suggests that parasuicide in BPD is maintained by its emotion-regulatory qualities. However, there are very little data to support this idea. We hypothesized that within a borderline population, both non-suicidal self-injurious behaviors as well as non-fatal suicide attempts are negatively reinforced by immediate reductions in negative emotions.

Method: Physiological and subjective measures of negative emotions associated with parasuicide imagery were examined in 42 BPD individuals with histories of parasuicide. Imagery "scripts" involving suicide attempts, non-suicidal self-injury, a high-stress event followed by accidental death, and control scenes were presented.

Results: Data were analyzed using a mixed models procedure, and supported an escape-conditioning model of non-suicidal self-injury and suicide ideation. Subjective and physiological measures indicated that negative emotions decreased during or after the non-suicidal self-injury. Similar decreases in negative emotion on both subjective/physiological measures were found during an imagined "accidental death." Results were less clear for suicide attempts, with different patterns for the physiological/subjective measures.

Conclusions: These results support an escape-conditioning model of non-suicidal self-injury and suicide ideation in BPD. Clinical implications will be discussed.

No. 72C
CALCULATING INSTABILITY IN BPD

Ulrich W. Ebner-Priemer, Ph.D., *Psychosomatic Medicine and Psychotherapy, Central Institute of Mental Health, Postfach 122120, Mannheim 68072, Germany*

SUMMARY:

Objective: Affective instability is an essential criterion for borderline personality disorder (BPD) in DSM-IV. In ICD-10, BPD is even listed under the emotionally unstable personality disorders. However, instability was never used as outcome criterion in treatment studies. We investigated if the calculated instability of momentary ratings in BPD is heightened compared with healthy controls (HC), if there is a concordance of calculated instability and the DSM-IV criterion of affective instability, and if an optimal temporal design could be determined.

Method: We employed a 24-hour ambulatory monitoring approach in 50 patients with BPD and 50 HC assessing momentary ratings of specific emotions and distress every 15 minutes. Instability was calculated by the Mean Square of Successive Differences.

Results: Data analysis revealed a heightened instability in BPD compared with HC. There was no concordance of calculated instability and the DSM-IV criterion. However, in other criterions like anger, with concordance was evident. Furthermore, increasing space between observations resulted in overestimation of instability.

Conclusions: Ambulatory assessment seems to be a promising way to assess instability in BPD, whereas interviews may be problematic. Because affect changes rapidly, short time intervals are necessary. Results suggest the potential utility of ambulatory assessment for evaluating treatment outcome.

No. 72D
EMOTIONAL SENSITIVITY AND REACTIVITY IN BPD: EMPIRICAL EVIDENCE

Thomas R. Lynch, Ph.D., *Psychiatry and Behavioral Sciences, Duke University Medical Center, 4323 Ben Franklin Blvd, Suite 700, Durham, NC 27704*

SUMMARY:

According to Linehan's biosocial theory, borderline personality disorder (BPD) is driven by the interplay between environmental invalidation, emotional vulnerability, and problems with emotion regulation. Although the Biosocial Theory provides the underpinnings of the most successful and best-validated treatment for BPD (dialectical behavioral therapy), empirical support for this model is only now materializing. This presentation will outline new advances in empirical support for the presence of heightened emotion vulnerability and greater difficulty with physiological aspects of emotion regulation in patients with BPD when compared with a non-clinical control sample. Specifically, BPD patients demonstrated greater sensitivity to expression of emotion, especially anger, as measured by speed to correctly identify emotional facial expressions. BPD patients also demonstrated greater physiological reactivity to both neutral and valenced lexical stimuli, as measured by galvanic skin response (GSR). Heightened sensitivity to emotional stimuli may contribute to problems with regulation, in that they may have more frequent and intense emotions to regulate. BPD patients also demonstrated slower return to GSR baseline following a stressful math task, demonstrating delayed regulation of emotion when compared with a non-clinical control group. Implications for interventions focused on emotion regulation in patients with BPFD will be discussed.

No. 72E
NEUROFUNCTIONAL CORRELATES OF AFFECTIVE DYSREGULATION AND CHANGES UNDER PSYCHOTHERAPY

Sabine Herpertz, M.D., *Department of Psychiatry, University of Rostock, Gehlsheimer Str. 20, Rostock 18147, Germany*

SUMMARY:

Objective: Preliminary data indicate that a dysfunctional amygdalar-prefrontal circuit may be the neurofunctional correlate of affect dysregulation in borderline personality disorder (BPD). Up to now, the most prominent and best replicated finding in BPD is a hypersensitive amygdala that appears not to be sufficiently controlled by prefrontal areas. Our fMRT study intended to contribute to the identification of neurofunctional correlates of affect dysregulation in BPD and to clarify if psychobiological dysfunctions can be changed by means of dialect behavioral therapy (DBT).

Method: Six female BPD subjects were scanned twice before therapy (to control for test/retest stability) and three times in the course of a 12-weeks DBT inpatient treatment programme. In addition, six age-matched, female, healthy controls were investigated with the same study design. For induction of aversive effects we applied sets of standardized emotional slides from the International Affective Picture System.

Results: Preliminary data indicate a significant correlation between activity in the anterior cingulated cortex (posterior rostral subdivision) and decrement of anxiety in BPD subjects.

Conclusions: Psychotherapy that focuses on improvement of cognitive control over aversive affects in BPD is associated with stronger activations in brain areas that have been reported to be involved in cognitive control and behavioural inhibition.

REFERENCES:

1. Herpertz SC, Dietrich TM, Wenning B, Erberich SG, Krings T, Thron A, Sass H: Evidence of abnormal amygdala functioning in borderline personality disorder: a functional MRI study. Biological Psychiatry 2001; 50(4):292-298.
2. Ebner UW, Badeck S, Beckmann C, Wagner A, Feige B, Weiss I, Lieb K, Bohus M: Affective dysregulation and dissociative experience in female patients with borderline personality disorder. Journal of Psychiatric Research, in press.

3. Haines J, Williams CL, Brain KL, Wilson GV: The psychophysiology of self-mutilation. Journal of Abnormal Psychology, 1995; 104, 471-489.
4. Lynch TR, Chapman AL, Rosenthal MZ, Kuo JR, Linehan MM: Mechanisms of change in dialectical behaviour therapy: Theoretical and empirical observations. Journal of Clinical Psychology, in press.
5. Haines J, Williams CL, Brain KL, Wilson GV: The psychophysiology of self-mutilation. Journal of Abnormal Psychology 1995; 104, 471-489.
6. Ebner UW, Badeck S, Beckmann C, Wagner A, Feige B, Weiss I, Lieb K, Bohus M: Affective dysregulation and dissociative experience in female patients with borderline personality disorder. Journal of Psychiatric Research, in press.
7. Lynch TR, Chapman AL, Rosenthal MZ, Kuo JR, Linehan MM: Mechanisms of change in dialectical behaviour therapy: Theoretical and empirical observations. Journal of Clinical Psychology, in press.
8. Herpertz SC, Dietrich TM, Wenning B, Erberich SG, Krings T, Thron A, Sass H: Evidence of abnormal amygdala functioning in borderline personality disorder: a functional MRI study. Biological Psychiatry 2001; 50(4):292-298.

SYMPOSIUM 73—CHOOSING THE RIGHT TREATMENT FOR SUBSTANCE ABUSE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should know the best methods, both pharmacologic and behavioral, for treating the major addictions to illicit drugs and prescription opioids. In addition, the participant will have an understanding of phenomenology of substance-induced addictions.

No. 73A
CHOOSING THE RIGHT TREATMENT FOR OPIOID DEPENDENCE

Herbert D. Kleber, M.D., *Department of Substance Abuse, Columbia University, 1051 Riverside Drive, Unit 66, New York, NY 10032*

SUMMARY:

The number of heroin addicts is estimated at 1 million and prescription opioid abusers at least double that. Relatively few are in treatment. The agonists methadone and LAAM decrease opiate use and improve psychosocial outcome, but present problems such as high rates of concurrent alcohol and cocaine abuse, need for frequent clinic visits, major difficulty in withdrawal, and, with LAAM, increased risk of torsade de pointes. The antagonist naltrexone, while blocking opiate use and decreasing alcohol abuse, has low rates of acceptance and high dropout rates. The partial agonist buprenorphine may have the advantages of these three agents but also with easier withdrawal, ceiling effect on respiratory depression, protection against diversion because of the combination with naloxone, and, as compared with methadone, office based prescribing. This opens the possibility of mainstreaming addiction treatment and attracting individuals who have not sought help. Agents in development include an injectable form of naltrexone, which can block heroin for up to five weeks, an implant, which may block for three to 12 months, and a depot buprenorphine. New approaches to opiate detoxification, including lofexidine, rapid detoxification, especially using buprenorphine and naltrexone, and the use of NMDA antagonists hold out hope for less discomfort and higher completion rates. The paper discusses using available medications in office-based settings including patient selection, treatment, and safety issues.

No. 73B
CHOOSING THE RIGHT TREATMENT FOR COCAINE DEPENDENCE

Adam M. Bisaga, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Unit 120, NYSP1, New York, NY 10032*

SUMMARY:

Cocaine abuse and dependence remain severe health problems, with treatment difficult and few successful controlled trials. A combination of pharmacological and behavioral interventions will likely be required for patients to achieve and maintain abstinence. Antidepressants, with desipramine most studied, have yielded inconsistent results. Medications that affect dopaminergic neurotransmission, including dopamine receptor agonists, dopamine transporter inhibitors, and dopamine receptor blockers, have also not been consistently successful. Recently studied medications, including disulfiram, d-amphetamine, tiagabine, and topiramate, are more promising. Current areas of research interest include the use of medications that affect the neurotransmission of excitatory and inhibitory amino acids, and the function of the HPA axis. Strategies to prevent cocaine from entering the brain are also being developed and initial results with a "cocaine vaccine" are promising. A new approach in cocaine treatment trials involves the induction of initial abstinence using behavioral methods and medications that may extend abstinence and prevent relapse. Despite the absence of reliable pharmacotherapy, there are several effective psychosocial treatment approaches that should be a part of every treatment effort. Although no single treatment is currently suggested, several treatment combination approaches will be discussed.

No. 73C
CHOOSING THE RIGHT TREATMENT: MARIJUANA AND CLUB PARTY DRUGS

David M. McDowell, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Dr., Unit 66, New York, NY 10032*

SUMMARY:

Marijuana is the most commonly used illicit substance in the United States. In addition, the use of club drugs, in particular MDMA, Ketamine, and GHB, are increasing. Contrary to public perception, club drugs cause real and substantial morbidity and mortality and heavy and chronic use of marijuana carries with it substantial morbidity as well as the risk of dependence and withdrawal. These issues have far reaching implications for substance abuse treatment and psychiatric treatment in the future. Pharmacological interventions for marijuana dependence have included mood stabilizers and medication focused on withdrawal symptoms. Treatment strategies for these conditions have focused on prevention measures and psychosocial interventions. These conditions are not as well studied as other substance abuse conditions. In recent years a great deal of work has been completed concerning the basic mechanisms of actions, pharmacology, and neurophysiology of marijuana and its endogenous ligand, anandamide. Given the increasing knowledge about marijuana, new and potential treatments are being studied and even more can be theorized. Especially promising are various pharmacological interventions for marijuana as well as for comorbid conditions. This portion of the seminar will focus on the latest developments in the study of marijuana and club drugs as well as treatment strategies. New and potential pharmacological treatments will be emphasized.

No. 73D
TREATMENT OF COMORBID CONDITIONS

Frances R. Levin, M.D., *Department of Psychiatry, Columbia University, State Psychiatric Inst., 722 West 168th Street, Unit 66, New York, NY 10032*

SUMMARY:

Evidence for a link between psychiatric and substance use disorders is strong and converging. Epidemiologic studies have demonstrated that substance abuse is over-represented among individuals with psychiatric conditions. Similarly, numerous prevalence studies among substance abusers seeking treatment have found that the majority of patients have at least one comorbid psychiatric disorder. These psychiatric disorders may include major depression, bipolar disorder, anxiety disorders, attention-deficit hyperactivity disorder, and schizophrenia/schizo-affective illness. Although there are established pharmacologic and nonpharmacologic approaches for each of these psychiatric conditions in nonsubstance abusing patients, the efficacy of these approaches in substance-abusing patients is not well established. Several questions will be addressed in this presentation: (1) What are the appropriate pharmacologic treatment approaches for specific dually-disordered patients? (2) Should medications with abuse potential be avoided? (3) Is substance use reduced if the psychiatric comorbid condition is treated? (4) What are some possible modifications of currently available nonpharmacologic strategies that might be used for various diagnosed groups? Although there are no definite answers, clinical guidelines will be offered.

No. 73E
CHOOSING THE RIGHT PSYCHOSOCIAL TREATMENTS FOR SUBSTANCE DEPENDENCE

Edward V. Nunes, M.D., *Department of Psychiatry, NYS Psychiatric Institute, Columbia University, 1051 Riverside Drive, #51, New York, NY 10032*

SUMMARY:

Psychosocial treatment is the cornerstone of treatment for addictions, either alone or in combination with medications. Several types of psychotherapeutic interventions have been developed and studied including cognitive-behavioral skill-building approaches such as relapse prevention, community reinforcement approach, contingency management, motivational enhancement therapy, and 12-Step facilitation. Such interventions have served as a means of achieving abstinence, encouraging lifestyle change, and promoting compliance with medications. Despite encouraging findings in treatment outcome research, many challenges remain. The behavioral interventions are not always successful in securing longer-term abstinence and commitment to change. Transferring and integrating such treatment models from research to community treatment settings remains complex. An overview of these models will be provided as well as their known efficacy in working with different substances of choice. Obstacles encountered in the delivery of these approaches, the clinical implication of integrating such models, and the efforts thus far to generalize research findings to community settings will also be addressed.

REFERENCES:

1. Kleber HD: Pharmacologic treatments for heroin and cocaine dependence. The American Journal on Addictions 2003; 12:S5-S18.
2. Gorelick DA, Gardner EL, Xi ZX: Agents in development for the management of cocaine abuse. Drugs 2004; 64:1547-73.
3. Budney AJ, Hughes JR, et al: Marijuana abstinence effects in marijuana smokers maintained in their home environment. Archives of General Psychiatry 2001; 58:917-924.
4. Levin FR, Evans SM, Kleber HD: Treatment of substance abusers with adult ADHD: practical guidelines for treatment. Psychiatric Services 50:1001-1003.
5. Rothenberg JL, Sullivan MA, Church SH, Seracini A, Collins E, Kleber H, Nunes EV: Developing behavioral naltrexone therapy: an integrated treatment for opiate addiction and naltrexone maintenance. Journal of Substance Abuse Treatment 2002; 23:351-360.

SYMPOSIUM 74—A WORLD VIEW OF MEDICAL AND PSYCHIATRIC COMORBIDITY

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the similarities and differences in the way medical conditions are associated with psychiatric conditions in different parts of the world.

No. 74A
SOMA AND PSYCHE IN MIDDLE EASTERN CULTURES: A HISTORICAL REVIEW

Nasser F. Loza, M.B., *Department of Psychiatry, The Behman Hospital, PO 11421, 32 El Marsad Street - Helwan, Cairo 11421, Egypt*

SUMMARY:

Throughout the history of Middle Eastern culture, somatization has been a common way of expressing psychological disorder. The Arabs have for centuries recognized that psychological disorders can be the main presentation of physical illnesses. This presentation is an attempt to review the evidence across ancient civilazitions in the area explaining the theoretical view of the relation between physical and psychological disorders.

From the ancient writings of the medical papyri of the Pharaonic era to the Canon of Avicenna references to that complex link of mind and body in scientific works reflect the common beliefs of those times, of which some have survived till today. A presentation of current cultural explanation of psychiatric presentation of medical disorders will study the link of ancient cultural ideas.

Finally, a review of literature of current studies in liaison psychiatry in the area of somatization looking at available services, their needs and plans for future developments will be discussed.

No. 74B
AN INTERNATIONAL STUDY OF PHYSICAL AND PSYCHIATRIC COMORBIDITY IN PRIMARY CARE

Stephen R. Kisely, M.D., *Department of Psychiatry, Dalahousie University, Abbie J Lane Memorial, 5909 Veterans Memorial Lane, Suite 9211, Halifax, NS B3H 2E2, Canada;* Gregory E. Simon, M.D.

SUMMARY:

Aim: To determine the association between physical morbidity and recovery from psychiatric illness in primary care.

Method: 1,252 psychiatric cases were recruited using a two-stage design from 5,447 subjects presenting for primary care in 14 countries. Cases were assessed at the time of screening and one year subsequently. Information on physical, psychiatric, and social status was obtained using the Composite International Diagnostic Instrument adapted for use in primary care (CIDI-PHC) and the Groningen Social Disability Schedule (GSDS). Assessments of psychiatric morbidity were also obtained from the patients' family practitioners.

Results: Medically explained somatic symptoms were strongly related to psychiatric outcome one year later. Whereas just over a half of patients (614 out of 1078) with four or fewer medically explained symptoms had recovered from a psychiatric disorder, the percentage recovery fell to 38% (67/174) in those with five or more medically explained symptoms. Patients with five or more medically explained symptoms had a 70% increase in risk of remaining a psychiatric case one year later, after controlling for demographics, country, initial severity of psychiatric disorder, medically unexplained somatic symptoms, and social disability.

Conclusions: Physical ill health is independently associated with psychological outcome one year after a patient has been seen.

No. 74C
PSYCHIATRY AND MEDICINE IN PAKISTAN

Haroon R. Chaudhry, M.D., *Department of Psychiatry, Fatima Jinnah Medical College, 83 Shah Jamal Colony, Lahore, Pakistan (west);* Muhammad M. Igbal, Fahd A. Cheema, Khalid A. Mufti, M.D.

SUMMARY:

Physical illness and physical symptoms are associated with an increase of psychiatric disorder. The WHO collaborative study of patients presenting to primary care in 14 countries showed a strong association between somatic symptoms and psychiatric morbidity in all the centers, despite their different cultural approaches to illness and its care. Moderate and severe physical disorders were associated with psychiatric disorder, whilst there was a linear relationship between number of medically unexplained symptoms (i.e. symptoms in which no adequate pathological cause was evident) and psychiagtric disorder. Medically and non-medically explained somatic symptoms often occurred together. This presentation will discuss some studies done in Pakistan. It was found that in a recently reported study from Pakistan, there was considerable burden associated with neuropsychiatric disorders. The socioeconomic adversity and relationship problems were major risk factors, whereas supportive family and friends may protect against development of psychiatric disorders. The presentation will also cover an ongoing study in which we have found that over 900 depressed patients presented exclusively with somatic symptoms in urban slums of Lahore.

No. 74D
WHAT KILLS OUR PATIENTS: A KENYAN PERSPECTIVE

Frank G. Njenga, M.D., *Upperhill Medical Center, Ralph Bunche Road, Nairobi 00200, Kenya*

SUMMARY:

According to several studies, mortality in psychiatric patients is higher than in the general population. In some studies, the death risk for all causes is up to four times that of the general population and up to 30 times higher in the age group 25-34 years, with suicide explaining the majority of the causes, which include diseases of the circulatory system, respiratory complication from smoking, accidents, and neoplasia. Schizophrenia as a disease has been reported as a cause of death, while infections were the primary cause of death in half the cases seen in Tanzania. This paper presents data on the causes of death in a Kenyan population, based on prospective 20-year, naturalistic study set in a large urban private practice in Nairobi. In this cohort, a diagnosis of depression predicts suicide, while in the past 10 years AIDS is emerging as an important cause of death in this population. People with psychiatric illness may be at a higher risk of contracting lifestyle-related disorders including obesity, smoking-related disorders, infections (including HIV), and trauma. This is the first long-term study of an African population, and the findings support this hypothesis.

No. 74E
COMORBIDITY BETWEEN PSYCHIATRIC DISORDERS AND SUBSTANCE DEPENDENCE: RESULTS FROM A NATIONAL SURVEY

Maria E. Medina-Mora, Ph.D., *Department of Epidemiology, National Institute of Psychiatry, Calz. Mexico-Xohimilco 101, Mexico, DF 14370, Mexico;* Guilherme Borges, Ph.D., Carmen Lara, Ph.D.

SUMMARY:

The presentation will describe comorbidity between psychiatric and substance abuse/dependence disorders, ages of onset, and progression of disorders, in the Mexican urban non institutionalized adult population (18 and 65 years of age). The sample design was probabilistic, stratified, and multistage. (N= 5,826; response rate 76.6%). The instrument was a computer-assisted version of the WHO CIDI certified version 15, installed on a laptop and administered face-to-face by trained lay interviewers. Likelihood of co-occurrance of both disorders was high with odds ratios varying between 1.9 for the co-occurrence of anxiety and drug abuse/dependence disorders and 4.9 for the risk of developing substance dependence when the individual presents an impulsive disorders. All impulsive disorders, around half of the depressions and two-thirds of the anxiety disorders occurred prior developing substance abuse or dependence. When mental problems antecede drug exposure, it was more likely for females than for males to develop a substance abuse/dependence disorder; it was ten times more likely for a female with an impulsive disorder, seven times more likely when they suffered from an anxiety disorder and three times more likely when they were depressed. Odds ratios for males were 3.1, 2.6, and 4.1, respectively.

REFERENCES:

1. Kisely S, Goldberg D, Simon G: A comparison between somatic symptoms with and without clear organic cause: results of an international study. Psychol Med 1997; 27:1011-1019.
2. Miza I, Jenkins R: Risk factors, prevalence, and treatment of anxiety and depressive disorders in Pakistan: systematic review. BMJ 2004; 328:794-7.
3. Ndosi NK, Kisesa AF: Causes of death among mental patients at Muhimbili Medical Center, Dar es Salaam. EAMJ 1997; 74(2):82-4.
4. Benjet C, Wagner FA, Borges G, Medina-Mora ME: The relationship of tobacco smoking with depressive symptomatology in the Third Mexican National Addictions Survey. Psychological Medicine 2004; 34:1-8.

SYMPOSIUM 75—RUNNING A MEDICINE/PSYCHIATRY SERVICE: THE DUKE EXPERIENCE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should recognize the importance of dual training in medicine and psychiatry and better understand the role of dually-trained physicians in patient care, research, and education.

No. 75A
CARING FOR PATIENTS ON A COMBINED INTERNAL MEDICINE/PSYCHIATRY SERVICE: ADVANTAGES OVER CONSULTATION-LIAISON PSYCHIATRY

Y. Pritham Raj, M.D., *Department of Psychiatry, Duke University Medical Center, Box 3369 DUMC, Durham, NC 27710;* Jane P. Gagliardi, M.D.

SUMMARY:

A 38-year-old woman with a history of anxiety disorder and recent significant life stressors has intractable nausea, vomiting, and abdominal pain and is referred to the medicine/psychiatry service after a thorough but negative medical and gastroenterological evaluation. The medical team is concerned about somatoform or conversion disorder, but the patient is ultimately diagnosed with adrenal insuffi-

ciency. A 65-year-old woman with renal tubular acidosis, diabetes mellitus, and recurrent urinary tract infections needs to take multiple medications, but when she stops her antipsychotic for chronic paranoid schizophrenia she becomes suspicious of all medications and food and experiences life-threatening electrolyte abnormalities. A high prevalence of psychiatric disorders is seen in the general population and especially in patients admitted for medical or surgical reasons. Meanwhile, many medical conditions can give rise to psychiatric symptoms and vice versa. The medicine/psychiatry service at Duke has developed strategies aimed at unraveling complex diagnoses and providing comprehensive intervention for these challenging patients. Unique features of the care provided by the service will be discussed.

No. 75B
TRAINING INTERNIST/PSYCHIATRISTS: AN OVERVIEW OF THE LITERATURE, CURRENT PRACTICE, AND FUTURE DIRECTIONS

Erin Silvertooth, M.D., *Box 3519 DUMC, Durham, NC 27710;* Jane P. Gagliardi, M.D.

SUMMARY:

Previous reports show combined training programs in internal medicine/psychiatry and family practice/psychiatry have various approaches to the education of trainees. Commonly viewed as a predominantly outpatient or primary care specialty, combined internal medicine/psychiatry training may have particular utility in the inpatient setting. In the current era of new duty hours and educational guidelines from the Accreditation Council for Graduate Medical Education, training directors in combined programs face particular challenges while trying to provide sufficient educational opportunities for trainees. Coordinating activities and facilitating communication between departments, providing educational conferences, facilitating trainee involvement in research, maintaining an evidence-based focus, and preparing trainees for the world beyond graduate medical education have been goals of the training program at Duke, where there are currently five full-time, dually-trained attendings and eight current trainees. Our curriculum has evolved over the last ten years and includes a variety of clinical and research opportunities. Trainees and faculty are active participants of both departments. We hope to prompt brainstorming and discussion about future directions in dual training.

No. 75C
RESEARCH IN MEDICINE/PSYCHIATRY: INVESTIGATING INTERACTIONS BETWEEN BODY AND MIND

Wei Jiang, M.D., *Department of Psychiatry, Duke University, Box 3862 DUMC, Durham, NC 27710*

SUMMARY:

A clinical vignette: A middle-aged man with acute coronary syndrome and normal cardiac function was diagnosed with major depressive disorder during hospitalization. Over the next two to three years, he visited his local ER six times for chest pain, resulting in repeated cardiac catheterization revealing no re-stenosis or new blockage. His left ventricular ejection fraction (LVEF) deteriorated and he developed heart failure. What has been happening with this patient? What is the role of depression in his cardiac rehabilitation? Why did his heart fail when no new blockages were seen? What kind of treatments would improve his cardiac function? This case leads to discussions on investigations of interactions between body and mind or between medicine and psychiatry, including findings of epidemiological studies, laboratory studies, and field work. The speaker, who has extensive experience in conducting research examining the relationship of mental health and cardiovascular disease and underlying mechanisms, will share with the audience how to formulate and implement a research question. Furthermore, the speaker will discuss future studies needed to target interactions between the mind and cardiovascular system as well as between the mind and other somatic systems.

No. 75D
ADMINISTRATIVE CONSIDERATIONS IN OPERATING A MEDICINE/PSYCHIATRY SERVICE

Eric J. Christopher, M.D., *Department of Psychiatry, Duke University, Box 3519 DUMC, Durham, NC 27710;* Jane P. Gagliardi, M.D.

SUMMARY:

Previous studies have demonstrated that involvement of consultation-liaison psychiatrists in the care of medical patients with psychiatric comorbidities can result in decreased length of stay, lower hospital costs, and improved outcomes. One challenge of consultation psychiatry is the appropriate medical care of psychiatrically ill patients who have not undergone appropriate diagnosis and management for their medical problems. Many psychiatric inpatient units do not allow for medical treatment strategies; at the same time, medical inpatient units are often ill equipped to manage particular challenges of agitated, violent, or suicidal patients. Run as a hospitalist practice, the combined medicine/psychiatry service at Duke provides medical care to patients with diagnoses ranging from toxidromes and delirium to catatonic depression with medical complications; combined faculty also rotate through the inpatient psychiatry and C/L services, providing continuity of care and access to patients. Patient safety, thorough evaluation, and improved efficiency of hospitalization are goals. Estimates of profitability are difficult to make, but patients on the combined service appear to experience shorter length of stay and smoother transition to appropriate psychiatric follow up.

REFERENCES:

1. von Rad M, Sellschopp A: The integrated psychosomatic inpatient unit. A new approach to hospital medical care. Psychotherapeutics and Psychosomatics 1987; 48(1-4):101-109.
2. Doebbeling CC, Pitkin AK, Malis R, Yates WR: Combined internal medicine-psychiatry and family medicine-psychiatry training programs, 1999-2000: Program directors' perspectives. Academic Medicine 2001; 76(12):1247-1252.
3. Jiang W, Krishnan RR, O'Connor CM: Depression and heart disease: evidence of a link, and its therapeutic implications. CNS Drugs 2002; 16(2):111-127.
4. Goldberg RJ, Stoudemire A: The future of consultation-liaison psychiatry and medical-psychiatric units in the era of managed care. General Hospital Psychiatry 1995; 17:268-277.

SYMPOSIUM 76—NEW SCIENTIFIC ADVANCES IN THE NEUROBIOLOGY OF BEHAVIOR
National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES:

At the conclusion of the symposium, the participant should be able to demonstrate a fundamental understanding of recent advances in brain and behavioral science, particularly how aspects of genes, cells, and circuits mediate brain function and generate behavior, and how environmental factors affect these biological variables to modify behavior.

No. 76A
MOLECULAR MECHANISMS OF DRUG ADDICTION

Eric J. Nestler, M.D., *Department of Psychiatry, UT Southwestern Medical Center, 5323 Harry Hines Blvd, Dallas, TX 75390-9070*

SUMMARY:

A key challenge in addiction research is to identify neuroadaptations that underlie the relatively stable behavioral changes that characterize addiction. One mechanism that could play a major role in such stable plasticity is the regulation of gene expression. Accordingly, there has been great interest in identifying genes and proteins whose expression is altered by drugs of abuse in brain regions important for addiction. This talk will focus on one particular transcription factor, deltaFosB. DeltaFosB is induced in the nucleus accumbens, a major brain reward region, after chronic exposure to drugs of abuse. DeltaFosB, a product of the fosB gene, is a unique member of the Fos family of transcription factors due to its enhanced stability. As a result, once induced by drugs of abuse, deltaFosB persists in brain for relatively long periods of time. Current research in mouse models, which overexpress deltaFosB itself or an inhibitor of the protein in nucleus accumbens of adult animals, supports the hypothesis that deltaFosB mediates enhanced sensitivity and incentive drive for drugs of abuse. We are also currently searching for the target genes through which deltaFosB produces these effects. Gene array profiling supports a dominant role played by deltaFosB in mediating the long-term genomic effects of drugs of abuse in this brain region. Together, this work supports a scheme in which deltaFosB functions as a sustained "molecular switch" that gradually converts acute drug responses into relatively stable adaptations that contribute to drug addiction.

No. 76B
ENVIRONMENTALLY-INDUCED MODIFICATIONS IN CHROMATIN STRUCTURE AS A POTENTIAL MEDIATOR FOR THE EFFECTS OF EARLY EXPERIENCE ON LATER VULNERABILITY

Michael Meaney, Ph.D., *Department of Neuroscience, Douglas Hospital Research Center, 6875 Lasalle Boulevard, Montreal, Quebec H4H1R3, Canada*

SUMMARY:

Individual differences in psychostimulant self-administration among rodents are associated with variations in hypothalamic-pituitary-adrenal activity, and thus circulating levels of glucocorticoids, and subsequent effects on the mesolimbic dopamine system. In the rat, individual differences in HPA function are associated with variations in maternal care in early postnatal life. The mechanisms for these effects involve changes in the expression of genes in brain regions that mediate HPA activity. Most notable are the effects on systems that regulate central corticotrophin-releasing factor (CRF) synthesis and release from hypothalamus. The adult offspring of mothers that exhibit increased pup licking/grooming and arched-back nursing (LG-ABN) show increased glucocorticiod receptor mRNA throughout the hippocampus, enhanced feedback inhibition of hypothalamic CRF, and dampened HPA responses to stress. The results of adoption studies suggest that these effects are indeed directly related to variations in maternal care and may form the basis for a non-genomic transmission of emotionality across generations. Recent studies focus on the mechanisms for these effects by examining DNA methylation within the promoter regions of the rat glucocorticoid receptor gene. These studies reveal sustained effects of maternal behavior on the cytosine methylation of the consensus binding sequences for specific transcription factors. Studies targeting histone deacetylation suggest that methylation is indeed the mechanism underlying the sustained effects of maternal care on glucocorticoid receptor gene expression. Finally, recent studies suggest that parental care may also influence the development of individual differences in HPA responses to stress and dopamine function in humans. These findings suggest that parental care in early life may alter neural development and thus influence the development of individual differences in vulnerability for psychostimulant use.

No. 76C
NEURAL SUBSTRATES OF MEMORY: FROM SYNAPSE TO SYSTEM

Tim Tully, Ph.D., *Ctr For Learning & Memory, Cold Spring Harbor Lab, 1 Bungtown Rd, Cold Spring Harbor, NY 11724*

SUMMARY:

Behavioral and biochemical properties of simple forms of (Pavlovian) learning in Drosophila show properties conserved across the animal kingdom. Given this observation, we designed automated "Robotrainers" and screened 6,700 randomly generated mutants for defects in long-term memory of an odor-shock association. From this "forward"-genetic strategy, we have identified 60 new memory mutants. Using a "reverse"-genetic strategy, we also have begun to identify genes that are transcriptionally regulated during long-term memory formation—using DNA microarray technology. We have developed a novel statistical approach to analyze DNA chip data, yielding more than 3,900 candidate memory genes (CMGs) genome-wide. This method has been validated by establishing significant overlap between CMGs from the DNA chip and molecular lesions associated with the memory mutants. These results suggest new biological pathways involved in memory formation, one of which has been biologically validated in vivo.

Given the well-established molecular homology in neuronal function among invertebrates and vertebrates, such gene discovery leads to drug discovery ultimately to develop effective therapies for human cognitive dysfunction. A high-throughput, cell-based screen for modulators of the CREB pathway has yielded several novel drug compounds. The most advanced of these, a phosphodiesterase inhibitor, has been shown in animal models to facilitate several forms of memory loss, including a genetic model of mental retardation.

No. 76D
NEUROIMAGING HUMAN REWARD CIRCUITRY AND USING IT FOR ACROSS-SCALE SYSTEMS BIOLOGY IN ADDICTION

Hans C. Breiter, M.D., *60 Chestnut Street, Charlestown, MA 02129-3422*

SUMMARY:

Neuroimaging experiments in humans have provided strong evidence for a generalized circuitry that processes reward/aversion information. Composed of an extended set of subcortical gray matter regions and the surrounding paralimbic girdle, these neural systems form the core of an information backbone (iBM) for motivated behavior. Components of this iBM appear to be affected in several neuropsychiatric illnesses. Made up of multiple circuitry-based quantitative measures, heritable and state indices, this systems biology will provide more accurate etiological insights than the diagnostic categories based on statistical clusters of behaviors and symptoms that are used in current psychiatric diagnosis. Recent studies have alluded to parallels between the events at the molecular and brain circuitry levels during presentation of motivationally salient stimuli. This talk will explore how integrative systems biology approaches can bridge the distributed neural circuits responsible for the processing of reward/aversion function and the networks of genes responsible for the development and maintenance of these neural cir-

cuits. These combined genetics and integrative neuroscience approaches have the potential to redefine our conceptualization of neuropsychiatric illnesses with the implementation of objective quantitative measures.

REFERENCES:

1. Chao J, Nestler EJ: Molecular neurobiology of drug addiction. Annu Rev Med 2004; 55:113-32.
2. Weaver IC, Cervoni N, Champagne FA, D'Alessio AC, Sharma S, Seckl JR, Dymov S, Szyf M, Meaney MJ: Epigenetic programming by maternal behavior. Nat Neurosci 2004; 7(8):847-54.
3. Dubnau J, Chiang AS, Tully T: Neural substrates of memory: from synapse to system. J Neurobiol 2003; 54(1):238-53.
4. Breiter HC, Rosen BR: Functional magnetic resonance imaging of brain reward circuitry in the human. Annals of the New York Academy of Sciences 1999; 877:523-547.

SYMPOSIUM 77—PSYCHIATRIC ADVANCE DIRECTIVES: KEY ISSUES AND CLINICAL CHALLENGES
Collaborative Session With the National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of the symposium, the participant should (1) learn about prevalence of and demand for psychiatric advance directives in the United States; (2) understand basic legal, clinical, systemic, and ethical issues implementing psychiatric advance directives; and (3) discern whether consumers document preferences generally in agreement with standard practice.

No. 77A
PSYCHIATRISTS' ATTITUDES ABOUT PSYCHIATRIC ADVANCE DIRECTIVES

Marvin S. Swartz, M.D., *Department of Psychiatry, Duke University School of Medicine, Box 3173, Durham, NC 27710*

SUMMARY:

Some critics of psychiatric advance directives (PADs) see an ethical flaw in the theory of anticipatory planning for mental health care, comparing these legal tools to Ulysses contracts. The values, interests, and stated preferences of a competent person with SMI may change fundamentally when the same person becomes incompetent. These ethical concerns among psychiatrists may create substantial barriers to the use of PADs, but, in addition, there may be numerous other barriers to use of PADs from the perspective of psychiatrists. This presentation will seek to understand how psychiatrists view these and other potential obstacles to effective use of PADs, based on a randomly drawn survey of psychiatrists practicing in North Carolina, a state with a PAD statute since 1997. We will explore how clinicians view their clinical, ethical, and legal responsibilities to implement PADs. What are clinicians' understandings of the relevant laws relating to these issues? How do they interpret their own legal and ethical responsibilities with respect to PADs, particularly in situations involving disagreement about need for treatment, or conflict between patients, clinicians, and/or family members? These are some of the important questions to be answered by the results of the survey.

No. 77B
PREVALENCE AND DEMAND FOR PSYCHIATRIC ADVANCE DIRECTIVES IN THE U.S.

Jeffrey W. Swanson, Ph.D., *Department of Psychiatry, Duke University, DUMC Box 3071, Durham, NC 27710*

SUMMARY:

Although 20 states have adopted PAD statutes, there have been no studies examining the prevalence of or demand for PADs among people with severe mental illness. Data were collected from interviews with 1,011 individuals with severe mental illness receiving outpatient services in five states (NC, MA, FL, IL, CA). Descriptive data showed that approximately 7% of the sample completed a PAD or HCPA, but that 75% stated they wanted to complete a PAD or HCPA if they had assistance to do so. Preliminary multivariate analyses showed that completion of PAD was associated with greater insight into one's mental disorder, having a representative payee, recent involvement with police in transportation to treatment, and feeling pressured by others to keep mental health treatment appointments. The data showed that being female, nonwhite, history of self-harm, recent criminal justice contact, feeling pressured by others to take medication, and low sense of mastery and personal autonomy predicted wanting to complete a PAD. In sum, the findings indicate that although few subjects reported having actually completed a PAD and/or HCPA legal document, the majority of persons with severe mental illness surveyed indicated that they would prefer to have one.

No. 77C
PSYCHIATRIC ADVANCE DIRECTIVES: ISSUES FOR VETERANS WITH MENTAL ILLNESS

Marian I. Butterfield, M.D., *Department of Psychiatry, Durham VA Medical Center, 508 Fulton Street, 116A, Durham, NC 27705;* Jennifer L. Strauss, Ph.D., Eugene Oddone, M.D., Morris Weinberger, Ph.D., Timothy Wompler, M.S.W., Jennifer Zervakis, Ph.D.

SUMMARY:

This presentation continues the overall symposium theme of understanding and implementing psychiatric advanced directives (PADs). This talk will focus on the relevance of PADs to the Department of Veterans Affairs (DVA). The VA is the largest integrated mental health service system in the U.S. providing care to over 750,000 veterans per year, with an extensive integrated computerized medical record system. PADs are in keeping with the VA commitment to patient-centered care that involves veterans in their treatment decisions. The VA does have a national policy for medical advanced directives, which can be interpreted to extend to PADs. As federal mandates put forth in the Patient Self-Determination act, and a growing number of state statues establishing patient rights to prepare PADs, there is now a pressing need for local and national VA policies to address this issue. One layer of complexity is that in VA facilities, federal laws take precedence over state laws. For the DVA, PADs provide a new policy research opportunity for patient-centered care and a potential to plan for and streamline treatment during a mental health crisis. Will PADs be effective in a mental health crisis for veterans seeking mental health services in the VA? With a computerized VA medical record system, can PADs be accessible to VA providers? For veterans with SMI, can PADs serve to give voice to their treatment preferences and ideally improve clinical management and psychiatric outcomes? These issues and a recently funded VA randomized trial to evaluate PADs will be discussed.

No. 77D
PSYCHIATRIC ADVANCE DIRECTIVES: WHAT ARE PATIENTS' PREFERENCES?

Eric B. Elbogen, Ph.D., *Department of Psychiatry, Duke University, DUMC 3071, Durham, NC 27710*

SUMMARY:

To our knowledge, there has been no study describing the content of information documented in PADs by persons with mental illness. In this paper, we describe actual statements in PADs and evaluate whether patient preferences match community standards of care. Data were collected from 120 subjects with schizophrenia or related disorder receiving outpatient services at two mental health centers in North Carolina and who met with a study research assistant who helped the subject complete a PAD document as part of a larger randomized clinical trial of PADs. Content analysis is ongoing, but preliminary findings from the first 50 PADs showed: (1) all subjects listed medications they preferred or did not prefer in the event of a crisis; (2) no subjects refused all medications; (3) 32% listed conventional antipsychotics under medications they did not prefer; (4) 42% listed comorbid medical conditions and/or allergies that could have bearing on mental health treatment; (5) 88% of subjects wrote in their PADs that they wanted to be treated with respect by clinical staff in the event they were hospitalized. Overall, the findings suggest that patients tended to include reasonable and useful information in PADs that can facilitate mental health service delivery.

REFERENCES:

1. Srebnik DS, LeFond JQ: Advance directives for mental health treatment. Psychiatric Services 1999; 50(7):919-925.
2. Swanson JW, Tepper MC, Backlar PB, Swartz MS, Estroff SE: Psychiatric advance directives: an alternative to coercive treatment? Psychiatry 2000; 63(2):160-172.
3. Swanson JW, Tepper M, Backlar P, et al: Psychiatric advance directives: An alternative to coercive treatment? Psychiatry 2000; 63, 160-172.
4. Swanson JW, Swartz MS, Hannon MJ, Elbogen EB, Wagner HR, McCauley BJ, Butterfield MI: Psychiatric advance directives: a survey of persons with schizophrenia, family members, and treatment providers. International Journal of Forensic Mental Health 2003; 2:73-86.
5. Appelbaum P: Advance directives for psychiatric treatment. Hospital and Community Psychiatry 1991; 42, 983-984.

SYMPOSIUM 78—TEACHING PSYCHOPHARMACOLOGY FOR THE 21ST CENTURY
American Society of Clinical Psychopharmacology

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize recent developments and future goals in teaching modern era psychopharmacology.

No. 78A
THE CHALLENGE OF TEACHING PSYCHOPHARMACOLOGY IN THE NEW MILLENNIUM: THE ROLE OF CURRICULA

Ira D. Glick, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Suite 2122, Stanford, CA 94305-5723;* Sidney Zisook, M.D.

SUMMARY:

For a variety of pedagogical, political, and financial reasons, there are major problems in achieving effective teaching of cutting-edge psychopharmacology for psychiatric residents. This paper focuses on ways to improve the teaching/learning process, in part through the use of structured curricula. We review (1) attempted solutions to the educational problems including use of the 1980s ACNP and 2000 ASCP model curriculums; (2) evaluation of and obstacles to change, and (3) suggestions of what to do now. The long-term objective of improving the teaching/learning process is to improve the clinical practice of psychopharmacology.

No. 78B
ALTERNATE TEACHING VENUES

Sidney Zisook, M.D., *Department of Psychiatry, University of California, San Diego, 9500 Gilman Drive, # 0603R, La Jolla, CA 92093-0603;* Richard Balon, M.D., Richard Benjamin, M.D., Ira D. Glick, M.D., Alan Louie, M.D., Cynthia Santos, M.D.

SUMMARY:

Traditionally, didactic lectures and apprenticeship models of teaching have dominated psychiatric education. Yet, these traditional modes of training may not be fully satisfactory. There is more information about psychopharmacology than can possibly be imparted during residency, and much of that information is likely to change within a few years. Information taught in lectures is often forgotten, and not always applied clinically. It is therefore more important to teach residents to identify their own knowledge gaps and develop self-directed learning habits. Thus, new ACGME requirements stress the importance of assessing residents' competence in practice-based learning and improvement. The "new" psychopharmacology training must emphasize important skills and attitudes necessary to become and remain good physicians: clinical judgment, critical thinking abilities, development of interpersonal and reflective skills, professional identity, and functioning as a team member. This presentation will describe three different approaches to teaching psychopharmacology to psychiatric residents that take advantage of adult learning theory and that may compliment more traditional lectures and apprenticeship models: (1) integrated journal clubs and case conferences (the UMass Model), (2) problem-based learning modules (the UT Houston Model), and (3) real-time conjoint consultation (the UCSF Model). These alternative teaching venues are highly interactive, often even fun, and have been well received by faculty and residents where they have been employed.

No. 78C
TEACHING COLLABORATIVE AND INTEGRATED TREATMENTS FOR PSYCHIATRISTS

Richard Balon, M.D., *2543 Elm Brook Court, Rochester Hills, MI 48309-4077*

SUMMARY:

The combination of psychotropic medication(s) and various forms of psychotherapy has been found as most beneficial in various mental disorders. Psychotropic medications and psychotherapy could be delivered either by one person (integrated treatment) or by two persons (collaborative treatment). The latest residency review committee requirements mandate training programs to implement, among others, competency training in combined psychotherapy and psychopharmacology. Several texts address the issue of collaborative and integrated treatment, yet none has addressed the issue of training in this treatment approach. Training in collaborative and integrated treatment faces numerous questions, such as which approach to select (collaborative or integrated); when is integrated treatment superior

to collaborative treatment, and vice versa; what are the critical factors to the success of these approaches; how to start and sequence both approaches; how to relate to and communicate with the therapist in collaborative treatment; and how, when, and in what sequence to successfully terminate collaborative or integrated treatment. This presentation will discuss the teaching of practical skills of collaborative and integrated treatment using didactic lectures, interdisciplinary case conferences, supervision, and evaluation of competency in this treatment approach. Further discussion will include also the psychology of prescribing psychotropic medication, an important element of both approaches.

No. 78D
RESIDENT AS TEACHER: ARE WE READY FOR SOME CHANGES?

Andres Sciolla, M.D., *Department of Psychiatry, University of California, San Diego, 140 Arbor Drive, 0603G, San Diego, CA 92103*

SUMMARY:

Residents spend up to 20% of their time teaching medical students, junior residents, and health team members. Despite the importance of residents' role as teachers, half of residency training programs do not provide formal training in teaching. Worse, of five published, randomized controlled trials of resident teaching curricula, most have shown conflicting results or small size effects. This presentation will discuss two recent developments that might change this unpromising situation. First, a curriculum that has been validated recently in a randomized, controlled trial with educationally significant effect size is an example of a reproducible teaching skills intervention that can be carried out during existing noon conferences. Second, is the use of objective, structured teaching examinations (OSTE) to assess resident teaching competence. Residents who teach clinical psychopharmacology skills to medical students and non-psychiatric residents face unique challenges. Effective psychopharmacology requires a sophisticated application of a bio-psycho-social approach to patient care. These challenges offer unique opportunities to refine the above educational developments in future psychiatric education research.

No. 78E
PSYCHOPHARMACOLOGIC EDUCATION: INTERACTIONS WITH DRUG COMPANIES

Paul C. Mohl, M.D., *Department of Psychiatry, University of Texas, Southwestern, 5323 Harry Hines Blvd, Dallas, TX 75390-9070*

SUMMARY:

This presentation will address the educational and ethical issues involved in pharmaceutical industry support of psychiatric education. The ethical issues have led some educators to advocate eliminating all contact with drug companies. However, the presenter, while acknowledging the pitfalls and risks, identifies other ethical imperatives that suggest that psychiatric training programs should work carefully with pharmaceutical companies to enhance educational agendas.

The key is recognizing areas of confluence vs. conflicts of interest between psychiatric education and drug company marketing interests. Once recognized, for any given interaction, the balance can be analyzed and decisions made to seek and accept support, or not to. In order to implement this principle, it is paramount that control lies in the hands of the psychiatric educator. Examples of the application of these principles will be applied to such areas as funding of grand rounds, use of teachers whose research is supported by pharmaceutical companies, outside speaker dinners, national fellowships and awards, free samples, small gifts, reprint circulation, and meals for trainees.

Finally, an outline of an educational program to sensitize trainees to the dilemmas involved in their interactions with pharmaceutical companies will be presented.

REFERENCES:

1. Glick ID, Janowsky DS, Zisook S, Lydiard RB, Oesterheld JR, Ward NG, Ellison J, Halper J, Doraiswamy PM, Preven DW, Ross P, Klein DF: How should we teach psychopharmacology to residents? Results of the initial experience with ASCP model curriculum. Academic Psychiatry 2001; 25:90-97.
2. Stahl SM: The 7 habits of highly effective psychopharmacologists, part 3: sharpen the saw with selective choices of continuing medical education programs. J Clin Psychiatry 2000; 61:401-402.
3. Beitman BD, Glinder BJ, Thase ME, Riba MB, Safer DL: Integrating Psychotherapy and Pharmacotherapy. Dissolving the Mind-Brain Barrier. WW Norton & Company, New York, New York, 2003.
4. Wamsley MA, Julian KA, Wipf JE: A literature review of "Resident-as-Teacher" curricula. J Gen Intern Med 2004; 19(5 Pt 2):574-581.
5. Mohl PC: Psychiatric Training Program Engagement with the Pharmaceutical Industry: An Educational Issue, Not Strictly an Ethical One. Academic Psychiatry, in press.

SYMPOSIUM 79—TOXIC LOVE: CINEMA ON ROMANTIC LOVE AND ITS PATHOLOGIES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) conceptualize romantic love as a spectrum that spans "normality" and pathology, (2) use film as a teaching tool in discussing psychiatric concepts that abut the concept of romantic love, (3) recognize the need to view issues of romantic love within a broad and multi-disciplinary perspective, and (4) improve his/her practice by appreciating the nuances of human relationships using the narrative strategies of film.

No. 79A
USING MOVIES TO PORTRAY PATHOLOGIC INTERPERSONAL STYLES

Robert J. Boland, M.D., *Department of Psychiatry, The Miriam Hospital/Brown University, 164 Summit Avenue, Box G-MH, Providence, RI 02906-2853*

SUMMARY:

Videotapes and movies are often used in educational settings to demonstrate psychopathology. Though dramatic presentations can be useful for this purpose, there are important limitations to this method. The thesis of this presentation is that though television and movies are often successful at portraying the details (i.e., symptoms) of a disorder, they often misportray the personality behind the disorder. The style and quality of relationships, both love relationships and intimate contacts, are often over- and under-appreciated in the portrayals of mental illness. Examples from popular media will be used to demonstrate this thesis.

No. 79B
OBSESSIVE LOVE AND LOSS OF THE SELF IN RECENT FILMS

Anton C. Trinidad, M.D., *Department of Psychiatry/Psychosomatic Medicine, Washington Hospital Center, 110 Irving Street, NW, Washington, DC 20010*

SUMMARY:

The absorption of the self within the context of a love relation manifests in phenomena like stalking, violence, and suicide. Films like Lyne's Fatal Attraction, Wilder's Sunset Boulevard, and Almodovar's Talk To Her, visually articulate the process of the fusion of the individual to his/her love object; in this way, these films also narrate the continuity between a love that starts as normal but something that can easily transmogrify into the clinical realm. These films and others will be discussed to highlight the difficulties in a cleancut classification of love pathologies and the utility (or lack thereof) of turning to narrative film to understand contemporary Western culture's idea of normal romantic love.

No. 79C
RECENT FILMS ON THE SPECTRUM OF LOVE FROM NORMALITY TO PATHOLOGY

Anton C. Trinidad, M.D., *Department of Psychiatry/Psychosomatic Medicine, Washington Hospital Center, 110 Irving Street, NW, Washington, DC 20010;* Robert J. Boland, M.D.

SUMMARY:

Contemporary films such as Jeunet's Amelie and Brooks' As Good As it Gets te.. stories of psychiatric "caseness" through the strategy of film dramatization. These films chronicle the search for a love object among characters drawn as neurotic. Narrated within the genre of a comedy, it can be argued that these films defend against the pathos of their neurotic characters through the strokes of comedic interpretation. It can also be argued that these films nay actually represent normal love. Other films such as Sofia Coppola's Lost in Translation will be cosidered as representations sitting within a fluid spectrum from classifiable psychopathology to normality. We will explore these antipodal positions at length and the audience participates in situating these characters within this spectrum. We will ask these questions: Do cinematic interpretations accurately portray psychiatric conditions? Can we justifiably turn to films to wnrich our paychiatric knowledge base?

REFERENCES:

1. Cook DA: A History of Narrative Film. New York, WW Norton, 1996.
2. Gabbard GO, Gabbard K: Psychiatry and the Cinema, 2nd ed. Washington, D.C., American Psychiatric Press, 1998.
3. Fleming MZ, Peidmont RL, Hiam CM: Images of madness: feature films in teaching psychology. Teaching of Psychology 1990; 17(3):185-187.
4. Kernberg O: Internal World and External Reality: Object Relations Theory Applied. New York, Jason Aronson, 1980.

SYMPOSIUM 80—DEFINING MENTAL DISORDER IN DSM-V: PROBLEMS AND CHALLENGES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the difficulties inherent in defining mental disorder for psychiatric classification, and appreciate the implications of using different approaches to the problem.

No. 80A
WHAT CAN A DSM DEFINITION OF MENTAL DISORDER DO? WHAT SHOULD IT DO?

John Sadler, M.D., *Department of Psychiatry, UT Southwestern, 5323 Harry Hines Boulevard, Dallas, TX 75390-9070*

SUMMARY:

Since DSM-III an explicit definition of mental disorders has been offered, intended to guide inclusion or exclusion of categories and criteria for mental disorders. However, recent literature has questioned the utility of the DSM definition for these purposes. If the DSM definition of mental disorder is of limited value for this purpose, two questions pose themselves: (1) "How can the DSM definition be revised so that it serves its original function more effectively?" and (2) "If not for guiding clinical judgments about disorder or no disorder, then for what purposes should we have a DSM definition?" This presentation addresses the latter question. Six additional potential functions for a DSM definition for mental disorders are discussed: (1) preventing false-negative or false-positive diagnoses, (2) presenting a rhetorical device for addressing antipsychiatry, (3) staking out mental-health turf, (4) a means for making metaphysical (the nature of things) claims about mental disorders, (5) a reassurance to insurers about the worthiness of mental health treatment, (6) an educational tool about mental illness. The professional significance of each function will be discussed, and the conclusion made that any definition of mental disorder implies important values that bear on clinical practice, public policy, education, and research.

No. 80B
THEORETICAL MODELS OF SCIENTIFIC CLASSIFICATION AND THE DSM-V

Peter Zachar, Ph.D., *Department of Psychology, Auburn University Montgomery, P. O. Box 244023, Montgomery, AL 36124*

SUMMARY:

Many different theories about the nature of scientific categorization are relevant for psychiatric nosology in general and the DSM-V in particular. Two common theories are essentialist theories and nominalist theories. Essentialist theories claim that psychiatric disorders are objectively real and defined by true underlying properties. Nominalist theories often claim that psychiatric disorders are not real categories, rather, they are constructions and arbitrary with respect to the objective world. A more modern kind of nominalism, called the practical kinds model, holds that psychiatric disorders are too complex to be simply defined by true underlying properties, but they are still real things. The geneticists' spectrum disorder concept is one example of this kind of model. This talk is for mental health professionals interested in philosophical issues related to classification.

No. 80C
CAN A FAMILY HAVE A MENTAL DISORDER?

Christian D. Perring, Ph.D., *Department of Philosophy, Dowling College, Idle Hour Blvd, Oakdale, NY 11769*

SUMMARY:

DSM assumes that mental disorder must be attributed to an individual rather than a group of people. This assumption is problematic in child and adolescent psychiatry where often the focus of clinical attention is the family system. There is substantial evidence that

some mental disorders of individuals are caused by their relationships with other people and furthermore the return to functionality is greatly facilitated by treating the group, such as a family, as a whole. However, there has been little conceptual work on defining what mental disorder might mean when applied to a couple, family, or other group. Through examining a debate on whether it is part of the concept of a mental disorder that must be caused by an internal malfunction of a person and a proposal that we do away with the concept of mental disorder altogether and instead use a broader concept of mental health problem, the paper argues that it is not an a priori conceptual truth that mental disorders are essentially of individuals. Rather than starting with a narrow definition of mental disorder, we need to bring in pragmatic considerations to decide whether it is helpful to restrict ourselves to such a definition or whether we could be better served by a more expansive definition.

No. 80D
THE CONCEPT OF MENTAL DISORDER: PSYCHIATRY'S GORDIAN KNOT

Claudio E.M. Banzato, M.D., *Department of Psychiatry, State University of Campinas (Unicamp), PO Box 6111, Campinas 13081-970, Brazil*

SUMMARY:

Medicine has pragmatic rather than logical boundaries. In psychiatry, it has long been at stake the question of the boundaries both between normal and pathological and within the highly heterogeneous group of the mental disorders. Not only continuity from normality seems to be the rule, but also the very disease entity concept is yet to be empirically corroborated. In this state of affairs, the intentionally loose concept of mental disorder is expected to perform several different roles, both for clinical and research purposes. However, it is necessary to pay close attention to the way such concept is ordinarily used, as it may carry important ethical implications. The general concept of mental disorder should help to define the field of psychiatry and to establish its legitimacy, without explaining away its intrinsic tensions, scientific and politic. It is also desirable that such concept proves to be theoretically fruitful. There is nothing wrong with the current pragmatic approach regarding the concept of mental disorder, as far as the several kinds of key factors that come into play are properly acknowledged and articulated. In sum, any provisional concept of mental disorder should stand as a constant reminder of the inevitable tensions faced by psychiatry.

REFERENCES:

1. Sadler JZ: Values and Psychiatric Diagnosis. Oxford, Oxford University Press, 2004.
2. Zachar P: The practical kinds model as a pragmatist theory of classification. Philosophy, Psychiatry, and Psychology 2002; 9:219-227.
3. Murphy D, Woolfolk RL: The harmful dysfunction analysis of mental disorder. Philosophy, Psychiatry, and Psychology 2000; 7(4):241-252.
4. Fulford KWM: Moral theory and medical practice. Cambridge, Cambridge University Press, 1989.

SYMPOSIUM 81—CULTURAL ASPECTS OF PSYCHIATRIC DIAGNOSIS: TOWARD A NEW CLASSIFICATION
APA Council on Global Psychiatry

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) recognize the relevance of cultural factors in the delineation of psychiatric diagnoses, (2) combine the cultural perspective with other approaches toward a comprehensive diagnosis, and (3) identify research areas in psychiatric diagnosis at the U.S. and international settings.

No. 81A
CULTURAL VIEWS FROM U.S. MINORITIES AND RELEVANCE OF THE CULTURAL FORMULATION

Annelle B. Primm, M.D., *Office of Minority/National Affairs, American Psychiatric Association, 1000 Wilson Boulevard, Arlington, VA 22209;* Russell F. Lim, M.D.

SUMMARY:

The DSM-IV-TR represents a major breakthrough for culture and psychiatric diagnosis in the western world. In DSM-III-R (revised), there were few references to culture. DSM-IV-TR has an Outline for Cultural Formulation, a Glossary of Culture-Bound Syndromes, as well as diagnosis-specific considerations in each of the narrative sections, and culturally sensitive diagnostic categories. Uses of the cultural formulation in resident education will be presented to show its usefulness as a diagnostic and teaching framework.

The APA supports the continued focus on the effect of culture on diagnosis in DSM-V, the next edition. Research has shown that minorities are more likely to be misdiagnosed with a psychotic disorder instead of an affective disorder. The Surgeon General's Supplement to the Report on Mental Health, "Mental Health: Culture, Race and Ethnicity" states that minorities have less access to appropriate care due to cultural and linguistic differences, and there are insufficient numbers of ethnic minority mental health professionals, conclusions supported by The Institute of Medicine's two reports, "Unequal Treatment," and "In the Nation's Compelling Interest." The presentation will provide examples of APA programs designed to increase the diversity of the workforce and minority involvement in research through development of residents from under-represented groups.

No. 81B
AN UPDATE ON RACE, ETHNICITY, AND CULTURE IN CURRENT PSYCHIATRIC LITERATURE

Roberto Lewis-Fernandez, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, Room 3200, Unit 69, New York, NY 10032;* Maria A. Oquendo, M.D., Ivan Balan, Ph.D., Dana Wachtel, Ph.D., Naelys Diaz, M.S.W., Anne O'Connell, M.D., Renato D. Alarcon, M.D.

SUMMARY:

The use of race and ethnicity categories in psychiatric research has risen steadily over the last decades. This is due in part to growing awareness of the association of minority status with disparities in psychiatric disorder prevalence and outcome, specialty care access, and misdiagnosis. Federal agencies, such as the NIMH and the surgeon general's office, either require or actively encourage psychiatric research along racial and ethnic categories in order to identify and correct the source of these disparities. At the same time, the use of race and ethnicity as analytical variables has come under criticism in public health, epidemiology, and anthropology. Critique of these categories centers on their vague and inconsistent definitions, their lack of relationship to biological markers, their potential confounding of illness determinants such as poverty or racism, and their ability to obscure intra-racial (or -ethnic) sociocultural heterogeneity. The contemporary status of race, ethnicity, and cultural categories in psychiatric research has received little empirical attention. We will present data on the use of these categories in seven mainstream

psychiatric journals during 2000-2002 as compared with other demographic variables, such as gender or SES. A critique of specific design and analytical strategies involving these categories will also be presented.

No. 81C
EPIDEMIOLOGY, DIAGNOSIS, AND CULTURE

Bedirhan T. Ustun, M.D., *Department of Classification, World Health Organization, 20 Ave Appia, Geneva Ch 1211, Switzerland*

SUMMARY:

Epidemiological studies in mental health have raised the question of applicability of a set of uniform standard criteria and questions in different cultures. Because all the mental health surveys depend on self-reported answers to questions, context of the interview plays an important role in eliciting the responses. The issue goes beyond a proper formulation and translation of the intended questions as to whether we could capture the same essential human experience in different individuals. Given the assumption that mental disorders rise from underlying brain dysfunctions, their manifestations should be similar in different members of the human species. Culture, however, plays an important role in shaping the content of the symptoms as well as their reporting and interpretation. Epidemiological data from the recent WHO surveys will be presented to illustrate various examples of similarities and differences in international studies. Methods borrowed from social sciences to elicit, understand, and account for differences, will be proposed.

No. 81D
DIVERSITY IN DIAGNOSIS ACROSS CULTURES

Ahmed M.F. Okasha, M.D., *Institute of Psychiatry, Ain Shams University, 3, Shawarby Street, Kasr El-Nil, Cairo, Egypt;*

SUMMARY:

The United States will no longer have a white majority in the second half of the 21st century. Thus, the domestic as well as the international utility of DSM-IV and its successors will depend on suitability for use with many different cultures. All medical diagnoses are socially constructed. The concepts we invent to account for disease come to shape not only the observations we make and the remedies we prescribe, but also the very manifestations of disease itself. Beliefs about mental disorder have real consequences for the behavior of patients, physicians, and society. The ultimate criterion for the longevity of a classification is utility; the difficulty is that there is not one utility but many utilities, each serving different purposes. What suits one may not fit another. A clinical classification that captures most outpatient attenders may be poorly suited for research uses.

This body of work documents and clarifies how cultural factors influence (1) the experience of psychopathology, (2) the manifestations, assessment, and course of mental disorders, and (3) response to treatment, wherever these processes take place, not only in exotic locations. The cultural contribution to diagnosis was outlined in DSM-IV. The text will clarify how the concept of diagnosis in some traditional societies is dependent upon how they perceive mental illness as a whole and how they express their psychopathology.

No. 81E
APA'S WORK TOWARD DSM-V: THE CULTURAL COMPONENT

William E. Narrow, M.D., *Department of Research, American Psychiatric Association/APIRE, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209*

SUMMARY:

As the United States becomes increasingly multicultural and globalization becomes the norm, the developers of the DSM-V will need to respond to these trends. The APA is currently working to set multiple research agendas in advance of DSM-V. This work includes the development of white papers on broad diagnostic issues, as well as a multi-year, NIH-supported conference series focusing on specific diagnostic categories. These efforts have attended to national and international cultural issues in research, which will be detailed in this presentation. Recommendations of the White Paper on Culture and Psychiatric Diagnosis will also be presented. Finally, implementation of culturally-cognizant research agendas will be discussed along with potential gaps, barriers, and solutions.

No. 81F
ACUTE PSYCHOSES: CROSS-CULTURAL AND CROSS-SYSTEM COMPARISONS

Byron J. Good, Ph.D., *Department of Social Med, Harvard Medical School, 641 Huntington Avenue, Boston, MA 02115*

SUMMARY:

Significant differences remain in the nomenclature and diagnostic criteria for acute psychotic disorders, classified as brief psychotic disorder in DSM-IV and acute and transient psychoses in ICD 10. These differences reflect considerable conceptual disagreement, historically and across intellectual traditions, about the nature of psychoses, which have very rapid onset and good prognosis, raising questions about "atypical psychoses" that fit poorly in subcategories of affective disorders or schizophrenia. Cross-cultural differences are especially significant in this domain, with Ezra Susser arguing that rates of "non-affective, acute, remitting psychoses" may be ten times greater in some low income countries than in Europe and North America, and that the mean duration of acute onset psychoses is four months. Given recent interest in the influence of prodrome and early phases of psychosis on prognosis, acute psychoses may assume special importance. This paper will review the literature on acute psychotic disorders and present data from research in Indonesia. The paper will conclude by raising specific questions about the diagnostic criteria for brief psychotic disorder, including the importance of rapid onset versus short duration, and making suggestions for empirical research that is needed to enhance reliability and validity of diagnosis of the acute psychoses.

REFERENCES:

1. United States Department of Health and Human Services: Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General Rockville, MD: US Dept of Health and Human Services, Public Health Service, Office of the Surgeon General, 2001.
2. Comstock RD, Castillo EM, Lindsay SP: Four-year review of the use of race and ethnicity in epidemiologic and public health research. American Journal of Epidemiology 2003; 159:611-619.
3. Kessler RC, Ustun TB: The World Mental Health Survey Initiative Version of the World Health Organization (WHO) Composite International Diagnostic Interview (CIDI). International Journal of Methods in Psychiatric Research 2004; 13(2):93-121.
4. Eisenberg L: Foreword, in Culture and Psychiatric Diagnosis, a DSM-IV Perspective. Edited by Mezzich J, Kleinman A, Fabrega H, Parron D. American Psychiatric Press, Washington DC, 1996.
5. Alarcon RD, Bell CC, Kirmayer LJ, Lin K-M, Ostün B, Wisner KL, Alegria M, Boyce C, Jackson JS, Lopez S, Rubio-Stipec M, Takeuchi D: Beyond the funhouse mirrors: research agenda on culture and psychiatric diagnosis, in A Research Agenda for DSM-V. Edited by Kupfer DJ, First MB, Regier DA. Washington DC, American Psychiatric Association, 2002, pp 219-289.

6. Susser E, Finnerty MT, Sohler N: Acute psychoses: a proposed diagnosis for ICD-11 and DSM-V. Psychiatric Quarterly 1996; 67:165-76.

SYMPOSIUM 82—DEPRESSION AND COMORBID PERSONALITY DISORDERS: IMPLICATIONS FOR TREATMENT

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participants should be able to (1) recognize the implications of comorbidity of depressive disorders and personality pathology, and (2) will have an overview of the state of the art concerning this comorbidity.

No. 82A
EFFICACY OF PHARMACOTHERAPY COMPARED WITH COMBINED THERAPY FOR DEPRESSED PATIENTS WITH OR WITHOUT PERSONALITY DISORDERS

Mariëlle Hendriksen, M.A., *AAZ West, Mentrum Mental Health Organisation, Frederik Hendrikstraat 47, Amsterdam 1052 HK, Netherlands*

SUMMARY:

In a second RCT, patients with major depression were treated either with pharmacotherapy or combined therapy (antidepressant medication plus psychotherapy). Patients with comorbid personality pathology responded significantly better to combined therapy than to pharmacotherapy alone. In patients without comorbid personality pathology, combined therapy was not more effective than pharmacotherapy alone for the treatment of depression.

The results of these studies suggest that, in depressed patients with comorbid personality pathology, combined therapy is the best option. In depressed patients without personality pathology, combined therapy is not more effective that either psychotherapy or pharmacotherapy alone. The implications of these findings for both our theoretical understanding of the issue of comorbidity and for clinical practice will be discussed.

No. 82B
THE INFLUENCE OF PERSONALITY PATHOLOGY ON THE EFFICACY OF PSYCHOTHERAPY AND COMBINED THERAPY FOR DEPRESSIVE DISORDERS

Henricus L. Van, M.D., *Mentrum Mental Health Institute, Postbus 75848, 1070 AV Amsterdam, Netherlands*

SUMMARY:

Objective: In clinical practice, it is frequently argued that comorbid personality pathology has a negative influence on both course and results of treatment of Axis I disorders.

In this study the following research questions are addressed: do depressive patients with comorbid personality disorder have poorer results of treatment and do they have to be treated differently?

Method: On two outpatient departments, 208 patients with a mild-to-moderate depression were included in a RCT. Treatment consisted of either short-term psychodynamic psychotherapy (SPSP) alone, or SPSP in combination with antidepressants. Outcome was measured with a HDRS administrated by an independent observer. Personality was measured by the Dutch, self-reporting version of the IPDE.

Results: The main finding is that depressive patients with comorbid personality pathology show significantly better response to combined therapy, compared with psychotherapy alone. However, in patients without personality pathology, no difference on outcome of the two treatment conditions have been found. Adjustment for severity and duration of depression have no influence on these results.

Conclusions: This study suggests that depressive patients with comorbid personality pathology should be treated with combined therapy, whereas in patients without such pathology, psychotherapy alone is sufficient.

No. 82C
CHANGES IN PERSONALITY PATHOLOGY AFTER TREATMENT OF MAJOR DEPRESSION WITH COMORBID PERSONALITY PATHOLOGY

Simone Kool, M.D.; *Mentrum Mental Health Institute, Postbus 75848, 1070 AV Amsterdam, Netherlands*

SUMMARY:

Personality characteristics are considered to be stable criteria that do not easily respond to short-term treatment of depression. The results of our studies, however, suggest that this view may not be sustainable. We examined whether treatment with pharmacotherapy or with combined therapy produces different changes in personality pathology at follow-up after 40 weeks. The study population consisted of 128 outpatients in whom personality pathology and severity of depression were determined at the start of the study. For 72 patients, this was determined again after 40 weeks. Of the group of 72 patients, 25 patients received only pharmacotherapy for six months and 47 patients received combined treatment. We also measured whether recovery from depression has an influence on outcome.

Personality scores at follow up were significantly lower for the group as a whole than at the start. Combined therapy resulted in a greater improvement in personality pathology than pharmacotherapy alone. Recovery from depression also played a significant role. There was more improvement in terms of personality disorders in patients who had recovered from depression than in patients who had not recovered, particularly with pharmacotherapy. With combined treatment, recovery from depression did not have any effect on the reduction of personality pathology.

No. 82D
NONADHERENCE TO PHARMACOTHERAPY, PSYCHOTHERAPY, OR COMBINED THERAPY IN THE TREATMENT OF DEPRESSED OUTPATIENTS WITH OR WITHOUT COMORBID PERSONALITY DISORDER

Gerda van Aalst, M.D., *AAZ West, Mentrum Mental Health Organization, Frederik Hendrikstraat 47, Amsterdam 1052 HK, Netherlands*

SUMMARY:

Non-adherence is significant problem for effective treatment of major depressive disorder with high dropout rates. In longer therapies, the addition of psychotherapy to pharmacotherapy helps to keep patients in treatment. Depression is often complicated by the presence of comorbid personality disorder. Adherence to therapies in patients with depression and comorbid personality disorder is scarcely investigated.

The purpose of this study was to explore non-adherence to pharmacotherapy, psychotherapy, or combined therapy in two patient groups: depressed outpatients with or without comorbid personality disorder.

In two randomized, controlled trials over 24 weeks, we evaluated a sample of depressed outpatients (n=333) receiving pharmacotherapy,

psychotherapy, or combined therapy. We defined adherence to pharmacotherapy as the percentage of days that patients took the correct amount of prescribed antidepressants. In the psychotherapy condition we defined adherence as the percentage of completed therapy sessions that patients were offered. We assessed personality characteristics with the IPDE. We also assessed depression severity, psychiatric and somatic complaints, demographic data, coping mechanism, and quality of life.

After 24 weeks, dropout rates differed between treatment conditions. There were no differences in dropout rates between patients with or without comorbid personality disorder. Other outcome data will be presented and discussed.

No. 82E
A META-ANALYSIS OF TREATMENT STUDIES IN DEPRESSED PATIENTS WITH OR WITHOUT PERSONALITY DISORDER

Robert A. Schoevers, M.D., *Program Director, Mentrum Mental Health Care, 2e Constantijn Huijgensstraat 37, Amsterdam 1054 AG, Netherlands*

SUMMARY:

According to clinical lore, treatment of depression is less effective in patients with comorbid personality disorder. Available studies, however, show conflicting findings. The association between treatment results and personality disorder may depend on a number of methodological and clinical differences between studies, such as the assessment of personality disorder, study design, depression characteristics, types of intervention, follow-up time and outcome criteria. A meta-analysis is presented in which data are pooled using only high-quality, randomized clinical trials, and differentiating pharmacotherapy, psychotherapy, and combined therapy. The evidence suggests that overall, treatment of depression in patients with personality disorder is (nearly) as effective as in patients without comorbid personality disorder. These conclusions will be discussed and compared with the findings from the Mentrum Depression Research Project.

REFERENCES:

1. Kool S, Dekker J, Duysens I, de Jonghe F, Puite B: Efficacy of combined therapy and pharmacotherapy for depressed patients with or without personality disorders. Harvard Review of Psychiatry 11, 133-141.
2. Jonghe de F, Hendriksen M, Aalst van G, Kool S, Peen J, Van HL, Eijnden van de E, Dekker J: Psychotherapy alone and combined with pharmacotherapy in the treatment of depression. Br J Psychiatry 2004; 185:37-45.
3. Kool S, Dekker J, Duysens I, de Jonghe F: Changes in personality pathology in depressed patients with pharmacotherapy and combined therapy. Journal of Personality Disorders 2003; 17:60-73.
4. Pampallona S, Bollini P, Tibaldi G, Kupelnick B, Munizza C: Combined pharmacotherapy and psychological treatment for depression Arch Gen Psychiatry 2004; 61714-719.
5. Mulder RT: Personality pathology and treatment outcome in major depression: a review. Am J Psychiatry 2002; 159(3):359-71.

SYMPOSIUM 83—APA WOMEN PRESIDENTS: LESSONS LEARNED, ROAD AHEAD
Association of Women Psychiatrists

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the road to leadership, ways to facilitate participation in the system, and the role of gender in the process of effecting change.

No. 83A
HOW TO OPEN DOORS AND KEEP THEM OPEN

Carol C. Nadelson, M.D., *Beth Israel Hospital, 30 Amory Street, Brookline, MA 02446*

SUMMARY:

As the first woman president of the APA, I will discuss my personal journey, how I came to it, what I learned about women in leadership positions, and my reflections almost 20 years later, both personally and professionally. I will also consider the challenges for women in psychiatry leadership in the future.

No. 83B
CREATING CHANGE, EVALUATING RESPONSES, AND PARTICIPATING IN THE NEW COURSE

Elissa P. Benedek, M.D., *Department of Psychiatry, University of Michigan, 2311 East Stadium, Suite 111, Ann Arbor, MI 48104*

SUMMARY:

At the time I became the second woman president of the APA, the reality of women holding leadership positions in this association and in other walks of life was still a novelty. Our struggle represented the struggle of a gender trying to institutionalize what had become a socio-cultural movement for equal opportunity in the workplace and in life in general. The gains have been obvious; still the meaning of these gains need to be seen in perspective to secure that women's presence in "leadership" positions are more than a token gain. These concepts will be developed in the context of how the power of the presidency has changed and how one can remain involved after one's term.

No. 83C
BEYOND APA PRESIDENCY: LEADERSHIP AS A WAY OF LIFE

Mary Jane England, M.D., *Regis College, 235 Wellesley Street, Weston, MA 02493-1571*

SUMMARY:

By the time I became APA third woman president, I had had the advantage of two wonderful role models ahead of me. Still the challenges to become a recognized woman leader, and the road to follow were still very much unmarked. Women that wish to become leaders and pioneers have to understand that the desire to participate, to be heard, to be respected, and to make a difference, permeates all facets of their lives. To succeed in fully expressing one's individuality while committing oneself to participate in the fabric of society is the true meaning of leadership. To express such desire and capacity in our personal and professional lives, in a world that while more open and benevolent to our full participation is still concerned about such participation is the challenge of the current and future generations of professionals. This talk will try to develop such concepts based on a life-long commitment to serve.

No. 83D
ASSERTIVE OR AGGRESSIVE?

Marcia K. Goin, M.D., *Department of Psychiatry, University of Southern California, 1127 Wilshire Boulevard, Suite 1115, Los Angeles, CA 90017-4085*

SUMMARY:

There is often a different kind of emotional reaction to an assertive woman championing a cause than when a man mouths the same

words with similar intensity. The former may be seen as frighteningly aggressive and the latter appropriately passionate. Rather than decry these differences, it is important to examine and understand them. Potential stumbling blocks can be mastered with exciting success.

This presentation will explore the struggle within, the useful means to move forward, and the future generations it breeds. Fathers and brothers are often integral to the success of this process. The men in ones adult life, at work and at play, also have an important role. A hard look at femininity and freedom from stereotypes can lead to the accomplishment of many of things.

No. 83E
SUCCESS IS A TEAM EFFORT

Michelle B. Riba, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0295*

SUMMARY:

I have been extremely proud to serve as the President of the American Psychiatric Association. It has been a wonderful journey and I have many women and male friends, colleagues, teachers, and mentors to thank for this achievement.

One of the important goals during my presidency has been to increase the number of psychiatry residents who are choosing research careers. I was fortunate enough to be part of the 2001 Institute of Medicine Committee that was commissioned by the NIMH. Our report, Research Training in Psychiatry Residency: Strategies for Reform, was published in October 2003. As the committee studied and reviewed the many obstacles for psychiatry residents, it was clear that gender issues were an important barrier for many women who might be interested in research careers. The committee tried to provide recommendations that included the formation of a national coordinating body that could integrate research training into psychiatry residency and also to monitor the efforts that would need to be undertaken. In 2004, NIMH Director Tom Insel convened the National Psychiatry Training Council (NPTC). The work of the council focused on integrated training, flexibility, collaboration, interaction with the RRC, mentorship, etc.

This is an important issue for our field, for our psychiatry residents, and for our patients. It is important that we review the obstacles that exist and develop flexible strategies to allow for success in achieving research and academic excellence in residency training. The APA is a strong partner in this effort.

REFERENCES:

1. Dickstein L, Nadelson C, (eds): Women Physicians in Leadership Roles. Washington, DC, American Psychiatric Press, 1986.
2. Jamieson KH: Beyond the Double Bind, Women and Leadership. Oxford University Press, NY, Oxford, 1995.
3. Chin EL (Editor): This Side of Doctoring. Reflexions From Women in Medicine. Sage Publications Inc. California, London, New Delhi, 2002.
4. Marmor J: Changing patterns of femininity: psychoanalytic implications. The Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry 2004; (32)1:7-20.
5. Research Training in Psychiatry Residency: Strategies for Reform. Institute of Medicine, 2003.

SYMPOSIUM 84—NATIONAL HEALTH INFORMATION INITIATIVE AND PSYCHIATRY
American Association for Social Psychiatry and American Association for Technology in Psychiatry

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to summarize the development of the national health information initiative, goals, and plans.

No. 84A
HEALTH INFORMATION TECHNOLOGY: A FRAMEWORK FOR STRATEGIC ACTION

Rex W. Cowdry, M.D., *ONCHIT, U.S. Department of Health and Human Services, 3101 34th Street, N.W., Washington, DC 20008-3308*

SUMMARY:

If implemented well, health information technology (HIT) has the potential to transform health care delivery. HIT provides a potentially powerful tool to provide better information at the time and place of care, improving the quality and cost effectiveness of care and preventing medical errors. But beyond that, HIT can empower both patients and providers with information, enlist patients in the active management of chronic illnesses, and help integrate a health care system often criticized as fragmented. Finally, HIT can usher in a new era of clinical and health services outcomes research based on actual practice, while providing public health surveillance for natural and terrorist threats. However, major challenges—cultural, technological, economic, and privacy-related—must be addressed to allow the timely and secure exchange of information while protecting privacy. The Framework for Strategic Action outlines the promise, the challenges, and the private and public actions necessary to develop a secure nationwide network, to promote regional health information organizations, and to assure widespread adoption of interoperable electronic medical records while protecting sensitive information about our health care.

No. 84B
NATIONAL HEALTH INFORMATION: GENERAL MEDICINE

Zebulon Taintor, M.D., *Department of Psychiatry, NYU School of Medicine, Nathan Kline Institute for Psychiatric Resear, Orangeburg, NY 10962*

SUMMARY:

Medicine's priorities for this initiative include those announced in the executive order creating national health information coordinator: ensure that doctors have information available to make decisions, reduce errors, evidence-based care, choice, outcome data, improve information coordination and sharing, patient and community health information, and privacy and confidentiality. Special concerns center around mortality, mistakes/malpractice, disasters/terrorism, and administrative burdens. Mortality trumps confidentiality, but morbidity does not. Specific information must be available immediately to avert potentially fatal drug interactions. Electronic prescribing is fast, reduces errors, and builds a data set of the patient's medications to which treating physicians of various specialties can have access. But there is time to be concerned with confidentiality when a patient has a chronic condition. Mistakes and malpractice must be reduced

simultaneously, so certain documents should not be discoverable in civil actions. How can medicine provide enough evidence of error reduction to justify changing current legal practices, and what allies might emerge to help? Disaster/terrorism crises require both access to evidence for diagnosis and treatment as well as communication with individual physicians and those who would deploy them. No initiative will succeed unless it reduces administrative burdens, especially paperwork, and helps deal with second-guessing by third-party reimbursers.

No. 84C
NATIONAL HEALTH INFORMATION: PSYCHIATRIC TREATMENT SYSTEMS AND THE APA

Steven S. Sharfstein, M.D., *Sheppard Pratt Health System, 6501 North Charles Street, Baltimore, MD 21204*

SUMMARY:

From the standpoint of the Sheppard Pratt Health System, a system that helped in the care for patients would be most welcome. We know services in 2003 were to 34,000 individuals, who received 799,306 mental health services provided by 1,500 employees. We have the ability to count what we do and have data on who we serve. But we don't know outcomes as much as we'd like. We'd like more reassurance about not making errors. We don't want data we have collected in the course of attempted self-improvement to be discoverable in a malpractice suit. We'd like to have a system that enabled us to monitor both clinical outcomes and progress toward our goals and future plans, which include contracting with general hospitals, emergency services, etc. Where do we go for such a system? How should it be set up to fit in with the initiative?

The APA has had its own information issues and an overwhelming and proper concern with confidentiality and privacy. Information systems are related to its vision statement. Service to members must include helping them deal with the health information initiative.

No. 84D
NATIONAL HEALTH INFORMATION: GENERAL HOSPITAL AND ADDICTION PSYCHIATRY

Richard N. Rosenthal, M.D., *Department of Psychiatry, Saint Luke's Roosevelt Hospital Center, 1090 Amsterdam Avenue, 16th Floor, Suite G, New York, NY 10025*

SUMMARY:

St. Luke's-Roosevelt Hospital is the result of a 1979 merger that brought together hospitals established in 1846 and 1871. Aspects of the two hospital cultures can still be encountered. There are 1,076 inpatient beds, of which 162 are devoted to psychiatry, and a complete range of specialty and subspecialty clinics and training programs. While some aspects of psychiatry are independent, it is expected to function like any other hospital department and play for the team, including using hospital information systems. There are various trade-offs and compromises in this process.

Addiction medicine is an important bridge between psychiatry and general medicine, as addictions have medical consequences and often present on medical services. Stigma problems and potentially lethal situations abound. Thus, the American Academy of Psychiatrists in Alcoholism and the Addictions is a psychiatric subspecialty organization with a very wide scope. Its members would welcome a chance to help design and participate in systems that can save lives; maintain privacy; reduce discrimination in insurance coverage; track impulsive, often transient, and self-defeating people; show cost offsets and benefits from addiction treatment; and show the efficacy of different prevention strategies.

No. 84E
NATIONAL HEALTH INFORMATION: PRIVATE PRACTICE, RURAL, AND ACADEMIC PSYCHIATRY

Joel Yager, M.D., *Department of Psychiatry, University of New Mexico, School of Medicine, 1 University of New Mexico, MSC09 5030, Albuquerque, NM 87131-0001*

SUMMARY:

Private practice psychiatry is involved in justifying treatment and submitting bills. Increasingly, going for self-pay and perhaps lower fees is attractive as mental health benefits shrink and paperwork burdens mount. However, this disenfranchises those who can't pay. Private psychiatric practitioners getting third-party reimbursement share the problems of downcoding, reimbursement demands, paperwork burdens without sharing rewards, etc., as their other medical colleagues, so common causes abound.

Rural psychiatry benefits from e-mail and teleconferencing capabilities. Would New Mexico have legislated psychologist prescribing privileges had these been so fully developed that psychiatrist availability could have bene convincingly demonstrated? Reimbursement strategies must keep up with new services:

Academic psychiatry has many information system priorities and interests, but often is at the mercy of those actually paying for whatever information system is being used. Organized psychiatry and academic medicine diverged in responding to HIPAA. There are special burdens for resident logs and documenting what information is divulged to whom. Research in academic departments has the most to gain from good information systems, and this initiative comes at a time when academic psychiatry is looking for ways to train more psychiatrist-researchers without sacrificing much curriculum time.

REFERENCES:

1. Office of the National Coordinator for Health Information Technology: The Decade of Health Information Technology: Delivering Consumer-centric and Information-rich Health Care (A Framework for Strategic Action). DHHS, 2005. http://www.hhs.gov/healthit/documents/hitframework.pdf
2. Taintor Z (Ed): Computers and the Psychiatric Patient. Washington D.C., American Psychiatric Press, Inc., 1997, p 87.
3. Eylers EM: The quality of health care in America. NEJM 2003(26); 365: 2435-2445.
4. Taintor Z: Confidentiality and Outcome, in Outcome in Psychiatry Edited by Sedener L, Burt T, Is-Hak W. Washington, American Psychiatric press. 2003, pp 351-359.

SYMPOSIUM 85—DISSEMINATION OF EVIDENCE-BASED MENTAL HEALTH MODELS
Collaborative Session With the National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to understand the evidence for mental health services interventions and key issues in dissemination of these models.

No. 85A
SUCCESSFUL MODELS FOR TREATMENT OF DEPRESSION AND ANXIETY IN PRIMARY CARE

David J. Katzelnick, M.D., *Healthcare Technology Systems, Incorporated, 7617 Mineral Point Road, Suite 300, Madison, WI 53717*

SUMMARY:

Outcomes for primary care patients with major depression can be improved by 20% or more, and are cost effective as demonstrated by numerous effectiveness studies. Key components of successful depression care programs will be discussed, including clinician decision support, patient self-management, care management (proactive monitoring of depression severity, visits, and prescriptions), and access to mental health specialists. Most successful models include multiple rather than single components.

Multiple barriers have inhibited dissemination of evidence-based depression treatment but this is rapidly changing. A new generation of dissemination initiatives is spreading improved depression care, including those sponsored by the Bureau of Primary Care and the Robert Wood Johnson, MacArthur, and Kaiser Foundations. In addition the APA, American Academy of Family Practice, and American College of Physicians are now collaborating to introduce the use of a standard depression severity measure (the PHQ-9) into routine care.

Less effectiveness research has been done testing models of care for the treatment of anxiety disorders. Effectiveness studies in panic disorder have shown robust improvements compared with usual care, are cost effective, and may produce a cost offset in some populations. Modifications needed to improve the treatment of anxiety disorders will be discussed.

No. 85B
DISSEMINATION OF FAMILY PSYCHOEDUCATION IN SCHIZOPHRENIA

Lisa B. Dixon, M.D., *Department of Psychiatry, University of Maryland, 685 West Baltimore Street MSTF/Room 300, Baltimore, MD 21201*

SUMMARY:

Family psychoeducation is considered an evidence-based practice in the care of persons with schizophrenia. Research has suggested that FPE that lasts at least nine months and includes a combination of support, education, problem-solving skills, and crisis intervention, reduces relapse rates, reduces family burden, and improves patient functioning. Yet, FPE is rarely offered in clinical care: even minimal family clinician contact occurs in less than one-third of cases. Barriers at the level of the consumer and his or her family members, the clinician and the administrator, and the mental health authority reflect the existence of attitudinal, knowledge-based, practical, and systemic obstacles to implementation. Family psychoeducation dissemination efforts that have been successful to date have built consensus at all levels, including among consumers and their family members, have provided ample training, technical assistance, and supervision to clinical staff, and have maintained a long-term perspective.

No. 85C
SYSTEMATIC REVIEW OF MODELS FOR INTEGRATING MEDICAL CARE INTO BEHAVIORAL SETTINGS

Benjamin G. Druss, M.D., *Health Policy, Emory University, 1518 Clifton Road, NE, Atlanta, GA 30322;* Silke Von Esenwein, Ph.D.

SUMMARY:

The barriers to diagnosing and treating medical problems in patients with serious mental and substance use disorders largely mirror those seen in the diagnosis and treatment of these behavioral disorders in primary care. In both cases, the clinical realities of morbidity and comorbidity are often at odds with systems that are separated geographically, financially, and ideologically. Potential approaches to overcoming these barriers also share many parallels, including an emphasis on collaboration, coordination, and communication across these two systems of care. This presentation will review all randomized trials of interventions in the literature for improving medical care of patients with serious mental and/or substance-use disorders. These models have each adopted differing strategies for integrating medical care into the behavioral settings. Methods for the review and synthesis of information followed Cochrane Collaborative Guidelines for Systematic Reviews. The findings will be used as a springboard for considering challenges and opportunities for dissemination of evidence-based models of medical care in the wide range of specialty mental health and substance-use facilities in the United States.

No. 85D
DEPRESSION AND DIABETES: THE PATHWAYS STUDY

Wayne J. Katon, M.D., *Department of Psychiatry, University of Washington, 1959 N.E. Pacific, Box 356560, Seattle, WA 98195-6560;* Michael Von Korff, Sc.D., Elizabeth H.B. Lin, M.D., Paul S. Ciechanowski, M.D., Gregory E. Simon, M.D., Evette J. Ludman, Ph.D.

SUMMARY:

Background: Patients with diabetes have been shown to have a higher prevalence of major depression. This presentation will describe the results of an epidemiologic study of 4,800 patients with diabetes enrolled in an HMO in Puget Sound and two randomized trials of patients with diabetes and depression/dysthymia.

Methods: A 20-page, mail survey was sent to approximately 8,000 patients with diabetes. Two randomized trials of enrolled, respectively, over 400 elderly patients (age $\geq$ 65) and over 300 mixed-aged patients with diabetes and depression in an intervention aimed at improving adherence to antidepressant medication or providing problem-solving therapy versus usual primary care.

Results: Patients with major depression and diabetes compared with patients with diabetes alone were found to have increased diabetic symptom burden, additive functional impairment, poor adherence to dietary and exercise regimens, poor adherence to three disease-control medications (oral hypoglycemics, antihypertensives and lipid-lowering drugs), an increase in total medical costs of 70%, increased diabetes complications, and significantly more cardiac risk factors. Over a two-year period, patients with diabetes and major depression have had an approximately two-fold increase in mortality compared with patients with diabetes alone. In the first intervention with elderly with diabetes and major depression, the intervention was compared with usual care and associated with improved quality of depression care and depressive outcomes over a one-year period. The intervention was also associated with improvement in physical disability compared with usual care over the one-year period, but no change in HbA1c. In the mixed-age sample, the intervention was associated with improved quality of care and outcomes of depression over a two-year period without any intervention versus control differences in HbA1c.

Conclusion: Depression is a common comorbidity in patients with diabetes, is associated with adverse outcomes, and treatment and patient-level outcomes can be improved in primary care systems.

REFERENCES:

1. Katon WJ: The Institute of Medicine Chasm report: implications for depression collaborative care models. Gen Hosp Psychiatry 2003; 25:222-229.
2. Dixon L, McFarlane W, Lefley H, Lucksted A, Cohen M, Falloon I, Mueser K, Miklowitz D, Solomon P, Sondheimer D: Evidence-based practices for services to families of people with psychiatric disabilities. Psychiatric Services 2001; 52:903-910.

3. Druss BG, Rohrbaugh RM, Levinson CM, Rosenheck RA: Integrated care for patients with serious mental disorders: a randomized trial. Archives of General Psychiatry 2001; 58:861-8.
4. Katon W: Clinical and health services relationships between major depression, depression symptoms and general medical illness. Biologic Psychiatry 2003; 54:216-226.

SYMPOSIUM 86—DIFFICULT DEPRESSION: LOOKING FOR OUR KEYS: BEYOND THE LIGHT, WE CAN SEE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the challenges in both the clinical development and practical application of current treatment options for the full spectrum of major depression, and have a greater understanding of the potential future expansion of pharmacologic and non-pharmacologic treatment options for these patients.

No. 86A
DIFFICULT-TO-TREAT DEPRESSION: BETTER CHOICES, BETTER OUTCOMES

William Potter, M.D., *Merck Inc, Mail Code BL 3-3, PO Box 4, West Point, PA 19486-0004*

SUMMARY:

Major depression is a common, disabling, and potentially lethal condition. The broad social, economic, medical, and personal consequences of this illness are substantial. Given these issues, it would seem that the case for the clinical study of effective new treatments for major depression is self-evident, profound, of interest to all participants in the health care system, and urgently needed. Despite major advances in disease awareness, delivery of care, and safer, more tolerable pharmacologic options, it remains true that the efficacy outcome expectations for patients with major depression who present to a physician for initial treatment are fundamentally no better than they were two decades ago. For many, the later stages of clinical management are complex, with medication combination or augmentation treatment strategies the norm, and a single later stage option, namely ECT. A more effective paradigm for difficult-to-treat depression should incorporate a more realistic understanding of the clinical spectrum of disease severity, a more sophisticated appreciation of the biological underpinnings corresponding to these severity stages, and a more balanced selection of treatment options tailored to these differing disease stages.

No. 86B
THE STUDY OF DIFFICULT DEPRESSION: THE RIGHT TOOL FOR THE RIGHT JOB

William Potter, M.D., *Merck Inc, Mail Code BL 3-3, PO Box 4, West Point, PA 19486-0004*

SUMMARY:

Major depression encompasses a heterogeneous set of clinical presentations. A comprehensive understanding of the illness and its treatment must define both the phenomenology of the illness as it presents at a point in time, as well as the manner in which different symptoms change over time. The latter is an area of increasing focus with such tools of clinical neuroscience as fMRI. The study of new antidepressant treatments has, in contrast, largely been concerned with the efficacy and safety of interventions in the earlier, and arguably, less complicated stages of the illness. Although substantial progress has been made in terms of safety of treatments for this end of the spectrum, non-response or partial response to first acute treatment is the norm for most patients. Traditional clinical measures appropriate for the more treatment-responsive forms of depression may be less sensitive to detecting relevant change when broadly applied. Varying patterns and time courses of symptom change with treatment, a particular problem for bipolar depression, as well as possible structural and functional changes in the brain contribute to the need for entertaining new measures of drug effects. This presentation will provide a framework for future clinical development that incorporates these considerations.

No. 86C
A CRITIQUE OF CURRENT AND FUTURE TREATMENTS FOR DIFFICULT-TO-TREAT DEPRESSION

Andrew A. Nierenberg, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street WACC 815, Boston, MA 02114-3117*

SUMMARY:

Patients with difficult-to-treat depression (DTD) present a quandary to treating clinicians: what will most likely be the next step to alleviate the depression? A large number of open, single-substitution studies have been published with limited controlled studies available. Similarly, many augmentation and combination studies have been done, but few compare competing strategies. The NIMH Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study will provide data so that clinicians know which switch and which augmentation will work the best for patients who do not remit with an SSRI, but the study will not be able to compare switching to augmentation. Nevertheless, STAR*D will be informative about how to optimally use selected available treatments patients with DTD. New promising pharmacological and somatic treatments in development that may help these patients include: medications that inhibit glucocorticoids, novel peptides, serotonin-norepinephrine-dopaminergic uptake inhibitors, as well as repetitive transcranial magnetic stimulation and deep brain stimulation. This presentation will critically review the evidence for the efficacy of existing and new treatments for DTD.

No. 86D
NEW ANTIDEPRESSANT TREATMENTS: INTEGRATING NEW TECHNIQUES IN PRACTICE

William M. McDonald, M.D., *Wesley Woods Health Center, 1841 Clifton Road, 4th Floor, Atlanta, GA 30329*

SUMMARY:

This presentation will cover somatic therapies from electroconvulsive therapy (ECT) to transcranial magnetic therapy (TMS) and the development of treatments that focus on specific brain regions and target the neuroanatomic pathways involved in depression. Historically, the use of ECT declined with the development of psychiatric medications in the 1950s and then increased in the 1980s as it became clear that a significant minority of patients were medication resistant. Although effective, ECT has a number of disadvantages including high cost, stigma and patient acceptance, side effects (e.g., amnesia), and lower response rates in certain patient populations. In the 1990s TMS research in depression renewed interest in the development of alternative somatic therapies. These therapies have been termed "brain stimulation techniques" and include TMS, vagal nerve stimulation, deep brain stimulation, and magnetic seizure therapy. Generally these treatments are more focal and target specific pathways in order to improve response and decrease potential side effects. Focal

stimulation also has the advantage of providing information on the underlying neuropathogy of depression. The current data on the efficacy of these therapies and their potential use in specific patient populations will be presented.

REFERENCES:

1. Demitrack MA: Clinical Perspectives on Antidepressant Drug Development: A Critical Discussion. Current Pharmaceutical Design, In press, 2004.
2. Rush AJ, Thase ME, Dube S: Research issues in the study of difficult-to-treat depression. Biological Psychiatry 2003; 53:743-753.
3. Rush AJ, Fava M, Wisniewski SR, Lavori PW, Trivedi MH, Sackeim HA, Thase ME, Nierenberg AA, Quitkin FM, Kashner TM, Kupfer DJ, Rosenbaum JF, Alpert J, Stewart JW, McGrath PJ, Biggs MM, Shores-Wilson K, Lebowitz BD, Ritz L, Niederehe G, STAR*D Investigators Group: Sequenced treatment alternatives to relieve depression (STAR*D): rationale and design. Controlled Clin Trials 2004; 25:119-142.
4. Lisanby SH: Focal brain stimulation with repetitive transcranial magnetic stimulation (rTMS): implications for the neural circuitry of depression. Psychol Med 2003; 33:7-13.

SYMPOSIUM 87—EFFICACY AND SAFETY OF SSRI MEDICATIONS IN CHILDREN AND ADOLESCENTS
Collaborative Session With the National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should better appreciate risks and benefits of SSRIs for the treatment of children and adolescents with mood and anxiety disorders.

No. 87A
SSRI RISK AND BENEFITS: LESSONS FROM THE TREATMENT FOR ADOLESCENTS WITH DEPRESSION STUDY (TADS)

John S. March, M.D., *Department of Psychiatry, Duke University Medical Center, P.O. Box 3527, Durham, NC 27710*

SUMMARY:

The Treatment for Adolescents With Depression Study (TADS) is a multisite, balanced, masked, randomized, controlled trial of fluoxetine, CBT, their combination, and pill PBO in 439 adolescents with a DSM-IV diagnosis of major depression. After 12 weeks of treatment, combined treatment appeared superior to fluoxetine alone and both medication conditions were superior to CBT and to placebo, which did not differ. Besides effectiveness outcomes, TADS included extensive monitoring of physical, psychiatric, and suicide-related adverse events. Following a summary of the TADS effectiveness outcomes for MDD, this presentation will (1) discuss the pattern of adverse events by treatment group and (2) using standard clinometric methods, evaluate the balance between risk and benefits. TADS demonstrates substantial benefit for combined treatment over monotherapy with either fluoxetine or CBT, with fluoxetine nonetheless more effective than CBT alone. Risk-benefit analyses favor including fluoxetine as part of treatment. Provision of CBT as part of a combined treatment package appears to reduce the probability of severe adverse effects.

No. 87B
SEARCHING FOR MODERATORS AND MEDIATORS OF TREATMENT IN ADOLESCENT DEPRESSION

Benedetto Vitiello, M.D., DSIR, *National Institute of Mental Health, 6001 Executive Boulevard, Room 7147, Bethesda, MD 20892-9633*

SUMMARY:

A number of pharmacological, psychotherapeutic, and combined treatments have been found to be effective for adolescents suffering from major depressive disorder. However, about one third of patients treated with any one intervention do not improve. It would be useful to identify which treatments work best for which type of patients in order to individualize treatment. This presentation will report on whether specific demographic and clinical characteristics of adolescents with major depression can help identify patients who are more likely to benefit from different treatment interventions, including pharmacotherapy with fluoxetine, cognitive-behavioral therapy, and their combination. In addition, treatment characteristics that may influence clinical outcome will be empirically examined in an effort to understand how treatment effects can be maximized. Moderator and mediator analyses of the Treatment for Adolescents With Depression Study (TADS) will be conducted using demographics (gender, age, race/ethnicity, socioeconomic status), clinical (severity of depression, comorbidity, referral source), and treatment-emergent variables (adherence, therapeutic alliance) that may influence outcome. Given the inclusion of both pharmacological and psychotherapeutic treatments in TADS and the relatively large sample size (N = 439), these analyses represent a unique opportunity to address the question of how to choose treatment modality for depressed adolescents.

No. 87C
EFFICACY AND SAFETY OF SSRIs IN OCD AND OTHER ANXIETY DISORDERS

John T. Walkup, M.D., *Department of Psychiatry, Johns Hopkins School of Medicine, 600 North Wolfe Street, CMSC 346, Baltimore, MD 21287*

SUMMARY:

Selective serotonin reuptake inhibitor medications (SSRIs) have been shown to be efficacious in the treatment of obsessive-compulsive disorder (OCD) in both children and adolescents. Fluoxetine, sertraline, and fluvoxamine are approved by the Food and Drug Administration for the treatment of OCD in pediatric patients aged 7 and above. In these patients, SSRIs are associated with increased incidence of certain adverse events (e.g., gastrointestinal, nervousness), but the balance between risk and benefit is considered favorable. However, many patients who improve on SSRIs do not completely remit. Recent data from a controlled study comparing sertraline, cognitive-behavioral therapy (CBT), and their combination, indicate that combining medication and CBT results in the best response rate. Some SSRIs have been tested for the treatment of children and adolescents suffering from generalized anxiety disorder, social phobia, and separation anxiety, and found to be highly efficacious, at least in the short term. A multi-site trial is currently in progress to test the relative efficacy of SSRI medication (sertraline) and CBT when used alone and in combination. In general, current data support the value of SSRIs in the treatment of children and adolescents with OCD and anxiety disorders.

No. 87D
ANTIDEPRESSANTS AND SUICIDE-RELATED EVENTS: AN ANALYSIS OF PEDIATRIC TRIALS

Thomas P. Laughren, M.D., *CDER, Food & Drug Administration, 1451 Rockville Pike, HFD-120, Rockville, MD 20857-0001*

SUMMARY:

Concerns have been raised about a possible causal association between antidepressant use for the treatment of depression and other psychiatric disorders in youths and suicide-related events. The relatively low rate of these events makes individual clinical trials statistically underpowered to test such an hypothesis. An alternative is to use analytical approaches applied to all the suitable placebo-controlled databases. More than 20 databases of placebo-controlled clinical trials of antidepressant medications conducted in children and adolescents were systematically searched for the emergence of possible suicide-related adverse events. These adverse events were blindly classified by a group of experts in pediatric suicidality. Results will be presented in the form of rates of suicide-related adverse events by treatment group (antidepressant vs. placebo). This presentation will provide the latest available results of the currently ongoing review by the Food and Drug Administration of antidepressant safety in youths.

REFERENCES:

1. The TADS Team: The Treatment for Adolescents With Depression Study (TADS): short-term effectiveness and safety outcomes. JAMA, In press.
2. Kraemer HC, Wilson GT, Fairburn CG, Agras WS: Mediators and moderators of treatment effects in randomized clinical trials. Arch Gen Psychiatry 2002; 59:877–883.
3. McClellan JM, Werry JS: Evidence-based treatments in child and adolescent psychiatry: an inventory. J Am Acad Child Adolesc Psychiatry 2003; 42:1388–1400.
4. U.S. Food and Drug Administration: Psychopharmacologic Drugs Advisory Committee and the Anti-Infective Drugs Advisory Committee, February 2, 2004. Briefing Information. Available at: http://www.fda.gov/ohrms/dockets/ac/04/briefing/4006bl.htm

SYMPOSIUM 88—NEW DIRECTIONS IN PSYCHIATRIC ASPECTS OF TERRORISM: CAUSES, CONSEQUENCES, RESPONSES
APA Council on Global Psychiatry

EDUCATIONAL OBJECTIVES:

At the conclusions of this symposium, the participant should be able to recognize several ways that psychiatry is addressing the contemporary problem of terrorism.

No. 88A
PSYCHOLOGICAL MECHANISMS UNDERLYING MARTYRDOM AMONG PALESTINIAN YOUTH

Daphne F. Burdman, M.D., *P.O. Box 3865, Jerusalem 91036, Israel*

SUMMARY:

The dream of and desire for martyrdom, or sacrificial death, as a suicide bomber or by facing down a tank or army patrol, is commonly voiced by Palestinian youth. This has not arisen *sui generis* but is the outcome of a longstanding indoctrination campaign from textbooks and from the media, particularly as evidenced by powerful television clips dramatizing youths departing for Jihad missions, comforting their families, and indicating their ultimate rewards in Paradise.

Independent observation and analysis of this material, relating both to style and content, permitted assessment of underlying psychological mechanisms that were particularly based on group process, learning theory, and modes of producing increased suggestibility. As such they are profoundly effective and can be expected to be enduring and recalcitrant.

In view of the fundamental psychological processes involved, spontaneous regression of martyrdom psychology, should an eventual Palestinian Authority decide to abandon it, is considered unlikely.

No. 88B
DYING TO KILL: THE SOCIO-CULTURAL FOUNDATIONS OF SUICIDE TERRORISM

Jerrold M. Post, M.D., *Political Psychology Program, George Washington University, 1957 East Street, NW #501, Washington, DC 20052*

SUMMARY:

Islamic youth increasingly are drawn to the path of radical Islam, and present a major dilemma in terms of counter-terrorism. Individuals who give their lives while killing the enemy in pursuit of jihad are not psychologically disturbed but represent increasingly a sociocultural norm. For each terrorist killed or captured, there are 10 waiting in line to take his (or her) place. "When hatred is bred in the bone," security alone cannot counter this violent phenomenon, and a systematic program designed to counter the psychology of hatred, which induce children to enter the path of terrorism is required. The elements of such a strategic information program are identified.

No. 88C
MUSLIM IMMIGRANT YOUTH IN DIFFICULT TIMES

Stevan M. Weine, M.D., *International Center on Human Responses, University of Illinois at Chicago, 2216 Lincoln Wood Drive, Evanston, IL 60201*

SUMMARY:

Psychiatry can play a role in better understanding and engaging Muslim immigrant youth in the U.S. so as to prevent radicalism and terrorism domestically. It is not an exageration to say that Muslim immigrant youth in America have suffered as a result of the war on terrorism on top of their own refugee and immigrant experience, poverty, troubled schools, discrimination, cultural humiliation and polarization, and political radicalization. There has been little attempt to understand or to address these problems in a systematic and evidence-driven way. This presentation describes a proposed plan for comprehensively describing and analyzing the vulnerabilities and strengths of Muslim immigrant youth in difficult times prompted by terrorism. It will describe its conceptual and methodological rationale, and likely policy, services, and scientific outcomes.

No. 88D
USING PSYCHOLOGY TO COUNTER TERRORISM AT THE PERSONAL AND COMMUNITY LEVEL

Chris Stout, Psy.D., *Department of Psychiatry, University of Illinois at Chicago, 1601 W. Taylor Street, Chicago, IL 60612*

SUMMARY:

This presentation examines the role psychology plays in preparing, responding, and deploying technologies in countering terrorism threats. A review of psychology's offerings in dealing with terrorism (including public preparation, counter-terrorism, and response), as well as a source of content and resources on what steps individuals, and groups of individuals (e.g., families, communities, businesses, etc.) can do themselves to be better prepared in this so called new "era of terrorism" will be canvassed. Accurate risk-assessment when combined with appropriate preparation can go a long way in mitigating unwarranted fears and anxieties, was well as provide a more

rational and appropriate use of the technological tools that are (and will be) available.

No. 88E
THINKERS AND DOERS: INTEGRATING ACADEME INTO TERRORISM'S REALITY

Gregory B. Saathoff, M.D., *Department of Psychiatric Medicine, University of Virginia, P.O. Box 800657, Charlottesville, VA 22908*

SUMMARY:

Over the past ten years, the FBI has undergone a transformation in the way that it prevents and responds to crisis and terrorism. Behavioral science needs of the new FBI have eclipsed requirements of criminal profiling. Just as it is important to appreciate terrorism's impact on society, it is also valuable to understand the changing role of federal law enforcement over the last decade. Terrorism's enigmatic problems have required operational changes in both physical and intellectual responses to terrorism. Although the resulting change in the relationship of federal law enforcement to other agencies and academe has yet to be fully appreciated, we can identify the milestones in the evolution of behavioral sciences within the FBI that provide future directions identification, mitigation, and response to terrorism.

REFERENCES:

1. Burdman D: Education, indoctrination and incitement: Palestinian children on their way to martyrdom, in Terrorism and Political Violence, 2003; 15(1):96–123.
2. Post J: Leaders and Their Followers in a Dangerous World. Cornell Univ Press, 2004
3. Weine SM: When History is a Nightmare: Lives and Memories of Ethnic Cleansing in Bosnia-Herzegovina. Rutgers University Press, 1999.
4. Stout C (Ed.): Psychology of Terrorism, Condensed Edition: Coping With the Continuing Threat. Contemporary Psychology, Praeger Publishers, 2004.
5. Barkun M: Project Megiddo, the FBI and the Academic Community, Terrorism and Political Violence, Special Issue on Millennial Violence, 14:1, Spring, 97–108.

SYMPOSIUM 89—LEADERSHIP IN PSYCHIATRY: WOMEN LEADERS IN ADVOCACY AND SERVICES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the scope for leadership in psychiatry, in responding to public health and clinical service needs. The participants will recognize the methods and relationship developed by women leaders in national, international, and service, government, and non-government organizations.

No. 89A
WOMEN AND LEADERSHIP IN PSYCHIATRY

Michelle B. Riba, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0295*

SUMMARY:

As President of the American Psychiatric Association, and the fifth woman APA president, it has been a great honor to serve. Throughout my years on the APA Board of Trustees and as an officer, I have been very conscious of the importance of being a good role model and mentor to women medical students, residents, and junior colleagues. Gender is important in our work and roles as leaders of professional and academic organizations. As preparation for my assuming the presidency of the APA, I was fortunate to participate in the Hedwig van Ameringen Executive Leadership in Academic Medicine (ELAM) Program for Women. ELAM was a training program for women to achieve success in their academic and professional organizations. It was also an opportunity to network, bond, form relationships and alliances, and learn from successful women from many disciplines in medicine and science. In order for our organizations to have excellent leaders, both female and male, it is important to develop training opportunities for those who aspire to be officers and leaders. Our national and international psychiatry organizations can explore ways to offer joint programs and training opportunities so that we have highly skilled and inspired leaders.

No. 89B
THE NEED FOR FEMALE LEADERSHIP IN INTERNATIONAL PROFESSIONAL ORGANIZATIONS

Marianne C. Kastrup, M.D., *Centre for Transcultural Psychiatry, University Hospital, Rigshospitalet, Blegdamsvej, Copenhagen DK-2100, Denmark*

SUMMARY:

The proportion of women entering psychiatry is gradually increasing and among psychiatrists in clinical leadership positions, women comprise an increasing proportion.

Yet few women are taking up leadership positions in international professional organizations. The aims of these organizations are:

- improving the care for the mentally ill,
- promoting parity in the provision of care to the mentally ill,
- preserving the rights of patients, and
- protecting the rights of psychiatrists, among others.

All areas where the input of women may contribute significantly to the outcome of any intervention.

Other key domains relate to:

- The development of ethical standards and procedures and how to monitor their observance.
- The growth of educational programs to be offered globally
- The mentorship of junior colleagues or colleagues working in professional isolation

The need to develop strategies to overcome the inner as well as outer obstacles preventing women from due representation in these organizations will be discussed as well as suggestions for strategies to overcome the obstacles outlined.

No. 89C
ASPECTS OF LEADERSHIP REQUIRED IN DEVELOPING A NATIONAL MENTAL HEALTH PLAN

Janice Wilson, M.D., *Department of Mental Health, Ministry of Health, 133 Molesworth Street, Wellington 6001, New Zealand*

SUMMARY:

The process of developing a national mental health strategy and plan requires leadership at different levels throughout the mental health sector. The key elements of leadership, such as strategic vision, the ability to influence culture; to walk in diverse worlds; to communicate engagingly; be responsive and connect personally with a wide variety of stakeholders; to have energy, drive, and an agile mind; and to show integrity, personal courage, and political nous are all essential through the phases of development to achieve an

acceptable and successful mental health plan. Leadership from psychiatrists is crucial, but the effective application of these key elements may need development through specific training. This presentation will explore how each of these leadership skills or attributes is applied through the formation to the acceptance of a national mental health plan, and how these skills are also essential in the implementation phase, albeit with different emphases.

No. 89D
EVIDENCE AND ACCOUNTABILITY FOR WOMEN'S MENTAL HEALTH

Donna E. Stewart, M.D., *Department of Women's Health, University Health Network, 200 Elizabeth Street, Toronto, ON M5G 2N2, Canada*

SUMMARY:

This presentation will discuss initiatives in education, collaboration, and advocacy by a psychiatrist at the provincial, national, and international levels though government and nongovernmental organizations to improve mental health and mental health services for women (and men).

Provincially as a member of the Ontario Women's Health Council, we led research projects that resulted in the first Ontario Women's Health Status Report. From this and other sources, we are developing indicators to measure health and mental health services for a hospital report card.

Nationally, as part of an academic consortium, which I co-led, we compiled and published the first Canadian Women's Health Surveillance Report (which included mental health). Our work against Trafficking in Women, also presented at the United Nations Commission on the Status of Women meetings, contributed to vital changes in national government policy on trafficking.

We have now developed, with international partners and NGOs, an International Consensus Statement on Women's Mental Health, which lists basic necessities for the improvement of women's mental health. We are seeking endorsement for this consensus statement from various organizations including the WPA and APA as first steps toward implementation.

The hallmarks of our work have been transparency, evidence, and accountability for equality and improvement.

No. 89E
THE PSYCHIATRIST AS CLINICAL LEADER

Helen Herrman, M.D., *Department of Psychiatry, University of Melbourne, P.O. Box 2900 Fitzroy, Melbourne Victoria 3065, Australia*

SUMMARY:

The way that psychiatrists and other mental health professionals work together has an impact on standards of clinical care and professional satisfaction. Although in the past many psychiatrists have worked in relative isolation, today it is rare for mental health care to be provided by a single professional, even where one person is designated as the primary direct-care provider. Much of contemporary mental health care is delivered either directly or indirectly by several persons, often working in teams. The working relationships in teams and collaboration is supported by several elements including agreed goals, and agreed approach, effective communication styles, established ground rules, clear team roles, and competent leadership. Obstacles to effective teamwork and collaboration include ambiguity and conflict over roles, conflict and confusion over leadership, differing understandings of clinical responsibility and accountability, poor understanding between the professions, and differing rewards between the professions. The Royal Australian and New Zealand College of Psychiatrists through a committee of its Board of Professional and Community Relations convened a number of meetings and discussions on this topic. Developing an understanding of these issues opened the way to a series of recommendations in relation to education, professional organizations, workplaces, and government.

REFERENCES:

1. Bunker KA, Kram KE, Ting S: The young and the clueless. Harvard Business Review 2002; 81–87.
2. Wilson J: The flight of the wild goose: the psychiatrist as a leader. Australian and New Zealand Journal of Psychiatry 2000; 34:1–7.
3. Magistretti AI, Stewart DE, Brown AD: Performance measurement in women's health: the Women's Health Report, Hospital Report 2001 Series. Women's Health Issues 2002; 12:327–337.
4. Herrman HE, Trauer T, Warnock J and the Professional Liaison Committee (Australia), RANZCP: The roles and relationships of psychiatrists in mental health service provision. Aust & NZ Jrnl Psych 2002; 36:75–80.

SYMPOSIUM 90—IMPROVING MEDICAL CARE FOR PATIENTS WITH SERIOUS MENTAL DISORDERS
Collaborative Session With the National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand current evidence regarding delivery of medical care for patients with serious mental disorders, and potential roles for psychiatrists and clinicians in improving that treatment.

No. 90A
CO-OCCURRING SOMATIC DISORDERS AND QUALITY OF CARE IN SMI

Lisa B. Dixon, M.D., *Department of Psychiatry, University of Maryland, 685 West Baltimore Street MSTF/Room 300, Baltimore, MD 21201*

SUMMARY:

Overall somatic health outcomes for persons with severe mental illness need to take into account rates and severity of co-occurring medical conditions as well as the quality of care provided for these disorders. A variety of research methods have substantiated the observation that individuals with serious mental illness (SMI) have increased rates of co-occurring medical conditions. Illnesses consistently observed to be elevated among SMI include asthma, chronic bronchitis, emphysema, COPD and other respiratory diseases, diabetes, some cardiovascular diseases, and infectious diseases such as hepatitis C and HIV. These disorders have been consistently associated with elevated mortality rates among the SMI as well. With regard to quality of care, an emerging literature now suggests that overall, persons with SMI are less likely to receive guideline adherent somatic care than persons with SMI and may perceive greater barriers to care. Data regarding service utilization are less consistent, though overall coordination of care between the psychiatric and general medical sector is generally poor. However, the influence of the reduced quality of care on health outcomes is unknown. Integrated care models may reduce some of the inequities, though it is necessary to consider a range of solutions within both the psychiatric and general medical sectors.

No. 90B
PSYCHIATRISTS' ROLE IN ADDRESSING CARDIOVASCULAR RISK FACTORS IN SERIOUS MENTAL DISORDERS

Gail L. Daumit, M.D., *Department of Medicine, Johns Hopkins University, 2024 East Monument Street 2-500, Baltimore, MD 21205*

SUMMARY:

Persons with severe mental illnesses (SMI) have a high prevalence of smoking, poor dietary intake, and sedentary lifestyle. Through their impact on hypertension, obesity, diabetes and/or directly on atherosclerosis, these health behaviors combined with adverse effects of psychotropic medication contribute greatly to the burden of coronary artery disease and ultimately premature death in the SMI. The Framingham and other cardiovascular risk scores estimate a person's 10-year risk of a cardiac event; these scores may be useful tools when applied to persons with SMI in routine practice.

The challenge of intervening for these chronic health behaviors to reduce cardiovascular risk in a complex SMI patient population can appear daunting. Yet, only a modest 10-pound weight loss can prevent the development of hypertension and diabetes in the general population. Emerging work provides evidence that interventions in the mental health care setting for smoking cessation and weight loss (through improved diet and exercise) may reduce these unhealthy behaviors in the SMI. We will present a review of the evidence on cardiovascular risk factors in the SMI, a guide to using cardiac risk scores, and a practical update for reducing cardiovascular risk by improving lifestyle behaviors in the SMI.

No. 90C
TARGETED DELIVERY OF CLINICAL PREVENTIVE SERVICES TO THE SERIOUSLY MENTALLY ILL

Caroline C. Doebbeling, M.D., *Department of Psychiatry, Indiana University, 1111 West 10th St Suite 304, Indianapolis, IN 46202*

SUMMARY:

Background: Because of behavioral risk factors and lifestyle choices, persons with serious mental illness (SMI) may be especially vulnerable to the development of preventable conditions including infection, violence, cardiovascular disease, and malignancy. Unfortunately, those with SMI are at risk for failure to receive primary and secondary clinical preventive services. In this presentation, we will discuss the literature describing receipt of preventive services among persons with mental illness, and then will make recommendations for indicated preventive interventions.

Presentation Highlights: Recommendations made in this presentation are based on those by the United States Preventive Services Task Force. When applying these to persons with SMI, clinicians should assess counsel regarding tobacco use, unintended pregnancy, and violence, including access to firearms. Depending on lifestyle risk factors, screening for hepatitis B and C, sexually transmitted diseases, and tuberculosis may be indicated. Immunizations should include influenza, pneumonia, and hepatitis B, especially for those living in group settings or using intravenous drugs. Finally, cardiovascular disease screening and cancer screening will depend on risk factors, medication profiles, and family history.

Conclusions: Mental health providers can play an important role in delivering indicated preventive services to patients with serious mental illness.

No. 90D
HEALTH MONITORING IN SCHIZOPHRENIA

Stephen R. Marder, M.D., *Department of Psychiatry, VA Greater LA Health Care System, M1 RECC 210A 11301 Wilshire Boulevard, Los Angeles, CA 90073-1003*

SUMMARY:

Patients with schizophrenia are at an increased risk for a number of physical health problems including heart disease and diabetes. One approach to improving the health of these individuals is to monitor risk factors for these illnesses in psychiatric settings. This presentation will review clinical guidelines for monitoring patients with schizophrenia including those from the American Diabetes Association, the American Psychiatric Association, and the Mount Sinai Conference on Medical Monitoring. Each of these guidelines recommends regular monitoring of body mass index, blood pressure, glucose, and lipids. However, implementing these practices presents significant challenges in nearly every public and private mental health setting. This presentation will also highlight the issues that should influence monitoring practices in different psychiatric settings. These issues include access to primary care clinicians, an infrastructure to support clinical monitoring, and the medical skills of the psychiatrist.

REFERENCES:

1. Dickerson FB, McNary SW, Brown CH, Kreyenbuhl J, Goldberg RW, Dixon L: Somatic healthcare utilization among adults with serious mental illness who are receiving community psychiatric services. Medical Care 2003; 4, 560–570.
2. McCreadie RG: Diet, smoking and cardiovascular risk in people with schizophrenia: descriptive study. Br J Psychiatry 2003; 183:534–539.
3. U.S. Preventive Services Task Force: Guide to Clinical Preventive Services, 2nd ed. and updates: Alexandria, VA: International Medical Publishing, 1996; http://www.ahrq.gov/clinic/uspstfix.htm
4. Marder SR, Essock SM, Miller AL, Buchanan RW, Casey DE, Davis JM, Kane JM, Lieberman JA, Schooler NR, Covell N, Stroup S, Weissman EM, Wirshing DA, Hall CS, Pogach L, Pi Sunyer X, Bigger JT, Jr., Friedman A, Kleinberg D, Yevich SJ, Davis B, Shon S: Physical health monitoring of patients with schizophrenia. Am J Psychiatry 2004; 161(8):1334–49.

SYMPOSIUM 91—PSYCHOTHERAPY IS UNIVERSALLY FUTURE ORIENTED

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize that human distress is usually created by mismatches between expectations and experience and to clarify that psychotherapy, like all helping professions, attempts to help patients create better futures.

No. 91A
EXPECTATION VIDEOS

Bernard D. Beitman, M.D., *Department of Psychiatry, University of Missouri, 1 Hospital Drive, Columbia, MO 65212*

SUMMARY:

Psychotherapy provides a "reflective space" in which to consider dysfunctional patterns and how to change them. In various ways, therapists evoke self-observation by which patients are able to consider the elements that comprise the patterns to be changed. The focus of psychotherapy is the patient's future—helping them change how they will respond AFTER they leave the office and psychotherapy.

Individuals compose expectations about their futures from prior experiences within their culture, developmental norms, and the earlier events of their own lives. The brain registers the sum of one's experience and uses this material to rehearse future ways of thinking-

feeling-doing-living; this procedural memory becomes the foundation for mental movies of one's future, or Expectation Videos. While some individuals may only be dimly aware of these expectations, others may be cognizant of experiencing precise images of their plans and intentions. These future-oriented videos, occurring consciously or subconsciously, may be limited to the immediate short term (what is expected within the next few minutes) or may span a time continuum that reaches toward long-term potentials. They can be considered the focus of psychotherapeutic intervention.

No. 91B
MENTALIZING'S FUTURE

Howard E. Book, M.D., *2900 Yonge Street, Suite 101, Toronto, ON M4N 3N8, Canada*

SUMMARY:

This clinically-based presentation combines a didactic and interactive teaching style to explore "mentalizing," its relationship to empathy, and the crucial role both play in future-oriented psychotherapy. The guiding premise is that all psychotherapies are "future-oriented," with one of their goals being to aid the patient in his/her future functioning by facilitating the decrease in repetitive maladaptive behavior/relationships, and the encouragement of more adaptive fulfilling relationships in the future. "Mentalizing," defined as the capacity to understand or read and therefore influence another person's actions and motives, requires two awarenesses: that other people have beliefs, desires, knowledge, and deceits different from our own; and that their behavior can be explained by those mental contents. This acquired developmental capacity to have these twin awarenesses has been termed "mentalizing." Impaired mentalizing shows itself in a lack of social insight, a tendency to treat others as foreign, and impaired communications, all of which promote maladaptive relationships.

Briefly, mentalizing is the capacity to understand that the other's mind contains wishes, desires, knowledge, deceits that are different from our own; and allows us to predict that their behavior will be different from our own, even in the same situation. This knowledge allows us the potential of altering the other's behavior in the relationship we have with him/her.

Empathy overlaps with and is a more refined aspect of mentalization. It is the capacity to experience, in a discontinuous manner, the subjective world of the other. If mentalization is the relatively objective capacity to "know where another person is coming from", empathy is the more subjective capacity to momentarily experience what it feels like for the other to be coming from where he/she is. Mentalizing and empathy have in common future-oriented qualities: both allow us to predict, and therefore influence, how and why another person might behave—the former from a more objective position and the latter from a more subjective space.

This theoretical discussion will be illustrated with real-world clinical vignettes from the presenter and attendees that explore aspects of mentalization developmentally and the pivotal role it plays in psychodynamic psychotherapy.

No. 91C
USING THE FUTURE IN THE PSYCHOTHERAPEUTIC TREATMENT OF DEPRESSION

Maria T. Lymberis, M.D., *Department of Psychiatry, 1500 Montana Avenue #204, Santa Monica, CA 90403-1810*

SUMMARY:

This clinical presentation will highlight the usefulness of Dr Beitman's Concept of the Future in the teaching and learning that is the core of the psychotherapy process.

Clinical vignettes will illustrate its usefulness to patients in their learning to recognize (1) how their depressed regressed states can distort all of their perceptions including their perception of time, (2) how their failure to recognize and work to change their outdated patterns of behavior, including the repeated episodes of reliving of the past in the present, both in and out of treatment, continues to result in adverse life consequences, (3) how accepting responsibility for their maladaptive defense/resistance patterns and exercising their choice to change can empower them to create new futures, (4) how working to bring about their new future strengthens their sense of self, increases their self confidence and repairs their damaged self-esteem.

No. 91D
FUTURE-FOCUSED BRIEF PSYCHOTHERAPY IN CLINICAL PRACTICE

James L. Griffith, M.D., *Department of Psychiatry, George Washington University Medical Center, 2150 Pennsylvania Avenue, N.W., 8th Floor, Washington, DC 20037*

SUMMARY:

Future-focused psychotherapy emphasizes methods that utilize an imagined future to guide current perceptions, thoughts, feelings, and actions. It can be contrasted with psychodynamic psychotherapy, which typically prioritizes an exploration of the past and its influences upon the present. This use of "future" is distinguished from conventional uses of "goal" in brief psychotherapies. This presentation illustrates interviewing methods for first eliciting the vivid description of a desired future, then negotiating a therapeutic contract toward the realization of that future. Examples from several brief psychotherapies illustrate how this approach progresses through early, middle, and late stages of psychotherapy to a successful termination.

REFERENCES:

1. Beitman BD, Yue DM: Learning Psychotherapy: A Time-Efficient, Research-Based, and Outcome-Measured Psychotherapy Training Program. Second Edition, 2004.
2. Fonagy P, Gergaly G, Jurist E, Target M: Affect Regulation: Mentalization, and the Development of the Self. New York: Other Press, 2002.
3. Beitman B: Integrating the Psychotherapies Through an Emphasis on the Future. A Case Study. In press, 2004.
4. Madsen W: Collaborative Therapy With Multi-Problem Families: From Old Problems to New Futures. New York, Guilford Press, 1999.

SYMPOSIUM 92—PSYCHOSOMATIC MEDICINE IN PSYCHIATRIC PRIVATE PRACTICE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should understand the many aspects of psychosomatic medicine in a psychiatrist's private practice.

No. 92A
COMPREHENSIVE PSYCHIATRY: PATIENTS WITH MEDICAL ILLNESSES IN CHILD AND ADOLESCENT PSYCHIATRY

Jeffrey A. Naser, M.D., *Mainline Clinical Association, 121 North Wayne Avenue, #300, Wayne, PA 19087*

SUMMARY:

A good working relationship with other treating physicians is of vital importance when working in a private child and adolescent psychiatry practice. Today, pediatricians and family physicians treat many of the potential referrals that would be considered straightforward. Frequently, only the patients with more complicated clinical pictures, which can include comorbid medical issues or complications, are referred out to psychiatrists in the community. The author works as a child and adolescent psychiatrist in an outpatient, fee-for-service group practice, within which he sees children and adolescents of all ages and diagnoses. He also works, to a lesser extent, with adults. During this presentation, he will outline the potential benefits and difficulties in cultivating and maintaining a diverse multispecialty referral network. He will also discuss clinical cases that exemplify how to create and maintain a working relationship with the referring primary or subspecialty physicians, as well as issues that may interfere with the building of such a working relationship.

No. 92B
IRRITABLE BOWEL, INTERSTITIAL CYSTITIS, AND FIBROMYALGIA IN PRIVATE PRACTICE

Ronald D. Abramson, M.D., *25 Main Street, Suite 7, Wayland, MA 01778*

SUMMARY:

Irritable bowel syndrome (IBS), interstitial cystitis (IC), chronic fatigue syndrome (CFS), and fibromyalgia (FM) are conditions that cause pain, discomfort, disability. These syndromes often occur together. Their etiology and pathogenesis are unclear. There is a varying literature suggesting either psychiatric or organic etiologies, while presenting no convincing proof of either. Regardless of etiology, patients frequently present for psychiatric treatment who have one or all of these disorders and who are deeply affected and, at times, disabled by these syndromes. Patients experience these conditions as if they have an organic etiology.

This is a clinical report outlining strategies for treatment of patients with these disorders. The strategies of treatment include: assuming an organic etiology, abstaining from interpretations implying psychiatric meanings to these disorders, empathizing with patient suffering, and helping patients seek adequate medical treatment for these conditions, and utilizing available psychopharmacology. For example, certain atypical antipsychotic agents are potent serotonin blockers and are useful in reducing the symptoms of IBS. In addition to these measures, standard psychotherapy to address real stress and tension in patients' real world can provide substantial and meaningful benefit.

No. 92C
COMPREHENSIVE PSYCHIATRY: PATIENTS WITH MEDICALLY-UNEXPLAINED PHYSICAL SYMPTOMS AND PTSD

Brian Crowley, M.D., *Suite 215, 5225 Connecticut Avenue, NW, Washington, DC 20015-1845*

SUMMARY:

A full-time private adult and forensic psychiatric practice can include clinical work, teaching medical students, and research on complex medical conditions resulting from trauma. The psychosomatic aspects of automobile accidents and war trauma are often a prominent part of the resulting disorders, including medically unexplained physical symptoms, and PTSD, both of which have been a part of this psychiatrist's practice, including seeing soldiers (for Department of Defense) returning from combat zones.

The author will also describe psychosomatic issues in forensic practice, issues that need to be addressed to answer the questions put forth by the courts.

This richly varied practice affords a wide-angled view of the human person we call a patient, in his/her thinking, feeling, social, and physical being.

No. 92D
COMPREHENSIVE PSYCHIATRY: PATIENTS WITH MEDICAL ILLNESS

John C. Urbaitis, M.D., *Department of Psychiatry, Sinai Hospital of Baltimore, 2401 West Belvedere Avenue, Baltimore, MD 21215-5216;* Roger Peele, M.D.

SUMMARY:

The first author practices comprehensive psychiatry in an urban private-sector general hospital. Many patients also have active medical conditions and may be referred by their primary physicians associated with the hospital. His commitments are to (1) patients—he will see them in most settings, outpatient, inpatient, consultation, house calls; he will see them over the years. (2) colleagues—he shares in patient care, teaching, support. Also, he has been the mental health service for house staff for 27 years. (3) patients and profession, through advocacy in professional and lay organizations.

In the past year, he has faced many obstacles to good care and to efficient care: lack of insurance; lack of medication coverage—one can spend hours, even with help of case managers, obtaining medications; lack of specialized services—for example, inpatient for longer term, dual-diagnosis treatment with rapid access and support services, inpatient medical/psychiatric coordination.

We and our patients need major changes in practice environment—help with more resources for proper patient care.

The second author will describe what a local government psychiatrist can do to facilitate opportunities and remove the impediments to psychiatric patients receiving humane care and effective treatment in the private sector.

No. 92E
PSYCHOSOMATIC ASPECTS OF THE PRIVATE PRACTICE OF PSYCHIATRY IN A GERIATRIC PRACTICE

Walter P. Bland, M.D., *Department of Psychiatry, Howard University Hospital, 2041 Georgia Avenue, NW, Washington, DC 20060-0001*

SUMMARY:

The day-to-day practice of geriatric psychiatry overlaps considerably with psychosomatic medicine. Almost all patients have some substantial non-psychiatric medical or surgical condition that requires consideration in the psychiatric management. Hypertension, diabetes, and a variety of gastrointestinal disorders are very common. Furthermore, the boundaries of depression and other medicial illnesses are often a challenge.

Another major challenge is medication management as the geriatric psychiatrist often faces a patient already on a dozen medications. What medications can be added to achieve the effect needed is rarely answered by today's control medication studies of one mediation verses a placebo.

While the psychosomatic aspects of geriatric psychiatry are a huge challenge, positive resolutions are very satisfying.

REFERENCES:

1. Weissman MM, Gross R, Fyer, A, Heiman, GA, Gameroff MJ, Hodge SE, Kaufman D, Kaplan SA. Wickramaratne PJ: Interstitial cystitis and panic disorder. Archives of General Psychiatry 2004; 61:273–279.
2. Medically Unexplained Physical Symptoms (MUPS): A Guide for Re-Deploying Service Members. DoD's Deployment Health Clinical Center, Washington, DC, 2004.
3. Ruo B, Rumsfeld JS, Hlatky MA, Liu H, Browner WS, Wooley MA: Depressive symptoms and health-related quality of life. JAMA 2003; 290:215–221.
4. Small GW, Gunay IG: Geriatric medicine in Essentials of Consultation-Liaison Psychiatry. Edited by Rundell DR, Wise MG. Washington, American Psychiatric Association Press, 1999, pp 479–492.

SYMPOSIUM 93—REVIEW AND UPDATE OF EYE MOVEMENT DESENSITIZATION AND REPROCESSING

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to describe the nature of EMDR treatment, and identify appropriate cases for this therapy.

No. 93A
EYE MOVEMENT DESENSITIZATION AND REPROCESSING WITH VICTIMS OF TRAFFIC ACCIDENTS, SUICIDE BUS BOMBINGS, AND TERRORIST ATTACKS IN ISRAEL

Gary M. Quinn, M.D., *Jerusalem Stress and Trauma Institute, 624 5 Nerot Shabbat Street, Jerusalem Ramot, Israel*

SUMMARY:

Israel suffers a long history of terror. Various pervasive and debilitating symptoms consistent with post-traumatic stress disorder were generally experienced by the survivors including, flashbacks, hypervigilance, avoidance phenomena, emotional lability, social withdrawal, helplessness, memory and concentration impairment, fatalism, irritability, guilt and shame, phobias, depressed motivation, startle response, sleep disturbance, and somatic involvement. Eye Movement Desensitization and Reprocessing (EMDR) was applied to several post-traumatic victims of suicide bus bombing and terrorist attacks. The case presentations will include the clinical histories, treatment procedure, outcomes, and recommendations regarding the choice and efficacy of this treatment modality with the given population.

No. 93B
A PILOT BLINDED, RANDOMIZED STUDY OF ALTERNATING STIMULATION IN EYE MOVEMENT DESENSITIZATION AND REPROCESSING FOR PTSD

David D. Servan-Schreiber, M.D., *Department of Psychiatry, University of Pittsburgh, 117 Pheasant Drive, Pittsburgh, PA 15238;* Johnathan Schooler, Ph.D., Mary A. Dew, Ph.D., Cameron Carter, M.D., Patricia Bartone, R.N.

SUMMARY:

Background: EMDR is becoming a recognized and accepted form of psychotherapy for posttraumatic stress disorder (PTSD). Yet, its mechanism of action remains unclear and much controversy exists about whether eye movements or other forms of bi-lateral somesthetic stimulation contribute to its clinical effects.

Methods: Twenty-one patients with single-event PTSD (average IES: 49.5) received three consecutive sessions of EMDR with three different types of auditory and kinesthetic stimulation (tones and vibrations): rhythmic alternating right-left (as commonly used with the standard EMDR protocol), rhythmic simultaneous right and left, and continuous right and left. Therapists were blinded to the type of stimulation they delivered, and stimulation type assignment was randomized and counter-balanced.

Results: All three stimulation types resulted in clinically significant reductions of subjective units of distress (SUD). Yet, alternating stimulation resulted in larger and faster reductions of SUDs when only sessions starting with a new target memory were considered.

Conclusions: There are clinically significant effects of the EMDR procedure that appear to be independent of the nature of the somesthetic stimulation used. However, alternating stimulation may confer an additional benefit to the EMDR procedure that deserves attention in future studies.

No. 93C
SLEEP, MEMORY, AND TRAUMA

Robert Stickgold, Ph.D., *Department of Psychiatry, Harvard Medical School, 330 Brookline Drive, FD861, Boston, MA 02215*

SUMMARY:

Numerous studies have provided evidence for the efficacy of Eye-Movement Desensitization and Reprocessing Therapy (EMDR) in the treatment of posttraumatic stress disorder (PTSD), including recent studies showing it to be more efficient than therapist-directed flooding. But few theoretical explanations of how EMDR might work have been offered. Shapiro, in her original description of EMDR, proposed that its directed eye movements mimic the saccades of rapid-eye-movement sleep (REM), but provided no clear explanation of how such mimicry might lead to clinical improvement. We now revisit her original proposal and present a complete model for how EMDR could lead to specific improvement in PTSD and related conditions. We propose that the repetitive redirecting of attention in EMDR induces a neurobiological state, similar to that of REM sleep, which is optimally configured to support the cortical integration of traumatic memories into general semantic networks. We suggest that this integration can then lead to a reduction in the strength of hippocampally mediated episodic memories of the traumatic event as well as the memories' associated, amygdala-dependent, negative affect. Experimental data in support of this model are reviewed and possible tests of the model are suggested.

REFERENCES:

1. Silver S, Ropers S: Light in The Heart of Darkness. EMDR in The Treatment of War and Terrorism Survivors. WW Norton & Co.
2. Servan-Schreiber D, Schooler J, Dew MA, Carter C, Bartone P: A Pilot Blinded. Randomized Study of Alternating Stimulation in EMDR for PTSD.
3. Stickgold R: EMDR: a putative neurobiological mechanism of action. Journal of Clinical Psychology 2002; 58:61–75.

SYMPOSIUM 94—RESEARCH DURING PSYCHIATRY RESIDENCY: SHOULD IT BE REQUIRED OR BANNED?

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should be able to (1) identify five potential benefits of research experience during

psychiatry residency training, (2) recognize ways in which clinical training is affected by an individual's decision to undertake a research project, and (3) think critically about the value of research training during psychiatry residency from both individual and public health perspectives.

No. 94A
WHAT SHOULD PSYCHIATRIC RESIDENTS KNOW ABOUT RESEARCH?

Ronald O. Rieder, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, New York, NY 10032*

SUMMARY:

"Research" is often not understood by psychiatric residents, who may think globally, for example that they "like" or "dislike" research. This talk disaggregates research.

(1) *Research as Information:* Residents can benefit from predigested research, now available via evidence-based reviews such as the Cochrane Systematic Reviews and BMJ Clinical Evidence. This can look formidable, but once one learns to obtain it, it can solidly justify decision making. Journal articles seem easier, but these require even greater scrutiny, with techniques that may be learned in a journal club or other course on critical reading.

(2) *Research as a Process:* Residents should learn about various types of psychiatric research, including the kind of questions different studies can answer, and the types of analyses that are often used. The types include case reports, clinical trials, psychobiological investigations, epidemiological studies, and services research. Some important concepts such as intent to treat, correlations, odds ratios, and power help residents grasp the clinical significance of research findings.

(3) *Research as an Experience and Career:* Residents should know what doing clinical research is like. They frequently equate it with their laboratory experiences in medical school. They often do not know how it involves using their clinical skills, and can focus on their own clinical questions. They also should know the practicalities of a research career, often involving support via grant writing, and how to "experiment" with mentored clinical research in an elective.

No. 94B
A RESIDENT'S PERSPECTIVE ON RESEARCH DURING PSYCHIATRY TRAINING

Bret R. Rutherford, M.D., *Department of Psychiatry, New York State Psychiatric Institute, 1051 Riverside Dr. Box 95, New York, NY 10032*

SUMMARY:

The Institute of Medicine's report on research training during psychiatry residency identified important public health benefits of such training given the rising need for mental health researchers. However, the decision to pursue research is actually made at the level of the individual resident, for whom time spent pursuing research represents time away from other areas of training. Each resident must therefore consider the benefits and costs of research participation from an individual perspective. To illustrate this process, this writer's decision to pursue research at Columbia's residency program, which allows residents to select a "research option" providing them with eight hours of research time weekly, is discussed. The reduction in clinical experience, decreased time available for study, and inevitable overflow of research work into free time were significant costs of research participation. For this writer, outweighing these costs were the enrichment of remaining clinical work and the provision of continuity in an otherwise discontinuous time of changing rotations. Furthermore, the mentorship aspect of research participation provided education about career development that was less emphasized in the traditional curriculum.

No. 94C
THE WAY TO A K: A RESEARCH FELLOW'S EXPERIENCE

Jordan F. Karp, M.D., *Department of Psychiatry, Western Psychiatric Institute, 3811 O'Hara Street, Pittsburgh, PA 15213*

SUMMARY:

Dr. Karp became interested in clinical research while an undergraduate at Emory University. After graduation from Emory, he participated in the Mellon Fellowship in Neurosciences at the University of Pittsburgh School of Medicine where he met mentors who helped him begin to shape his career course; among these mentors was Dr. Charles F. Reynolds. In the years prior to and during medical school, and during residency at Columbia University, he continued to participate in the research of various mentors (including Dr. Stephen P. Roose), analyzing data, presenting his work at national meetings, and publishing peer-reviewed papers. Following a clinical fellowship in geriatric psychiatry, he began and is still a NIH-sponsored research fellow at the University of Pittsburgh. Dr. Karp will discuss the importance of cultivating relationships with mentors, responsibilities of the mentee, and making personal compromises between research and clinical interests.

No. 94D
TRAINING FUTURE GENERATIONS OF PSYCHIATRIST RESEARCHERS: THE FUNCTIONS OF RESIDENCY RESEARCH TRACK

Charles F. Reynolds III, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Pittsburgh, PA 15213*

SUMMARY:

As emphasized by the Institute of Medicine report, ("Research Training in Psychiatry Residency"), psychiatric residents make important career choices during residency, including whether to become researchers. While not essential to the pursuit of a research career, a research track is a useful means of accelerating, reinforcing, and focusing choices for those who are ready to do so. Conversely, some residents interested in research may choose to focus their development primarily as clinicians and educators. How can a research track be useful?

To be useful to the process of career choice, a research track can support residents by helping to maintain productive mentoring relationships, by developing survival skill sets essential to academic careers (writing, data analysis, study design, oral presentations, and networking), by demystifying career paths and day-to-day activities of psychiatric researchers (via scientific autobiographies), by helping residents with developmental challenges in launching a research career (ambivalence, confidence), by facilitating entry into postdoctoral research fellowships, and by providing structure and accountability. The research fellowship is a vital bridge to independence as a faculty researcher, but this developmental process itself often needs additional time, on the order of five to seven years beyond residency.

The major challenges faced in implementing research tracks during psychiatry residency include freeing up adequate time and paying for that time. Supporting the track with other departmental research infrastructure is essential to its success.

No. 94E
RESEARCH IN PSYCHODYNAMICS AND PSYCHOTHERAPY DURING RESIDENCY

Robert Michels, M.D., *Department of Psychiatry, Cornell Medical College, 418 East 71st Street, Suite 41, New York, NY 10021*

SUMMARY:

Most psychiatric residents plan careers in clinical, not research psychiatry, while most psychiatric researchers are interested in biological research, with phenomenologic second. Most residents not planning primary research careers have greater interest in research that is relevant to their clinical concerns, while most research support is derived from the pharmaceutical industry interested in drug trials or government institutions that emphasize basic research. The result of this array of forces is often experienced by residents as confusing, conflicting, or chaotic, with the unfortunate consequence of diminishing their interest in research and creating a two-tier profession. Research education is most effective if the student is interested in the question being addressed, and if the research is of good quality. As a result, from the perspective of research education of residents (certainly not the only important perspective) the current research enterprise in psychiatry might be improved by greater attention to quality research in psychodynamics and psychotherapy.

REFERENCES:

1. Psychiatric Research Reports, APA Division of Research. prr@psych.org.
2. Abrams MT, Patchan KM, Boat TF (ed): Research Training in Psychiatry Residency: Strategies for Reform. Washington, DC: The National Archives Press, 2003.
3. Kupfer DJ, Hyman SE, Schatzberg AF, Pincus HA, Reynolds CF 3rd: Recruiting and retaining future generations of physician scientists in mental health. Arch Gen Psych 2002; 59(7): 657–60.
4. Kupfer DJ, Hyman SE, Schatzberg A, et al: Recruiting and retaining future generations of physician scientists in mental health. Archives of General Psychiatry 2002; 59:657–660.

SYMPOSIUM 95—THE WAR COMES HOME: PSYCHOSOCIAL AND PSYCHOSOMATIC CONSEQUENCES OF DEPLOYMENT
APA Caucus of VA Psychiatrists

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe the rehabilitation/recovery orientation toward returning global war on terrorism veterans, describe application of these concepts to veterans and their families, list mental health concerns of injured veterans and their resolution, cite research issues of returning veterans.

No. 95A
REHABILITATION/RECOVERY ORIENTATION TOWARD RETURNING VETERANS

Laurent S. Lehmann, M.D., *Department of Veterans Affairs, (116) VA Central Office, 810 Vermont Avenue, NW, Washington, DC 20420-0002*

SUMMARY:

The Department of Veterans Affairs' (VA) orientation toward the care of veterans is based on the principles of rehabilitation and recovery, and the application of evidence-based practices in psychotherapy and pharmacotherapy. Rehabilitation implies identifying a patient's strengths and well as deficits: supporting the former while eliminating the latter.

Recovery implies involvement of the patient and his/her significant others in the treatment process, empowering them to the greatest degree possible. These principles are consistent with the goals of the President's New Freedom Commission on Mental Health and the VA/DoD Clinical Practice Guidelines on PTSD.

Psychiatrists, psychologists and other mental health professionals may benefit from this presentation.

No. 95B
VA OUTREACH, PSYCHOEDUCATION, AND CARE EFFORTS

Harold Kudler, M.D., *Mental Health, Department of Veterans Affairs, 508 Fulton Street, Durham, NC 27705*

SUMMARY:

Although it has taken a new war to force this paradigm shift, it is clear that action has long been needed across the DoD/VA continuum in order to create more flexible and accessible systems of care and recovery built upon a better understanding of the course and complexity of post deployment responses to psychological trauma. This presentation will describe ongoing outreach and consultation activities with returning veterans and their families.

No. 95C
DEPARTMENT OF DEFENSE CARE FOR INJURED TROOPS AND THEIR FAMILIES

Stephen J. Cozza, M.D., *Department of Psychiatry, Walter Reed Army Medical Center, 6900 Georgia Ave, NW, Washington, DC 20307-5001*

SUMMARY:

Method: The presenter will describe the experiences at Walter Reed Army Medical Center in providing psychiatric support to injured service members returning from military operations in Iraq and Afghanistan, as well as their families.

Results: This population of injured troops possesses unique treatment requirements. Psychiatric symptoms may not always be readily identified by medical and surgical teams treating the injured. Injured soldiers also may not mention their immediate concerns related to their families and children to members of the treatment team. Proactive attention to psychiatric sequelae and family issues in the injured population is essential to recovery.

Conclusions: Experiences suggest that psychiatric consultation that is routinely incorporated into overall medical treatment services best serves these injured troops and their families.

No. 95D
DEPLOYMENT RESEARCH ISSUES: STRESS AND PHYSICAL DISORDERS

Matthew Friedman, M.D., *Department of Psychiatry, Dartmouth Medical School, Hanover, NH 03755*

SUMMARY:

Since the end of the Vietnam War, there has been a growing research literature on the psychiatric and functional problems of veterans returning from war. This presentation will address this literature as it relates to returning Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans including stress responses and their relation to physical disorders. Research questions for the future will also be identified. This presentation will benefit

psychiatrists, psychologists and other mental health professionals including trainees.

REFERENCES:

1. VA/DoD clinical practice guideline for management of post-traumatic stress. Veterans Health Administration, 2004, online at http://www.oqp.med.va.gov/cpg/PTS/PTS base.htm
2. Wain HJ, Cozza SJ, Grammer GG, et al: Treating the Traumatized Amputee, in the Iraq War Clinician Guide. http://www.ncptsd.org//war/iraq_clinician_guide_v2/iraq_clinician_guide_ch_6.pdf.
3. Friedman MJ: Acknowledging the psychiatric cost of war. N Engl J Med 2004; 351:75–77.

SYMPOSIUM 96—RESEARCH AGENDA FOR A DIMENSIONAL CLASSIFICATION OF PERSONALITY DISORDER

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to demonstrate an understanding of current ideas about dimensional perspectives on personality disorder and their implications for classification and clinical practice.

No. 96A
ALTERNATIVE DIMENSIONAL MODELS: TOWARD INTEGRATION

Thomas A. Widiger, Ph.D., *Department of Psychology, University of Kentucky, 115 Kastle Hall, Lexington, KY 40506-0044*

SUMMARY:

Quite a few alternative dimensional models of personality disorder have been developed. The number of alternatives is itself a testament to the interest and importance of developing a dimensional model of personality disorder. This paper will provide a summary of these alternative models but, more importantly, will indicate how most are highly convergent with one another. Much of the existing research has focused on the advantages of one particular model relative to another. However, it is apparent that each model has at least some strengths and potential advantages. In addition, a future edition of the diagnostic manual is unlikely to simply advocate one model to the detriment and rejection of all of the possible alternatives. An important goal for future research will be to work toward an integration of the alternative models. An initial step toward their potential integration will be presented in this paper, along with the difficulties and advantages of working toward a consensus, integrated model.

No. 96B
IS AN ETIOLOGICAL CLASSIFICATION OF PERSONALITY DISORDER FEASIBLE FOR DSM-V?

John Livesley, Ph.D., *Department of Psychiatry, University of British Columbia, 2255 Wesbrook Mall, Vancouver V64 1L1, Canada*

SUMMARY:

The possibility of developing an etiologically-based dimensional classification of personality disorder based on the results of behavioral genetic research is examined. The starting point for such an approach is the convergence of findings across multiple studies of personality disorder phenotypes that three or four higher-order dimensions underlie personality disorder diagnoses. The robustness of this structure across clinical and nonclinical samples and different cultures suggests that it reflects fundamental differences in organization of personality pathology. These factors show some resemblance to some of the more common DSM-IV-TR diagnoses of borderline, antisocial, and schizoid-avoidant personality disorders, making for some degree of continuity with categorical classifications.

Evidence from behavioral genetic studies that genetic influences on personality are pervasive: no aspect of personality seems immune to genetic influence. It will be argued that there is high genotype-phenotype correspondence for the four factors and that the trait structure of personality disorder emerges from the self-organizing effects of multiple genetic influences, making it feasible to develop a genetically based classification of individual differences in personality disorder for DSM-V.

No. 96C
PERSONALITY DIMENSIONS INTEGRATE AXIS I AND AXIS II CLASSIFICATION SYSTEMS

Lee Anna Clark, Ph.D., *Department of Psychology, University of Iowa, E11 Seashore Hall, Iowa City, IA 52242-1407*

SUMMARY:

Going back to antiquity, personality and psychopathology have been viewed as related domains but, until recently, the nature of their relations has not been clear. With the rise of modern science in the early 20th century, they came to be studied as separate fields and, within psychopathology, finer and finer distinctions were made until clinical syndromes were separated from personality disorders in 1980. This division led, conversely, to the revelation of a high degree of overlap (comorbidity) among disorders both within and across axes, and back to the joint study of normal and abnormal personality. Further investigation has revealed that personality traits correlated with both Axis I and II disorders can account for their overlap. Moreover, other research has shown that personality dimensions have moderate to strong heritability and that at least two broad personality dimensions—negative and positive emotionality—are both affectively based and identifiable in infancy. Thus, personality trait dimensions and a broad range of psychopathology can be integrated into a single hierarchical model, with innate temperament primarily providing higher-order unifying links and specific lower-order factors defining the details of the structural interrelations.

No. 96D
CLINICAL UTILITY OF DIMENSIONAL MODELS OF PERSONALITY PATHOLOGY

Roel Verheul, Ph.D., *Department of Psychology, University of Amsterdam, Roetersstraat 15, Amsterdam 1018 WB, Netherlands*

SUMMARY:

The DSM-IV Axis II classification of personality disorders has often been criticized because of limited clinical utility. This problem partly accounts for the relative low frequency of systematic Axis II assessment in clinical practice. In addition, clinical research is often constrained by the categorical nature of Axis II. Dimensionalizing Axis II only solves part of the problems. It is therefore useful to consider the potential clinical utility of dimensional alternatives. This presentation focuses on the usefulness of alternative approaches for case identification (or diagnosis), treatment assignment (or matched care), treatment planning (or goal setting), and treatment evaluation (or effectiveness research). The utility is evaluated in terms of theoretical relevance, predictive validity, measurability, and feasibility. Finally, the alternatives will be considered from the perspective of changeability.

REFERENCES:

1. Widiger TA, Samuel DB: Diagnostic categories or dimensions: a question for DSM-V. Journal of Abnormal Psychology, in press.

2. Livesley WJ: Diagnostic dilemmas in classifying personality disorder, in K.A. Phillips, M.B. First, & H.A. Pincus (Eds.,) Advancing the DSM: Dilemmas in Psychiatric Diagnosis. Washington, DC, American Psychiatric Press, 2003, pp 153–189.
3. Clark LA: Temperament as a unifying concept in the study of personality and psychopathology. Journal of Abnormal Psychology, in press.
4. Verheul F, Widiger TA: A meta-analysis of the prevalence and usage of the personality disorder not otherwise specified diagnosis. Journal of Personality Disorders 2004; 18:309–319.

SYMPOSIUM 97—TRANSCULTURAL ARAB PERSPECTIVE ON SUBSTANCE ABUSE AND DEPENDENCE
Arab American Psychiatric Association

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the nature of drug abuse disorders and comorbidities in a sample of Arab population from Egypt and Saudi Arabia.

No. 97A
HIGHLIGHTS ON DEPENDENCE: AN EGYPTIAN PERSPECTIVE

Ahmed M.F. Okasha, M.D., *Institute of Psychiatry, Ain Shams University, 3, Shawarby Street, Kasr El-Nil, Cairo, Egypt*

SUMMARY:

In many Arab countries addiction is considered a social malady or a crime more than a medical disease. Egypt spearheaded many European countries in initiating in 1928 the first office for combating narcotics, which was the first one in the region. A global increase of psychoactive substance with regard to cannabis, amphetamine-type stimulants (ATS), cocaine, and heroin is an alarming state. Cannabis is the most commonly used drug (141 million current users), followed by ATS (30 million), and cocaine (13 million). ATS use shows the most dynamic growth. In Egypt there is a sharp increase in the consumption of hashish and bango. Between 1999 and 2003 there was a triple rise in the amount seized by narcotics combat administrator. There is decline in heroin, cocaine, stimulant, and narcotic tablets.

In 1996, WHO estimated that 6.7% of the global burden of disease was directly attributable to psychoactive substance use, including alcohol (3.5%), tobacco (2.6%), and illicit drugs (0.6%). Most EMRO countries report that addicts are treated under medical supervision and in medical facilities, mainly centralized inpatient settings in which services are almost exclusively limited to detoxification. Even where outpatient treatments exist, there is little or no real rehabilitation involved. The paper will discuss the size of the problem, economic aspects, and strategies to deal with narcotics supply, demand, and management in Egypt.

No. 97B
DUAL DIAGNOSIS IN SUBSTANCE ABUSE IN AN EGYPTIAN SAMPLE

Tarek A. Okasha, M.D., *Department of Neuropsychiatry, Ain Shams University, 3, Shawarby Street, Kasa El-Nil, Cairo, Egypt;* Afaf Hamed Khalil, M.D., Tarek A. Asaad, M.D., Mohamed Abouzied, M.D., Hisham Hatata

SUMMARY:

Comorbidity is defined as the temporal co-occurrence of different disorders in the same subject. The exact meaning of the term refers to the coexistence of different disease with specific aetiology and pathophysiologies. However, the actiology and path physiology of most psychiatric disorders are unknown. Thus, dual diagnosis might be a more appropriate term in psychiatry.

This study was carried out at the Institute of Psychiatry, Ain Shams University on 73 patients, both inpatients and outpatients. Our results showed the prevalence of current substance abuse as 7.9% with alcohol dependence, 21.1% cannabis dependant, 86.4% were opiate dependant, and 14.5% were sedative dependant. Regarding axis 1 comorbidity, 53.9% of subjects had an axis 1 diagnosis and 53.1% of subjects had a comorbid personality disorder.

The results of this study will be reviewed during this presentation.

No. 97C
SUBSTANCE ABUSE AND COMORBIDITIES AMONG MEN IN SAUDI ARABIA

Ossama T. Osman, M.D., *Department of Psychiatry, United Arab Emirates, P.O. Box 1766, Al-Ain, U. Arab Emirates*

SUMMARY:

Saudi Arabia has pioneered the development of comprehensive state-of the art multidisciplinary detoxification and residential addiction treatment services in the Gulf region through four freestanding addiction treatment centers "Al-Amal Hospitals." This presentation will discuss services provided through one of these regional hospitals, a 276-bed hospital in Jeddah serving the entire western region of the kingdom with a catchment area of over five million. The vast majority of admissions is from the age group 25–45 years, representing severe forms of addictive illnesses and comprising 85% of the total admissions.

The most commonly used illicit substances are as follows: amphetamine (29%), heroin (17%), alcohol (9%), cannabis (8%), inhalants (2.4%).

There is a substantial comorbidity with other psychiatric disorders using the MINI International NeuroPsychiatric Interview a DSM-VI based structured diagnostic assessment tool. The most common comorbid conditions are anxiety disorders representing 65%, and affective depressive disorders (38%). Most striking among the anxiety disorders is GAD (33%), panic (26%), social anxiety (16%), and agoraphobia (9%). The speaker will outline cross-cultural lessons that are learned from this experience. Specific diagnostic and treatment strategies will also be discussed.

No. 97D
SUBSTANCE ABUSE AMONG ARAB WOMEN: A SAUDI PERSPECTIVE

Mona H. Al-Sawaf, M.D., *Department of Psychiatry, King FAHD General Hospital, Al-Mosadia-Madina Road, P.O. Box 14528, Jeddah 21434, Saudi Arabia*

SUMMARY:

The prevalence of illicit substance abuse and dependence among women in Saudi Arabia is low, but has serious social consequences. In our experience the most commonly used drugs among women in a descending order are cannabis, alcohol, heroin, and amphetamine. The vast majority of women with substance abuse referred for treatment in Saudi Arabia are between the ages of 18–28, are of various socioeconomic groups, expatriots, and have family history of substance abuse. Most are never married or divorced and all have nicotine dependence through smoking cigarettes or inhaling burned tobacco in water pipes (Shisha-Argila). Bipolar affective disorders

and borderline personality disorder are the most frequent comorbid psychiatric conditions. The specific mental and cognitive effects of various substances that are observed in our population will be outlined. Interesting cases will be mentioned to demonstrate genetic and developmental vulnerabilities specific to this population. The socioeconomic consequences of substance abuse among women in this rapidly progressive country will be discussed. The unique collaboration of the Ministry of Health with the Ministry of Interior in Saudi Arabia to address substance abuse issues in women provides a unique care model that will be detailed.

REFERENCES:

1. Human Development Report 2003. Millennium Development Goals: A Compact Among Nations to End Human Poverty. New York, Oxford University Press, 2003.
2. Timko C, Sempel JM, Moos RH: Models of standard and intensive outpatient care in substance abuse and psychiatric treatment. Adm Policy Ment Health 2003; 30(5):417–36.
3. Sheehan D, Lecrubier Y, Sheehan K, et al: The MINI International NeuroPsychiatric Interview eMINI 5.0.0. Medical Outcomes Inc. Jacksonville, FL.
4. NIDA Reports 2000 to 2004.

SYMPOSIUM 98—DEPRESSION AND EPILEPSY: A UNIQUE AND COMPLEX RELATIONSHIP

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the biologic aspects of depression in epilepsy that are not present with depression in other chronic illness; diagnose depression in children and adults with epilepsy, considering that it may have atypical features; understand the relative safety of antidepressant medications in epilepsy; treat psychogenic pseudoseizures in collaboration with the neurologist.

No. 98A
THE UNIQUE RELATIONSHIP BETWEEN DEPRESSION AND EPILEPSY

Cynthia L. Harden, M.D., *Department of Neurology, Weill Cornell Medical Center, 525 East 68 Street, Room K-615, New York, NY 10021*

SUMMARY:

Depression is common in patients with epilepsy, and occurs at a much higher rate than in the general population, especially when seizures are not well controlled. Mood dysfunction greatly impacts quality of life for persons with epilepsy, but is often unrecognized and undertreated. The manifestation of depression in epilepsy is multifaceted, due to many interacting neurobiological and psychosocial determinants, including clinical features of epilepsy (seizure frequency, type, foci, or lateralization of foci). Depression is reported more frequently in patients with temporal lobe epilepsy and left-sided foci, than with other epilepsies. However, epidemiological studies have revealed a bidirectional association between depression and epilepsy, since major depressive disorders precede the onset of epilepsy at a higher than expected rate. The three main neurotransmitters targeted for the pathophysiology of mood disorders, serotonin, noradrenaline, and gamma-aminobutyric acid (GABA) are all strongly anticonvulsant in the brain. This mechanistic convergence supports a biologic relationship between the two disorders that goes beyond the psychosocial and treatment-related contributors to depression in epilepsy. Although the limbic substrate appears to be most involved in the vulnerability to depression in epilepsy, other epilepsies such as frontal lobe epilepsy and primary generalized epilepsies are associated with more subtle neuropsychiatric dysfunction as well.

No. 98B
MANIFESTATIONS AND TREATMENT OF DEPRESSION IN EPILEPSY

John J. Barry, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, MC 5723, Stanford, CA 94305*

SUMMARY:

Mood disorders, as a comorbid finding in people with medical disorders in general, and in those with epilepsy in particular, have become increasingly recognized as a serious health concern. The consequences of poor detection and treatment of mood disorders in people with epilepsy will be discussed, along with a review of the unique appearance of the disorder in this population. Prevalence rates of both depressive and bipolar spectrum disorders in people with epilepsy appear to be higher than in the general population. Recent data from community samples show elevated rates of both disorders in people with epilepsy, significantly above those in people with and without other chronic diseases. Assessment issues, including the positive and negative side effects of antiepileptic drugs, will be reviewed. Treatment options will be discussed, along with caveats concerning the use of antidepressants in people with epilepsy, with a focus on safety, utility, and drug interactions. Electroconvulsive therapy can also be used safely in people with epilepsy, and vagus nerve stimulation may have some utility in the treatment of depressive disorders as well. However, despite improved detection methods and effective treatments, implementation of this knowledge in neurology outpatient clinics is still problematic.

No. 98C
MOOD DISORDERS IN CHILDREN WITH EPILEPSY

David W. Dunn, M.D., *Riley Hospital Room 3701, 702 Barnhill Dr, Indianapolis, IN 46202-5128*

SUMMARY:

Children with epilepsy are at increased risk of behavioral and emotional problems compared with both children from the general population and children with other chronic illnesses not involving the central nervous system. Risk factors are multiple and include additional neurological impairment, intractable seizures, and family dysfunction. Recent work has shown in particular that children with both epilepsy and low IQ should be carefully assessed for mental health problems in the clinical setting. The more common psychiatric disorders seen in children with epilepsy are attention-deficit-hyperactivity disorder, mood disorders, and anxiety disorders. Symptoms of depression have been found in approximately one-fourth of adolescents with epilepsy. One recent study described suicidal ideation in 17% of adolescents with epilepsy. In this presentaqtion, we will discuss the neuropsychiatric aspects of epilepsy in children and adolescents and will include information on possible interventions for pediatric patients with epilepsy and psychiatric problems.

No. 98D
PSYCHOLOGICAL NONEPILEPTIC SEIZURES

W. Curt LaFrance, Jr., M.D., *Department of Psychoneurology, Brown Medical School, RIH 593 Eddy Street, Potter 3 Neuropsychology, Providence, RI 02903*

SUMMARY:

Psychological nonepileptic seizures (NES) are neuropsychiatric disorders presenting with a combination of neurologic signs and underlying psychological conflicts. Etiology is speculative, but patients with NES share some commonalities in their histories. A history of abuse, depression, post-traumatic stress symptoms, and dissociation are often present. The differential diagnosis for nonepileptic events is lengthy, and epileptic seizures of frontal lobe origin present a unique challenge. Presenting the diagnosis to the patient, the role of the neurologist, and the role of the mental health provider will be reviewed. Issues in the doctor-patient relationship are also addressed, as well as the overall prognosis. For more than a century, the medical community has accumulated data and insights about the phenomenology, epidemiology, risks, comorbidities, and prognosis of NES. We, however, have not progressed much beyond anecdotal reports of treatments for NES, and no randomized, placebo-controlled trials of treatment for the disorder have been conducted. In this discussion, the diagnosis and treatment of NES will be discussed, including directions for future research in these areas.

REFERENCES:

1. Harden CL: The comorbidity of depression and epilepsy: epidemiology, etiology, and treatment. Neurology 2002; 59(6 Suppl 4):48–55.
2. Barry JJ: The recognition and management of mood disorders as a comorbidity of epilepsy. Epilepsia 2003; 44 Suppl 4:30–40.
3. Dunn DW: Neuropsychiatric aspects of epilepsy in children. Epilepsy Behav 2003, 4(2) p101–6.
4. LaFrance Jr WC, Devinsky O: The treatment of nonepileptic seizures: historical perspectives and future directions. Epilepsia 2004; 45 Suppl 2:15–21.

SYMPOSIUM 99—CHILDHOOD SEXUAL ABUSE: VICTIMS AND PERPETRATORS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to demonstrate knowledge about (1) the pernicious impact of childhood sexual abuse on later mental health, (2) the personality characteristics of victims and perpetrators, (3) the effective assessment of perpetrators, and (4) the relationship between early childhood abuse and development of pedophilia.

No. 99A
THE ASSESSMENT AND TREATMENT OF SEXUAL OFFENDERS

Kostas Katsavdakis, Ph.D., *Department of Psychiatry, Kirby Forensic Center, Wards Island Complex, New York, NY 10035;* David Schaich, Ph.D., Sam Langer, M.D.

SUMMARY:

Kirby Forensic Psychiatric Center and Manhattan Psychiatric Center, facilities run by the Office of Mental Health, State of New York, currently have in place a sexual offender treatment program that integrates assessment and treatment. The integrated assessment and treatment program includes addressing sex offender stereotypes and how to make an assessment regarding discharge/return to the community. We present descriptive data detailing the demographics and risk assessment instrument findings, including the Static-99, SONAR, PCL-SV, and ABEL Assessment of Sexual Interest for approximately 25 patients currently undergoing treatment. Sexual offenders include persons engaging in child molestation, rape of adult victims, and mixed offenders (rape and child molestation). The risk assessment data provide risk estimation for sexual re-offense once discharged into the community. In addition, available baseline and follow-up data are provided to assess change over the course of one year of treatment.

No. 99B
ASSOCIATION OF DIFFERENT TYPES OF CHILDHOOD ABUSE AND PERSONALITY PATHOLOGY

Pamela McGeoch, M.A., *Department of Psychology, New School for Social Research, 65 5th Avenue, New York, NY 10003;* Jeffrey Johnson, Ph.D.

SUMMARY:

There is little current knowledge about how the different subtypes of childhood trauma are differentially associated with Axis II personality pathology. Only one community-based study (Johnson et al, 1999) has empirically examined the association of different kinds of childhood maltreatment with the entire range of personality disorders. Comparable findings have not yet been obtained from a clinical sample. In this presentation, data from 125 subjects both in inpatient and outpatient settings will be discussed in the context of relevant literature. The current study will investigate the differential associations of specific subtypes of childhood maltreatment (sexual, physical, and emotional abuse and neglect) with Axis II personality pathology. Based on a thorough review of the literature, the following specific associations were predicted: (1) childhood sexual abuse with borderline personality disorder and sexual dysregulation, (2) physical abuse with antisocial personality disorder, impulsivity, and aggression, (3) emotional abuse with avoidant and narcissistic disorder and self esteem deficits, and (4) neglect with schizoid, schizotypal, and paranoid disorder and intimacy deficits. Measures employed include the Structured Clinical Interview for DSM-IV Axis II disorders (SCID II), the Childhood Trauma Interview, and several dimensional measures. Implications for treatment as well as for further research will also be discussed.

No. 99C
PERSONALITY PATHOLOGY IN MALE PEDOPHILES COMPARED WITH TWO CONTROL GROUPS

Yuli Grebchenko, M.D., *Department of Psychiatry, Beth Israel Medical Center, 1st Avenue and 16th Street 6K42, New York, NY 1003;* Matthew Steinfeld, B.A., Mustafa Kaleem, M.D., Lauren Kunik, B.A., Ken Cullen, M.S.W., Igor I. Galynker, M.D., Lisa J. Cohen, Ph.D.

SUMMARY:

Despite the enormous literature documenting the pathological sequellae of childhood sexual abuse, there is surprisingly little literature on the personality profile of the perpetrators. In this presentation, relevant literature is summarized and results from a study comparing male pedophiles with a group of healthy controls and a patient control group of substance abusers. Specifically, levels of impulsivity, psychopathy, and propensity toward cognitive distortions were compared across groups. It was predicted that pedophiles, relative to substance abusers, would show lower levels of impulsivity, higher levels of propensity toward cognitive distortions, and equal levels of psychopathy. Measures included the Structured Clinical Interview for DSM IV disorders-Axis II (SCID II), the Hare Psychopathy Checklist-Revised (PCL-R), and the Barratt Impulsivity Scale. As predicted, pedophiles scored highest on Cluster A traits on SCID II, consistent with an elevated propensity toward cognitive distortion. Further, pedophiles scored lower than Substance Abusers on the

Barratt Impulsivity Scale. While both patient groups scored higher than controls on the Total and Behavioral (Factor 2) Psychopathy Score, only pedophiles scored higher than controls on the Attitudinal Psychopathy (Factor 1) score. Implications for treatment, assessment, and etiological theories of pedophilia will be discussed.

No. 99D
RELATIONSHIP OF CHILDHOOD SEXUAL ABUSE HISTORIES TO ADULT PEDOPHILIC BEHAVIOR

Lisa J. Cohen, Ph.D., *Department of Psychiatry, Beth Israel Medical Center, First Avenue at 16th Street, Suite 6K42, New York, NY 10003;* Yakov Semenov, M.D., Mustafa Kalim, Yuli Grebchenko, M.D., Matthew Steinfeld, B.A., Lauren Kunik, B.A., Igor I. Galynker, M.D.

SUMMARY:

Numerous reports indicate that pedophiles have an increased rate of childhood sexual abuse, but the degree to which such history is specific to pedophiles is unclear. We compared a sample of male pedophiles with two control groups, a group of substance abusers (SA) characterized by antisocial and impulsive traits, and a healthy control group. Further, we examined the relationship between childhood sexual history to number, age, and gender of admitted victims. Male pedophiles (n=40) were recruited from an outpatient facility specializing in the treatment of sex offenders. Opiate abusers (n= 16) were recruited from an inpatient treatment setting and healthy controls (n=36) from media advertising. As predicted, pedophiles reported the highest level of childhood sexual abuse (60%), substance abusers the second highest (20%), and controls the lowest (3%). Moreover, although both SA and pedophiles had a significantly earlier age of first sexual contact than controls, pedophiles but not SAs had a significantly higher age difference with their first sexual partners than controls. Surprisingly, pedophiles with a history of childhood sexual abuse did not report more victims or acts than those without such a history. The implications of these findings for treatment and assessment and the relevant literature will be discussed.

REFERENCES:

1. Beech AR, Fisher DD, Thornton D: Risk assessment of sex offenders. Professional Psychology: Research and Practice 2003; 4:339–352.
2. Johnson JG, Cohen P, Brown J, et al: Childhood maltreatment increases risk for personality disorders during early adulthood. Arch Gen Psych 1999; 56:600–606.
3. Cohen et al: Personality impairment in male pedophiles. J Clin Psychiatry 2002; 63:912–915.
4. Cohen LJ, McGeoch PG, Watras Gans S, Nikiforov K, Cullen K, Galynker II: Childhood sexual history of 20 male pedophiles vs. 24 healthy control subjects. J Nerv Ment Dis 190:(11):1–9.

SYMPOSIUM 100—HOW TO DETERMINE CAPACITY FOR MEDICAL DECISION MAKING IN PATIENTS ON MEDICAL-SURGICAL SERVICES

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand clinical, ethical, and legal aspects of four types of capacity determinations and improve skills in making those determinations.

No. 100A
MEDICAL DECISION-MAKING CAPACITY

James L. Stinnett, M.D., *Department of Psychiatry, University of Pennsylvania Founders II Hosp., 3400 Spruce St, Philadelphia, PA 19104-4204*

SUMMARY:

The evaluation of medical decision-making capacity involved an assessment of four aspects of the process of making a decision: (1) presentation of relevant information, (2) assessing whether the information is processed logically and rationally, (3) assessing whether the patient has an "appreciation" of the information, (4) determining whether the patient can communicate a clear and consistent decision concerning their treatment.

Clinical examples of each aspect will be presented and examples of how capacity can be improved with clinical intervention will be discussed.

No. 100B
HOW TO DETERMINE MATERNAL CAPACITY IN PATIENTS ON MEDICAL-SURGICAL SERVICES

Barbara K. Schindler, M.D., *Dean's Office & Psychiatry, Drexel University College of Medicine, 2900 Queen Lane, Philadelphia, PA 19129*

SUMMARY:

Psychiatric consultants are regularly challenged by requests to determine maternal competency on maternity services, pediatric inpatient units and clinics, and in the emergency room when there is evidence of child abuse or neglect, or an infant or child is viewed as vulnerable because of a maternal psychiatric or addictive disorder. Clinical evaluations are highly dependent on data from the patients as well as pediatricians, nurses, social workers, family members and frequently require interactions with the local human services departments and family court system. When the difficult decision is initially made to separate mother and child, the psychiatric consultant can be called to testify in court, and needs to be familiar with local and at times federal laws governing such actions. The United State Supreme Court has been involved in two recent state cases. The clinical situation is frequently fraught with polarized opinions about the mother's capacity to care for her child(ren) and counter-transference feelings can be high.

No. 100C
DISPOSITIONAL CAPACITY

Dilip Ramchandani, M.D., *Department of Psychiatry, Drexel University College of Medicine, P.O. Box 45358, Philadelphia, PA 19124-8358*

SUMMARY:

The symposium will include a discussion of the ethical and legal principles and different clinical approaches in an evaluation of capacity to make decisions concerning end-of-life and a safe disposition. A consultation psychiatrist may be asked to determine whether a hospitalized patient has the clinical capacity to make decisions about safe disposition. Such issues arise when a family member or a physician doubts the patient's ability to live safely in a post-hospital environment and favor discharge to a more structured setting, while the patient wishes to go to another setting after discharge, frequently back to his/her own home.

The dilemma before the psychiatrist is to balance the patient's right to choose where to live with the caretaker's duty to protect the patient from potentially harmful consequences of his/her decision.

This dilemma is resolved by evaluating the patient's clinical capacity for deciding to live in the patient's chosen setting.

REFERENCES:

1. Grisso T, Appelbaum P: Assessing Competence to Consent to Treatment. Oxford Univ Press, New York, 1998.
2. Nair S, Morrison M: The evaluation of maternal competency. Psychosomatica 2000; 41:523–530.
3. Younger SJ: Competence to refuse life-sustaining treatment, in End-of-Life Decisions. Edited by Steinberg MD, Younger SJ. Washington, DC, American Psychiatric Press, 1998.

SYMPOSIUM 101—LONG-TERM CARE AND TREATMENT OF ELDERLY PATIENTS WITH SCHIZOPHRENIA

APA Corresponding Committee on Long-Term Care and Treatment for the Elderly

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize: (1) how psychiatric/medical comorbidities affect access to/delivery of care for elderly schizophrenic patients (2) the range of models-of-care (3) developments in non-pharmacologic/pharmacologic interventions (4) the role of ethnic/cultural factors in the presentation/treatment of elderly schizophrenic patients.

No. 101A
THE IMPACT ON THE HEALTH CARE SYSTEM OF ELDERLY PATIENTS WITH SCHIZOPHRENIA

Helen H. Kyomen, M.D., *Department of Psychiatry, McLean Hospital, 115 Mill Street, Belmont, MA 02478-9106*

SUMMARY:

The number of Americans over 65 years of age with psychiatric illness, including schizophrenia, is expected to grow dramatically, with a projected total of 15 million in 2030—up from approximately 7 million currently and 4 million in 1970. Elderly schizophrenic patients differ from younger patients in many ways: They tend to have prominent negative symptoms, varying gradations of depressive symptoms, and greater cognitive diminution. Older persons with schizophrenia are especially prone to cardiovascular disease and diabetes, and are at greater risk for pharmacologic treatment complications and side effects. In addition, elderly patients with schizophrenia are subjected to the double jeopardy of stigma from both mental illness and advanced age. Older adults with mental illness, compared with younger adults, are often at greater risk for receiving inadequate assessments and inappropriate care, which may lead to greater disability and impairments. The growing numbers of elderly with schizophrenia, many with psychiatric and medical comorbidities, together with increasing financial constraints from insurance companies and inadequate resources devoted to the care of these patients, will increasingly impact health care delivery programs intended to serve elderly patients with schizophrenia.

No. 101B
LONG-TERM CARE, HEALTH MANAGEMENT, AND REHABILITATION OF ELDERLY PATIENTS WITH SCHIZOPHRENIA

Stephen J. Bartels, M.D., *Department of Psychiatry, Dartmouth Medical School, 2 Whipple Place, Suite 202, Lebanon, NH 03766*

SUMMARY:

Older adults with severe mental illness (SMI) are at high risk for early mortality, excess disability, and disproportionate institutionalization in nursing homes associated with deficits in community living skills, poor health behaviors, inadequate health care, and a lack of appropriate long-term care alternatives to nursing homes. The recent Olmstead Decision by the U.S. Supreme Court mandates that States provide community placements for people with disabilities when community placement is appropriate and desired by the affected individual. Approximately 40% of older persons with SMI are inappropriately placed in nursing homes according to consumers and their clinicians. Community-based long-term care alternatives include a range of settings and services that provide social support, rehabilitative services, and health care management for co-occurring persistent psychiatric illness and the high prevalence of multiple medical comorbidities. Provided in this presentation is an overview of research on the correlates of intensive service use, consumer preferences and clinical correlates of appropriate care, and data on the quality of health care for comorbid medical illness. Research on a combined model of community-based rehabilitation and health management will be discussed with specific attention to skills training, nurse care management, and health promotion interventions.

No. 101C
EVOLUTION OF TREATMENT INTERVENTIONS FOR ELDERLY PATIENTS WITH SCHIZOPHRENIA

Susan M. Edwards-Loidl, M.D., *Department of Geriatric Psychiatry, Cambridge Health Alliance, 1493 Cambridge Street, Cambridge, MA 02139*

SUMMARY:

Numerous factors may affect the course of schizophrenia in elderly patients. Nonpharmacologic interventions, especially psychosocial rehabilitation services and assistance with problem-solving skills and financial management, may be just as important as pharmacologic strategies—and can be more adaptable. Several literature reviews have suggested that the long-term use of antipsychotic medications may be associated with favorable outcomes. However, of notable concern in the elderly are such side effects as cognitive diminution, sedation, constipation, incontinence, orthostatic hypotension, acute extrapyramidal symptoms, and tardive dyskinesia. In a number of long-term studies, about half of the recovered patients discontinued their medications. Even in short-term studies, and even when treatment effects are significant, medication adherence has been found to be problematic. The advent of atypical antipsychotic agents has provided additional pharmacologic intervention options to treat both positive and negative schizophrenic symptoms with less risk for side effects. However, insurance coverage for these relatively expensive medications is variable, so that their long-term use by elderly schizophrenic patients may be impracticable in some instances.

In this presentation, the participant will learn how nonpharmacologic and pharmacologic interventions for elderly schizophrenic patients have evolved over time, and what treatments are currently considered to be safe and effective.

No. 101D
ETHNIC AND CULTURAL ISSUES IN THE CARE OF ELDERLY PATIENTS WITH SCHIZOPHRENIA

Iqbal Ahmed, M.D., *Department of Psychiatry, University of Hawaii, 1356 Lusitana Street, 4th Floor, Honolulu, HI 96813*

SUMMARY:

There is an increasing proportion of elderly who belong to minority groups in the U.S. This also applies to the elderly who suffer from

schizophrenia, and their families and caregivers. Diagnosis given to a patient, such as schizophrenia vs. bipolar disorder, has been demonstrated to be affected by differences in culture and ethnicity between the patient and the treatment provider. Culture and ethnicity of patients and their families also affect their attitudes toward psychiatric problems, and seeking of psychiatric help. There are also problems in access to culturally sensitive psychiatric care, and inadequate utilization of patients' ethnic/cultural community supports. Culturally competent care can lead to more accurate diagnosis, increased help seeking by patients and families, increased treatment adherence, more effective treatment, and greater patient and caregiver satisfaction.

REFERENCES:

1. Bartels SJ: Improving the system of care for older adults with mental illness in the United States. Am J Geriatr Psychiatry 2003; 11:486–497.
2. Bartels SJ, Miles KM, Dums AR, Levine KJ: Are nursing homes appropriate for older adults with severe mental illness? Conflicting consumer and clinician views and implications for the Olmstead Decision. J Am Geriatr Soc 2003; 51:1571–1579.
3. Jeste D, Glick ID: Intervention research in psychosis: past, present, and future. Schizophr Bull 2000; 26:527–531.
4. Takeshita J, Ahmed I: cultural aspects of geriatric psychiatry, in Wen Shing Tseng, J Streltzer (Eds), Culture Competence in Clinical Psychiatry. American Psychiatric Press Inc. Washington, D.C., 2004.

SYMPOSIUM 102—NEUROBIOLOGY OF COMPULSIVE REWARD-SEEKING
National Institute on Drug Abuse

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to identify the neurobiological substrates of compulsive reward seeking behavior, why some individuals are more vulnerable than others, how restricted access to rewards sets the stage for compulsive reward seeking, and how behavior is maintained despite aversive consequences.

No. 102A
COMPULSIVE DRUG USE AND THE DYSREGULATION OF BRAIN REWARD AND STRESS SYSTEMS

George F. Koob, Ph.D., *Department of Neuropharmacology, Scripps Research Institute, 10550 North Torrey Pines Road, CVN7, La Jolla, CA 92037*

SUMMARY:

A conceptual structure for drug addiction focused on allostatic changes in reward function that lead to excessive drug intake provides a heuristic framework with which to identify the neurobiologic and neuroadaptive mechanisms involved in the development of drug addiction and targets for medications development for treatment of addiction. Decreases in reward are associated with withdrawal from chronic drugs of abuse and escalation in drug intake. The brain reward system implicated in the development of addiction is comprised of key elements of a basal forebrain macrostructure termed the extended amygdala and its connections. Neuropharmacologic studies in animal models of addiction have provided evidence for the dysregulation of specific neurochemical mechanisms not only in specific brain reward systems in the extended amygdala (opioid peptides, ?-aminobutyric acid, glutamate and dopamine), but also is recruitment of brain stress systems (corticotropin-releasing factor and norepinephrine) and dysregulation of brain anti-stress systems (neuropeptide Y) that provide the negative motivational state associated with drug abstinence. The changes in the reward and stress systems are hypothesized to maintain hedonic stability in an allostatic state, as opposed to a homeostatic state, and as such convey the vulnerability for development of dependence and relapse in addiction. Future challenges for medications development center not only on identifying the molecular and cellular changes that contribute to the neuroadaptations within specific motivationally relevant neurocircuits associated with transition to dependence, motivational withdrawal, protracted abstinence and vulnerability to relapse, but also on identifying novel medications to redress these neuroadaptive changes.

No. 102B
A BEHAVIORAL MODEL OF BINGE-TYPE EATING: RELEVANCE TO SUBSTANCE ABUSE

Rebecca L. Corwin, Ph.D., *Department of Nutritional Sciences, Penn State University, 126 South Henderson, University Park, PA 16802*

SUMMARY:

Nonhomeostatic compulsive behaviors include those characterized by intermittent episodes of behavioral excess such as drug abuse and binge eating. We have developed a behavioral model of binge-type eating in which intermittent excessive fat intake (binge-type eating) is induced in non-food-deprived rats. Peptide signals involved in the regulation of fat intake in non-binge protocols are without effect under our conditions. In contrast, GABA-B receptor activation selectively reduces fat intake, while having no effect on, or stimulating, chow intake in our model. GABA-B receptor activation also reduces drug self-administration in animals and has shown clinical promise in the treatment of substance abuse disorders. Thus, GABA-B receptors provide a new direction for mechanistic studies as well as for the development of therapeutic interventions relevant to different types of intermittent compulsive behavioral excess.

No. 102C
INCREASING MOTIVATION TO SELF-ADMINISTER COCAINE: IMPORTANCE OF BINGE-ABSTINENCE CYCLES

David C.S. Roberts, Ph.D., *Departments of Physiology and Pharmacology, Wake Forest University School of Medicine, Medical Center Boulevard, Winston-Salem, NC 27157*

SUMMARY:

The process of addiction involves a transition from recreational drug use to compulsive drug taking. To understand or study this behavioral phenomenon from a neurobiological perspective, behavioral models that reflect this process are necessary. The development of a animal model that incorporates self-administration-induced changes in the reinforcing efficacy of cocaine will be described. Using a progressive ratio schedule of reinforcement to probe the motivational state of the animal, we have identified two necessary conditions for the development of this sensitization: extended access to cocaine and a deprivation period. This model, in conjunction with recently developed tools to characterize neurochemical and epigenetic changes, will provide a better understanding of the neurobiological bases of the addiction process.

No. 102D
ADDICTION-LIKE BEHAVIOR IN THE RODENT: INSIGHT INTO THE TRUE NATURE OF ADDICTION

Pier V. Piazza, Ph.D., *U588, INSERM, Rue Camille St Saens, Bordeaux 33000, France*

SUMMARY:

Although the voluntary intake of drugs of abuse is a behavior largely preserved throughout phylogeny, it is currently unclear whether pathological drug use, i.e. "addiction," can be observed in species others than humans. Here we report that behaviors that resemble three of the essential diagnostic criteria for addiction used in the DSM-IV, appear over time in rats trained to self-administer cocaine. As in humans, this addiction-like behavior is present only in a small proportion of subjects using cocaine and is highly predictive of relapse after withdrawal. It is then the interaction between a long exposure to drug and a vulnerable phenotype, not one or the other factor in itself, that seems to determine the development of addiction. These findings provide a new ground for developing a true understanding and treatment of addiction, suggesting that addiction is similar to other behavioral pathologies that most often results from the interaction between a pathogenic agent and a vulnerable substrate.

REFERENCES:

1. Koob GF: Neuroadaptive mechanisms of addiction: studies on the extended amygdala. European Neuropsychopharmacology 2003; 13:442–452
2. Corwin R, Buda-Levin A: Behavioral models of binge-type eating. Physiol Behav 2004; 82:123–130.
3. Morgan D, Roberts DCS: Sensitization to the reinforcing effects of cocaine following binge-abstinent self-administration. Neuroscience and Biobehavioral Reviews 2004; 27:803–812.
4. Deroche-Gamonet V, Belin D, Piazza PV: Evidence for addiction-like behavior in the rat. Science 305, 1014–1017.

SYMPOSIUM 103—BARRIERS TO THE EFFECTIVE TREATMENT OF PERSONALITY DISORDERS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should recognize that patients with personality disorders often receive inadequate treatment and understand some of the reasons why.

No. 103A
UTILIZATION AND BARRIERS TO TREATMENT BY PATIENTS WITH PERSONALITY DISORDERS

Donna S. Bender, Ph.D., *Department of Personality Disorders, New York State Psychiatric Institute, 1051 Riverside Drive, Box 129, New York, NY 10032;* Andrew E. Skodol II, M.D., Ingrid R. Dyck, M.P.H., Maria E. Pagano, Ph.D.

SUMMARY:

Objective: To examine patterns of, and possible barriers to, use of mental health treatments over a three-year period by patients with schizotypal, borderline, avoidant, or obsessive-compulsive personality disorders (PDs), or with major depressive disorder without PD.

Method: Prospective, longitudinal study design. Treatment utilization for 633 individuals was assessed at one year, two years, and three years following study intake.

Results: Patients with borderline personality disorder (BPD) were significantly more likely than depressed patients without PDs to use most types of treatments. All groups declined after one year in reported use of individual psychotherapy, while use of medication sessions, emergency rooms, and psychiatric hospital services remained constant over time. African-American and Hispanic patients received less treatment than white patients, and lower socioeconomic status was also associated with use of fewer treatment resources.

Conclusions: Decreasing utilization and inadequate amounts of individual psychotherapy may be related to lack of improvement in functioning for patients with PDs. Ethnic minority and lower socioeconomic status are possible barriers to receiving adequate treatment.

No. 103B
RECOGNITION OF PERSONALITY DISORDERS IN MENTAL HEALTH AND MEDICAL SETTINGS

Andrew E. Skodol II, M.D., *Department of Psychiatry, New York State Psychiatric Institute, 1051 Riverside Drive, Box 129, New York, NY 10032;* Donna S. Bender, Ph.D.

SUMMARY:

Personality disorders (PDs) are associated with significant morbidity and mortality. For patients with PDs to receive potentially beneficial treatment, their personality psychopathology needs to be recognized by clinicians and acknowledged by the patients themselves. This presentation reviews data on the prevalence of PDs in mental health and medical settings and on clinician recognition, as reflected in their diagnostic practices. Studies show that clinicians underdiagnose PDs in their patients, compared with results obtained with a semi-structured interview. For example, rates of any PD in large mental health samples range from 11% to 26%; rates by a semi-structured interview are as high as 80%. In one outpatient clinic, BPD was diagnosed 25 times more often by semi-structured interview than by routine clinical evaluation. Rates of clinically significant pathological PD traits are as prevalent as diagnosable disorders. In a primary care study, the prevalence of BPD was over 6%; half of these patients had received no treatment in the previous year and nearly half were not recognized by their physicians as having any mental health problems. With respect to recognition by patients, research indicates that informants (close others) report more PD psychopathology than patients, particularly socially undesirable traits. Thus, awareness of the nature and significance of PDs needs to be raised in both clinicians and their patients.

No. 103C
PERSONALITY DISORDERS: PATTERNS AND BARRIERS IN PSYCHIATRIC PRACTICE

William E. Narrow, M.D., *Department of Research, American Psychiatric Association/APIRE, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209;* Joyce C. West, Ph.D., Donald S. Rae, M.A.

SUMMARY:

Objective: Analyze patterns and financial barriers to treatment among psychiatric patients with personality disorders.

Methods: National data on patient sociodemographics, and clinical and treatment characteristics (including financial barriers to treatment) were gathered on 1,843 patients by 615 psychiatrists in APIRE's Practice Research Network (PRN) 1999 Study of Psychiatric Patients and Treatments (78% response).

Results: 19% of patients had an Axis II disorder reported; only .6% had an Axis II and no Axis I condition. Cluster B personality disorders were most prevalent. Personality disorders were associated with higher levels of prior hospitalizations (67%); depressive and anxious symptoms; disability in work/school, social, parenting/family, and sexual functioning; and drug, nicotine, and treatment compliance problems. 75% of personality disorder patients were prescribed antidepressants, 40% anti-anxiety medications, and 28% antipsychotics. 66% received psychotherapy. Personality disorder patients were more likely (43% versus 31%) to have financial considerations affect treatment provision. New study findings will be presented on psychi-

atrists' opinions regarding whether moving personality disorders to Axis I would improve patient care.

Conclusions: Personality disorders are prevalent among psychiatric patients and associated with higher rates of disability, functional impairment and clinical complexity. Despite increased severity and treatment need, patients with personality disorders experience significantly more barriers to treatment.

No. 103D
BARRIERS TO EFFECTIVE RESEARCH ON TREATMENT OF PERSONALITY DISORDER

Drew Westen, Ph.D., *Department of Psychiatry, Emory University, 532 Kilgo Circle, Atlanta, GA 30322*

SUMMARY:

At present, one psychotherapy (dialectical behavior therapy) has been identified as an empirically supported therapy in randomized clinical trials for borderline personality disorder (BPD), and two forms of psychoanalytic psychotherapy have just shown efficacy in RCTs. To what extent psychotherapy research can inform clinical practice is in many respects unclear, however, because of limitations in the designs used to established therapies as empirically supported. These limitations include implicit assumptions built into experimental methods as widely applied to identifying efficacious treatment "packages" that are invalid for personality disorders, most notably the assumption that psychopathology is malleable (and hence amenable to brief treatments). Aside from testing therapies designed by researchers, research needs to be undertaken to assess patients and treatments in everyday clinical practice, to identify intervention strategies that, empirically, are successful in changing not only troubling symptoms (e.g., self-mutilation) but underlying character structure (e.g., rejection sensitivity, problems with impulse regulation, externalizing defenses). Researchers should shift their focus from trying to validate treatment packages to identifying empirically supported change principles and intervention strategies that clinicians can integrate into *empirically informed therapies* that address both symptoms and personality or character structure and rely both on replicable research findings and clinical experience.

No. 103E
STIGMA, COUNTERTRANSFERENCE, AND PERSONALITY DISORDERS

Glen O. Gabbard, M.D., *Department of Psychiatry, Baylor College of Medicine, 6655 Travis, Suite 500, Houston, TX 77030*

SUMMARY:

One of the principal barriers to treating personality disorders is the stigma associated with the diagnosis. A substantial number of mental health professionals pointedly avoid treating personality disorders. Many third-party payors will not reimburse for the treatment of patients on Axis II. Patients may react with anger when given a diagnosis of personality disorder. Much of the stigma about personality disorders can be linked to typical countertransference reactions to personality disorders that mirror the way that people in close relationships react to this group of patients. The mechanism of countertransference will be discussed, and specific countertransference reactions will be illustrated. These will include guilt feelings, rescue fantasies, transgressions of professional boundaries, rage and hatred, helplessness, worthlessness, anxiety, and terror. The re-creation of the patient's internal object relations with treaters and others may lead to problems with stigma in a variety of settings. Examples will be provided and discussed. The result is negative bias against personality disorders as potential patients and as human beings.

REFERENCES:

1. Wells K, Klap R, Koike A, Sherbourne C: Ethnic disparities in unmet need for alcoholism, drug abuse, and mental health care. Am J Psychiatry 2001; 158:2027–2032.
2. Zimmerman M, Mattia JI: Differences between clinical and research practices in diagnosing borderline personality disorder. Am J Psychiatry 1999; 156:1570–1574.
3. Oldham JM, Skodol AE, Kellman HD, Hyler SE, Doidge N, Rosnick L, Gallaher PE: Comorbidity of Axis I and Axis II disorders. Am J Psychiatry 1995; 152:571–578.
4. Westen D. Novotny C, Thompson-Brenner H: The empirical status of empirically supported therapies: assumptions, methods, and findings. Psychological Bulletin 2004; 130, 631–663.
5. Gabbard GO: Psychodynamic Psychiatry in Clinical Practice: Fourth Edition. Arlington, VA, American Psychiatric Publishing, 2005.

SYMPOSIUM 104—IMPULSIVE AGGRESSION AND CRIMINAL RESPONSIBILITY

EDUCATIONAL OBJECTIVES:

At the conclusion of the symposium, the participant should understand: (1) a use for classification of aggression, (2) a general systems model-explanation of impulsive aggression, (3) the biology of impulsive aggression, and (4) impulsive aggression as a defense against a criminal charge.

No. 104A
ASSESSING AND TREATING AGGRESSIVE BEHAVIOR: THE IMPORTANCE OF SUBTYPING

Matthew S. Stanford, Ph.D., *Department of Psychology, Baylor University, One Bear Place, #97334, Waco, TX 76798*

SUMMARY:

Aggressive behavior has traditionally been classified into two distinct subtypes: (1) an emotionally charged, uncontrolled type (impulsive), or (2) a planned, controlled, unemotional type (premeditated). This presentation will outline the development of a clinically useful nosology for the characterization of aggressive behavior. Within the nosology, aggressive behavior is classified as either primary or secondary in nature. Primary aggression is defined as a pattern of aggressive behavior not secondary to a diagnosable Axis I psychiatric disorder or the direct physiological effects of a substance or general medical condition. While most primary aggressive individuals will display both premeditated and impulsive acts of aggression, one form will usually be predominant. Thus, individuals who display primary aggression are further classified into the following subtypes: predominately impulsive or predominately premediated. Secondary aggression is defined as a pattern of aggressive behavior due to the direct effects of a diagnosable Axis I psychiatric disorder or the direct physiological effects of a substance or general medical condition. This aggression may be premeditated or impulsive in nature. Supporting clinical data related to the assessment (personality, neuropsychology, psychophysiology) and pharmacological treatment of aggressive subtypes will be discussed.

This research is funded by a grant from the Dreyfus Health Foundation.

No. 104B
IMPULSIVITY RISK FACTOR OR SYMPTOM IN PSYCHOPATHOLOGY?

Ernest S. Barratt, Ph.D., *Department of Psychiatry, University of Texas Medical Branch, 301 University Boulevard, Galveston, TX 77550-0189*

SUMMARY:

Although impulsivity is implicated in a broad spectrum of behavior/impulse control disorders, the relationship of impulsivity to these disorders is controversial. This controversy will be addressed by outlining the two major sources for the confusion and suggesting a solution to resolving the confusion: (1) the complex multidimensional nature of impulsivity and resultant lack of synthesis of research data across disciplines; (2) considering impulsivity as a risk factor for behavior/impulse control disorders rather than as a consequence of the disorder. A "discipline neutral," closed feedback general systems theory model of personality that includes biological, behavioral, cognitive, and social/environmental measurements will be described. Three subdimensions of impulsivity (motor, non-planning, attention) have been defined in phenomenal self-research. These three subdimensions of impulsivity are related to different behavior/impulsive control disorders in DSM-IV (and ICD-10). As a heuristic approach to defining impulsivity, the four categories of constructs and measurements from the general systems personality model can be combined with the three subdimensions of impulsivity in a matrix. The identification of patterns across the matrix can serve to differentiate impulsivity as a risk factor for behavior/muscle control disorders from impulsivity as a consequence of the disorders.

No. 104C
THE BIOLOGY OF IMPULSIVE AGGRESSION: IMPLICATIONS FOR FORENSIC PSYCHIATRY

Frederick G. Moeller, M.D., *Department of Psychiatry, University of Texas Health Science Center, 1300 Moursund, Houston, TX 77030;* Ernest S. Barratt, Ph.D., Joel L. Steinberg, M.D., Ignacio H. Valdes, M.D., Alan C. Swann, M.D.

SUMMARY:

Recent research advances in the neurobiology of impulsivity and aggression have led to an increased interest in the role of biologic factors in impulsive aggression, both from a treatment and a forensic perspective. The purpose of this presentation will be to present an overview of research on biological correlates of impulsivity and aggression. Data from our group and others on the relationship of the neurotransmitter serotonin to impulsive aggression will be presented. Further, the role of the prefrontal cortex in behavioral control will be discussed along with recent research findings of the effects of substance abuse on prefrontal cortical function. This research will be presented in light of problems with sensitivity and specificity in prediction of impulsivity and aggression. Lastly, the role of neurobiological research in forensic psychiatry will be discussed, along with implications for sentencing in criminal trials.

No. 104D
IMPULSIVITY AND THE CRIMINAL LAW

Daniel W. Shuman, J.D., *School of Law, Southern Methodist University, PO Box 750116, Dallas, TX 75275-0016*

SUMMARY:

Daniel Shuman, a professor of law, will address the legal issues raised by psychiatric evidence about impulsivity. First, when is psychiatric evidence relevant/does it support an insanity offense, irresistible defense, negate mens rea, or mitigate punishment? Second, is such evidence reliable/does psychiatric evidence of impulsivity meet the threshold imposed by the United States Supreme Court in Daubert v. Merrell Dow Pharmaceuticals for the admissibility of expert testimony in the federal courts or alternative tests imposed in the state courts?

REFERENCE:

1. Stanford MS, Houston RJ, Mathias CW, Villemarette-Pittman NR, Helfritz LE, Conklin SM: Characterizing aggressive behavior. Assessment 2003; 10:183–190.
2. Ochsner K, Lieberman N: The emergence of social cognitive neuroscience. American Psychologist 2001; 56:717–734.
3. Moeller FG, Barratt ES, Dougherty DM, Schmitz JM, Swann AC: Psychiatric aspects of impulsivity. American Journal of Psychiatry 2001; 158:1783-1793.
4. Simon RI, Shuman DW (Eds): Retrospective Assessment of Mental States in Litigation: Predicting the Past. Washington, DC: American Psychiatric Publishing, Inc., 2002.

SYMPOSIUM 105—WITHDRAWN

SYMPOSIUM 106—EATING DISORDERS 2005: FROM SCIENCE TO PRACTICE

EDUCATIONAL OBJECTIVES:

At the conclusion of this seminar, participants will be able to describe current knowledge regarding the neuroanatomy and genetics of eating disorders, the impact on patients of being research subjects, the use of telemedicine in treating patients with bulimia nervosa, and the major features of the American Psychiatric Association's updated guidelines for patient with eating disorders.

No. 106A
DEFINING THE NEUROANATOMY OF ANOREXIA AND BULIMIA NERVOSA

Walter H. Kaye, M.D., *Department of Psychiatry, University of Pittsburgh, 38114 O'Hara Street, Suite 600, Iroquis Bldg., Pittsburgh, PA 15213;* Frank Guido, M.D., Ursula Bailer, M.D., Angela Wagner, M.D., Shannan Henry, B.S., Claire McConaha, B.S.

SUMMARY:

More than 20 studies have used brain imaging to study the neuroanatomy of anorexia nervosa (AN) and bulimia nervosa (BN). This literature has consistently implicated cingulate and parietal regions, as well as temporal and frontal regions. In order to characterize serotonin (5HT) and dopamine contributions, we have investigated women who were recovered from AN and BN (normal weight and menses, no pathological eating behavior, not on medications for > 1 year). We hypothesize that 5HT and dopamine vulnerabilities, which contribute to a risk for developing an eating disorder, are present premorbidly and persist after recovery. Positron emission tomography (PET) and radioligands were used to characterize binding of 5HT2A and 5HT1A receptors, the 5HT transporter, and dopamine D2 receptors. Recovered anorexics had reduced 5HT2A receptor activity and recovered bullmics had increased 5HT1A receptor activity in cingulate and parietal regions, as well as other regions. In addition, these finding shed light on mood, impulse control, appetitive, and body image distortions.

Preliminary data suggest that subcortical alterations of the 5HT transporter and dopamine D2 receptor occur and may be associated with subtype. In other studies, our group has used fMRI to investigate

nutrient activation of the brain and found changes in cingulate response to glucose in recovered bulimics. Together, these studies offer new clues about understanding the pathways that contribute to the pathophysiology of eating disorders.

No. 106B
THE GENETICS OF ANOREXIA NERVOSA AND BULIMIA NERVOSA

Katherine A. Halmi, M.D., *Department of Psychiatry, Weill-Cornell Medical, 21 Bloomingdale Road, White Plains, NY 10605*

SUMMARY:

Background: Evidence for the familiality of eating disorders from family studies and twin studies of anorexia nervosa (AN) suggests this familiality is primarily due to genetic causes.

Methods: Using an allele-sharing linkage strategy, a multi-collaborative group conducted an analysis of 192 families with 230 affected relative pairs. The probands had a DSM-IV lifetime diagnosis of AN restricting type and affected relatives had a diagnosis of AN with binge symptoms accepted. The genome scan used a screening panel of 387 fluorescent tag markers.

Results: There was an area of significant linkage with AN on chromosome 1. This area contains the serotonin 1D receptor and a delta opioid receptor gene locus. Further association analyses showed significant polymorphisms of these two genes in AN. Additional analyses of behavioral covariates showed significant linkage on chromosomes 1, 11, and 2. A similar linkage study with bulimia nervosa (BN) patients yielded a significant linkage on chromosome 10 for BN.

Conclusion: These first genome-wide linkage analyses of eating disorders give evidence for a robust genetic factor in both AN and BN. Further analysis of the genes in these linkage areas should provide insight into the role of biological factors in precipitating and maintaining these disorders.

No. 106C
DOES PARTICIPATION IN OSTEOPOROSIS TREATMENT STUDIES INFLUENCE EATING DISORDER SYMPTOMS IN PATIENTS WITH ANOREXIA?

David B. Herzog, M.D., *Department of Psychiatry, Massachusetts General Hospital, 725 ACC-EDU 15 Parkman Street, Boston, MA 02114;* Debra L. Franko, Ph.D., David J. Dorer, Ph.D., Safia C. Jackson, B.S., Mary Patricia Manzo, A.B., Karen K. Miller, M.D., Anne Klibanski, M.D.

SUMMARY:

Studies on treatments for anorexia nervosa (AN) are commonly limited by modest sample sizes associated with the low base frequency of the disorder, difficulties in recruiting patients, and high attrition rate. For over a decade at MGH, we have conducted several large studies of osteoporosis in AN. Though our findings may suggest promising treatments, there are questions about how trials that do not focus on treating the eating disorder affect the course of AN. In a one-year, placebo-controlled, double-blind study with IGF-I and estrogen (4-cell design) in 82 anorexic women, the combination of IGF-I and estrogen significantly improved bone health. Preliminary data on the first 30 consecutive subjects indicated that between baseline and 12-month follow up, subjects gained weight (mean IBW increased from 76% to 82%; $p = 0.001$), and experienced improvement in total EDI score ($p = 0.011$). Results from the complete dataset will be presented and clinical and research implications will be discussed.

No. 106D
CBT FOR BULIMIA NERVOSA DELIVERED VIA TELEMEDICINE VERSUS FACE-TO-FACE

James E. Mitchell, M.D., *Neuropsychiatric Research Institute, 700 First Avenue, South, P.O. Box 1415, Fargo, ND 58107;* Ross D. Crosby, Ph.D., Stephen A. Wonderlich, Ph.D., James Roerig, Pharm.D., Tricia Myers, Ph.D., Lorraine Swan-Kremier, Ph.D., Kathy Lancaster

SUMMARY:

Cognitive-behavioral therapy has been shown to be an effective treatment for many patients with bulimia nervosa; however, research has shown that this therapy has not been widely disseminated and the majority of patients treated for bulimia nervosa do not receive empirically validated treatment. Also, specialized services for bulimia nervosa are usually not available in rural areas. The purpose of this study was to evaluate the effectiveness and acceptability of delivering cognitive-behavioral therapy via telemedicine versus face-to-face. This was a randomized trial wherein subjects ($n = 117$) were recruited in rural areas in North Dakota and northwestern Minnesota and randomly assigned to treatment by a Ph.D-level therapist who traveled to their vicinity, or via telemedicine. The results of this study suggest that cognitive-behavioral therapy can be delivered in an effective manner via telemedicine and is an acceptable form of therapy to patients. However, on some variables, including depression, there was some advantage for face-to-face compared with telemedicine-delivered therapy. The implications of this study for the delivery of psychotherapy via telemedicine will be discussed.

No. 106E
UPDATING APA EATING DISORDERS PRACTICE GUIDELINES: WHAT'S NEW FOR PRACTICE?

Joel Yager, M.D., *Department of Psychiatry, University of New Mexico, School of Medicine, 1 University of New Mexico, MSC09 5030, Albuquerque, NM 87131-0001;* Michael J. Devlin, M.D., James E. Mitchell, M.D., Katherine A. Halmi, M.D., Pauline Powers, M.D., David B. Herzog, M.D., Kathryn J. Zerbe, M.D.

SUMMARY:

Since the most recent revision of the American Psychiatric Association's Practice Guideline for the Treatment of Patients With Eating Disorders was published in January 2000, a substantial amount of additional research and clinical experience has appeared to provide clinicians with better guidance for treating patients with anorexia nervosa, bulimia nervosa, and eating disorders not otherwise specified (including binge-eating disorder). Based on extensive literature reviews that have expanded the evidence base and clinical treatment perspectives and on consultation with a broad range of psychiatrists, psychologists, pediatricians, general physicians, and other health professionals treating these patients, the APA's work group on eating disorders has proposed new revisions for a forthcoming edition of the practice guidelines. This presentation will highlight features from the proposed revision that address assessment, clinical management, nutritional and pharmacological treatment, individual and family psychotherapies, and related interventions for these disorders and their associated complications.

REFERENCES:

1. Frank GK et al: Neuroimaging studies in eating disorders. CNS Spectrum 2004; 9(7):539–48.
2. Grice DE, Halmi KA, Fichter MM, et al: Evidence for a susceptibility gene for anorexia nervosa on chromosome 1. Am J Hum Genet 2002; 70:787–792.
3. Gordon CM, Grace E, Emans SJ, Feldman HA, Goodman E, Booker KA, Rosen CJ, Gundberg CM, LeBoff MS: Effects of

oral dehydroepiandrosterone on bone density in young women with anorexia nervosa: a randomized trial. Journal of Clinical Endocrinology and Metabolism 2002; 87(11):4835–41.
4. Mitchell JE, Swan-Kremeier L, Myers T: Delivering psychotherapy to patients with bulimia nervosa via telemedicine. Eating Disorders Review 2003; 11:13–20.
5. American Psychiatric Association Work Group on Eating Disorders: Practice guideline for the treatment of patients with eating disorders (revision). Am J Psychiatry 2000; 157(1 Suppl):1–39.

SYMPOSIUM 107—WITHDRAWN

SYMPOSIUM 108—NEW DEVELOPMENTS IN NEUROIMAGING IN BPD

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the rapid growth of neuroimaging research in borderline personality disorder and the clinical implications of these studies.

No. 108A
OVERVIEW OF NEW NEUROIMAGING RESEARCH STRATEGIES FOR BPD

Larry J. Siever, M.D., *Department of Psychiatry, Mt. Sinai School of Medicine, One Gustave Levy Place, Box 1230, New York, NY 10029*

SUMMARY:

Over the last several years, there has been a dramatic increase in neuroimaging studies of borderline personality disorder. These include functional imaging studies using FDG-PET, functional MRI, structural imaging studies using MRI, and neurochemical imaging studies of the serotonergic system and opiate systems. Structural imaging studies suggest reductions in volume of temporal/limbic circuitry, including amygdala and hippocampus and in some studies, prefrontal cortex and anterior cingulate. Functional imaging studies suggest hyperactivity of limbic regions such as amygdala and altered frontal metabolism with focal reductions in orbital frontal cortex and, in some cases, increased activation of other prefrontal regions including dorso lateral prefrontal cortex and medial frontal cortex that may reflect more effortable processing and self referential interpretation of stimuli. PET glucose imaging studies suggest reduced orbital frontal and cingulate activity associated with impulsive aggression. Increases in 5-HT_{2a} binding, reduced transporter binding, and reduced serotonergic synthesis, and abnormal opiate activation in response to pain are suggested by neurochemical imaging studies of borderline personality disorder. Issues to be addressed include choice of populations of borderline personality disorder including subsets with impulsive aggression and affective instability, baseline vs. provocation paradigms, potential neurochemical measures, and common neurocircuitry involved across paradigms.

No. 108B
MR-MORPHOMETRIC AND SPECTROSCOPIC FINDINGS IN PATIENTS WITH BPD

Ludger Tebartz Van Elst, M.D., *Department of Psychiatry, University of Freiburg, Hauptstr. 5, Freiburg 79104, Germany;* Juergen Hennig, Ph.D., Dieter Ebert, M.D., Martin Bohus, M.D., Klaus Lieb, M.D.

SUMMARY:

Context: Structural and functional amygdala abnormalities have been reported in patients with borderline personality disorder (BPD). However, the pathophysiological underpinnings of these abnormalities are unclear.

Objective: We performed a simultaneous morphometric and magnetic resonance spectroscopic investigation of the amygdala to further specify the neurochemical nature of the reported abnormalities.

Design: Twelve unmedicated female patients with BPD and ten matched healthy female controls were studied. Short echo single voxel-MR spectroscopic and structural data were acquired. Amygdala, hippocampal, orbitofrontal, and total brain volumes as well as absolute concentrations of N-acetylaspartate (NAA), creatine (Cr), and choline (Cho) of the amygdala were quantified.

Results: We found a significant reduction of amygdala volumes as well as a significant increase of amygdala creatine concentrations in BPD patients. There was a negative correlation between amygdala volume and creatine concentration. Amygdala creatine concentration correlated positively with measures of anxiety.

Conclusion: This is the first study of simultaneous MRI morphometry and spectroscopy in patients with BPD demonstrating a possible link between amygdala volume loss and disturbed limbic energy metabolism as indicated by increased amygdala creatine concentrations.

No. 108C
AMYGDALA/FRONTAL CIRCUITRY DYSFUNCTION IN BPD

Antonia S. New, M.D., *Department of Psychiatry, Mt. Sinai School of Medicine, 1 Gustave L. Levy Place, Box 1230, New York, NY 10029;* Monte Buchsbaum, M.D., Erin Hazlett, Ph.D., Randall Newmark, B.A., Serge A. Mitelman, M.D., Marianne Goodman, M.D., Larry Siever, M.D.

SUMMARY:

Objective: We explored correlations between orbitofrontal and amygdala brain glucose metabolism(rGMR) in borderline patients(BPD) at rest and in response to m-CPP(meta-chloropiperazine).

Methods: 27 BPD patients and 24 controls(NC) underwent ^{18}FDG-PET scans at baseline and in response to m-CPP. Brain edges and amygdala were visually traced; rGMR was obtained for ventral and dorsal amygdala and prefrontal Brodmann Areas(BAs). Correlation coefficients were calculated between rGMR for dorsal and ventral amygdala with ipsilateral prefrontal BAs.

Results: NC showed significant positive correlations between ventral amygdala and BA11,12,25,44,47(right),44(left), with one negative correlation with dorsal amygdala in BA6(right). In BPD, only negative correlations between the dorsal amygdala and BAs (6,8,9,10,32,46-left&right) and ventral amygdala with BAs(6,8,9,10,32,46-left&right) were found, with no distinction between dorsal and ventral amygdala. NCs showed positive correlations with dorsal amygdala and orbital BAs(11,12,25-left&right) and between ventral amygdala and orbital BAs(11,12,25-left). Patients showed positive correlations between dorsal and ventral amygdala and dorsolateral BAs(44-right&left,45-left), but negative correlations with orbital BAs(11,12,25-right). Group differences in correlation patterns were highly significant at baseline($p<.0001$) and in response to m-CPP ($p<.0001$).

Conclusions: This suggests a loss of functional specificity within the amygdala in BPD, and supports a model of disinhibition through the failure to activate OFC in response to amygdalar activation.

No. 108D
NEURAL CORRELATES OF BPD PATIENTS WITH AND WITHOUT PTSD

Charles A. Sanislow, Ph.D., *Department of Psychiatry, Yale University School of Medicine, 301 Cedar Street, P O Box 208098, New Haven, CT 06520-8098;* Nelson H. Donegan, Ph.D., Thomas H. McGlashan, M.D.

SUMMARY:

Background: Cognitive neuroscience offers methods for revealing the neural correlates of control mechanisms that may crosscut Axis I and II psychopathology.

Method: To test for differences in control regions of the brain in BPD patients with and without comorbid PTSD, fMRI activation patterns in response to emotional expressions (happy, sad, fearful, neutral) were compared in BPD patients with and without PTSD and normals.

Results: Differences were found in three brain areas associated with cognitive control: cingulate cortex (CC), BA10, and orbital frontal cortex (OFC). For BPD patients with PTSD compared with those without PTSD responding to fearful faces, less activation was found in CC whereas more activation was found in BA10. In response to sad faces. BPD patients with and without PTSD showed less OFC activation than those with PTSD and normals.

Conclusion: Areas associated with control are disrupted differently for BPD patients depending on the presence of PTSD. Understanding these mechanisms can improve personality disorder diagnosis and provide specific treatment targets.

No. 108E
NEURAL CORRELATES OF ANTINOCICEPTION IN BPD

Christian Schmahl, M.D., *Central Institute of Mental Health, J 5, Mannheim 68159, Germany;* Erich Seifritz, M.D., Rolf-Detlef Treede, M.D., Martin Bohus, M.D.

SUMMARY:

Background: Subjective pain sensitivity is reflected in differential patterns of pain-induced brain activity. Borderline personality disorder (BPD) is characterized by reduced pain sensitivity in conjunction with self-injurious behavior.

Method: We used painful heat stimuli in combination with psychophysical evaluation and fMRI to examine neural processes underlying pathologically reduced pain sensitivity in BPD. Seven patients with BPD and seven healthy, age-matched controls were investigated under two stimulus conditions: A fixed temperature (43°C) and a temperature matched to yield the same perceived pain intensity.

Results: Compared with normal controls, patients had higher pain thresholds and showed less brain activation when stimulated with the fixed temperature. With the same perceived pain intensity, the overall volume of activation was similar, but regional patterns differed significantly: BPD patients exhibited stronger activation signals in the dorsolateral prefrontal cortex and weaker signals in the posterior parietal cortex. In patients but not in controls, we found that pain induced a signal decrease in the perigenual anterior cingulate gyrus and in the amygdala.

Conclusion: Our data suggest that reduced pain sensitivity in BPD may be related to recruitment of antinociceptive circuits in the anterior cingulate and dorsolateral prefrontal cortex accompanied by reduced activity in cognitive evaluative networks.

REFERENCES:

1. New AS, Hazlett EA, Buchsbaum MS, Goodman M, Reynolds D, Mitropoulou V, Sprung L, Shaw RB Jr, Koenigsberg HW, Platholl J, Silverman J, Siever LJ: Blunted prefrontal cortical 18 fluorodeoxyglucose positron emission tomography response to meta-chlorophenylpiperazine in impulsive aggression. Arch Gen Psychiatry 2002; 59(7):621–629.
2. Driessen M, Beblo T, Mertens M, Piefke M, Rullkoetter N, Silva-Saavedra A, et al: Posttraumatic stress disorder and fMRI activation patterns of traumatic memory in patients with borderline personality disorder. Biological Psychiatry 2004; 55, 603–611.
3. Schmahl CG, Greffrath W, Baumgärtner U, Schlereth T, Magerl W, Philipsen A, Lieb K, Bohus M, Treede R-D: Differential nociceptive deficit in patients with borderline personality disorder and self-injurious behavior: laser-evoked potentials, spatial discrimination of noxious stimuli, and pain ratings. Pain 2004; 110:470–479.
4. Tebartz van Elst, L, Hesslinger B, Thiel T, Geiger E, Haegele K, Lemieux L, Lieb K, Bohus M, Hennig J, Ebert D: Frontolimbic brain abnormalities in patients with borderline personality disorder: a volumetric magnetic resonance imaging study. Biol Psychiatry 2003; 54:163–171.
5. New AS, Hazlett EA, Buchsbaum MS, Goodman M, Reynolds D, Mitropoulou V, Sprung L, Shaw RB, Koenigsberg H, Platholi J, Silverman J, Siever LJ: Blunted prefrontal cortical FDG-PET response to meta-chlorophenylpiperazine in impulsive aggression. Arch Gen Psychiatry 2002; 59(7):621–9.

SYMPOSIUM 109—EVIDENCE-BASED PRACTICES IN SUICIDE PREVENTION

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be better able to recognize suicide prevention programs and practices that meet the threshold of being evidence-based and understand the difficulties inherent in designing research in this field that can meet such standards.

No. 109A
RISK AND PROTECTIVE FACTORS IN SUICIDE PREVENTION

Morton M. Silverman, M.D., *Suicide Prevention Resource Center, Education Development Center, 4858 South Dorchester Ave, Chicago, IL 60615-2012*

SUMMARY:

There are many ways to classify risk factors for suicide—e.g., static v. plastic (gender, race, and age as examples of the former; depression as an example of the latter); acute v. chronic (or short v. longer-term), etc. Protective factors include the converse of risk factors but also may encompass broad social policy matters (e.g., better financial and social supports for mentally ill individuals). Such factors will be reviewed by Dr. Morton Silverman, who will also critique those that have not been definitively shown to increase risk or provide protection. For example, among means-restriction programs is gun control. We know that decreasing handgun availability would decrease the astounding U.S. homicide rate but do not know with certainty that the same is true for completed suicide rates (although there is some evidence in this direction). We take it as a given that school education programs on depression and suicide recognition will help prevent suicide, but there is little evidence-based support for such programs, to date.

Targeted populations for interventions employing these factors may be universal (primary prevention), meaning the general population—e.g., programs to help identify those at more risk from among this general population through testing all the 11th graders in a high school; or may be "selected" (secondary prevention) to begin with

(e.g., focused on adolescents who are truant or substance-abusing); or may be directed at "indicated" populations (tertiary prevention) such as bipolar adults or adolescents who have recently attempted suicide. These all call for unique evidence-based interventions.

No. 109B
SAFETY AND HARM ISSUES IN SUICIDE PREVENTION

Phillip Rodgers, Ph.D., *Evidence-Based Practices Project, American Foundation for Suicide Prevention, 210 West Washington Square, Mezzanine, Philadelphia, PA 19106*

SUMMARY:

Safety issues are especially pertinent for suicide-prevention programs since one is dealing with high-risk populations to begin with. Over the years, suicide research has been hampered by the perceived inability to compare various therapies for suicidal patients with placebo controls—for fear of harming the "untreated" and fear of litigation against the researchers if suicide occurs in the control group. Another concern has stemmed from the work of Shaffer and Garland, who demonstrated that adolescent boys who had been suicidal were made to feel worse following high-school educational programs about suicide and depression. This resulted in a pall being cast over such universal school educational programs.

A different problem results from a tension between primary and secondary (universal v. selected) programs concerning normalization v. stigmatization issues. Not just for suicide programs, but also for other preventive/intervention programs such as eating disorders, delinquency, etc. where educational efforts to decrease stigma for help seeking may inadvertently also normalize the behavior in question (e.g., eating problems are ubiquitous v. eating disorders represent pathology and warrant treatment). Thus, suicide as the result of stress runs the risk of "normalizing" it whereas "pathologizing" it as illness may stigmatize it and discourage help seeking. What we need is to to stigmatize suidical behavior without also stigmatizing (i.e., wanting to normalize) help seeking.

No. 109C
EXAMPLES OF EVIDENCE-BASED PRACTICES IN SUICIDE PREVENTION

Howard S. Sudak, M.D., *Department of Psychiatry, University of Pennsylvania, 210 West Washington Square, Mezzanine, Philadelphia, PA 19106*

SUMMARY:

In this session, the Center for Substance-Abuse Prevention (CSAP) criteria for program effectiveness, as used by the National Registry of Effective Prevention Programs (NREPP), which is used by SAMHSA, will be presented in more detail and examples of how these criteria are applied to actual programs will be given. The methodology that EBPP utilizes in ranking programs will be detailed as well as the modifications made by EBPP to the basic NREPP criteria; how programs are solicited and screened by internal review; how those meeting basic criteria for evaluation are independently reviewed externally by at least two experts in the field, and then scores are tabulated, which allows programs to be classified into four categories (Insufficient Current Evidence of Evidence-Basis, Promising, Effective, or Model).

Actual examples of such programs from the SPRC's on-line, searchable Registry of Effective Programs in Suicide Prevention will be given. The audience will understand that these "rankings" are not exhaustive and are subjective despite EBPP's goal of "objectivity," that we are in the beginning stages of the registry, and have had to make some allowances for the rudimentary nature or built-in limitations of much research in the field (e.g., studying low-frequency events). Furthermore, that not being classified as promising or effective does not necessarily mean that a program is without merit, per se.

REFERENCES:

1. SPRC Directory of Evidence-Based Practices in Suicide Prevention, www.edc.org (pending)
2. Sudak HS: Suicide, in Comprehensive Textbook of Psychiatry. Sadock B, Sadock V, editors. 2005, in press.
3. National Strategy for Suicide Prevention: Goals & Objectives for Action, USDHHS:PHS, Rockville, MD, 2001.
4. Garland A, Shaffer D, Whittle B: A national survey of school-based, adolescent suicide prevention programs. J Amer Acad Child Adol Psychiat 1989; 28:931–934.

SYMPOSIUM 110—TREATMENT AND INTERVENTION FOR AUTISM SPECTRUM DISORDERS

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium the participant should be able to recognize early markers for autism, treat target symptoms of autism spectrum disorders with appropriate medications, summarize the availability and effectiveness of early interventions for autism, understand developmental trajectories, prognosis, and outcomes of autism.

No. 110A
DETECTING SIGNS OF AUTISM IN INFANCY

Rebecca Landa, Ph.D., *Kennedy Krieger Institute, 3901 Greenspring Ave., Baltimore, MD 21211*

SUMMARY:

Objectives: (1) identify early markers for autism; (2) understand developmental trajectories in autism; (3) determine how the early manifestation and trajectory of autism differs from that of non-autism language delay. This was a prospective, longitudinal design involving two groups of children: (1) infants at high risk for autism (baby siblings of children with autism) and (2) low-risk controls (no family history of autism). Children were tested at 6, 14, 24, and 36 months of age. Social communication, cognitive, behavioral, and motor development were assessed. 87 children have longitudinal data. Data were analyzed comparing children with autism, non-autism language delay, and unaffected. Other analyses examined differences between high-risk and low-risk groups. Results showed that joint attention at 14 months is a predictor of autism at 24 months. Autism was diagnosable at 14 months in some children. Children with autism at 14 months of age were more delayed than 14-month-olds judged to have PDD-NOS, and they remained on the autism spectrum at 24 months of age. Trajectory of development in the children with autism differed from the language delayed and unaffected children. Implications for early detection of autism will be discussed.

Funding source: NIMH grant #MH59630

No. 110B
EFFECTIVE EARLY INTERVENTION FOR VERY YOUNG CHILDREN WITH AUTISM SPECTRUM DISORDERS

Ilene Schwartz, Ph.D., *Experimental Education Unit, University of Washington, Box 357925, Seattle, WA 98195*

SUMMARY:

Providing appropriate educational services to young children with autism may be one of the defining challenges of the 1990s and early 2000s for early childhood special education. The number of children with autism is increasing dramatically, the research literature is rich with evidence-based instructional strategies, and the internet is even more full of information and advice of unknown quality. Parents and school districts personnel, often working together, and sometimes at odds, need to develop programs to meet the needs of these young children with autism. Project DATA started as a federally-funded model demonstration project to develop a school-based program for young children with autism that is effective and acceptable to consumers (e.g., parents and school personnel). Project DATA consists of five components: a high-quality early childhood environment, extended instructional time, social and technical support for families, collaboration and cooperation across services, and transition support. We provide data demonstrating the effectiveness of this model and discuss the implications for this type of inclusive programming for young children with autism.

No. 110C
PSYCHOPHARMACOLOGICAL TREATMENTS FOR AUTISM SPECTRUM DISORDERS

Eric Hollander, M.D., *Department of Psychiatry, Mount Sinai School of Medicine, One Gustave L. Levy Place, Box 1230, New York, NY 10029*

SUMMARY:

Psychopharmacological treatments of autism spectrum disorders include both targeted treatments for specific problem symptom domains, and early interventions to improve the long-term developmental trajectory of the disorder. Core symptom domains of autism include repetitive behaviors, social deficits, and language deficits. Associated symptom domains include disruptive behavior, impulsive aggression, affective instability, inattention/hyperactivity, EEG abnormalities/seizure disorders, and cognitive deficits. Placebo-controlled trials support the use of atypicals for disruptive behavior, low dose SSRIs for repetitive behaviors, stimulants for inattention/hyperactivity, and anticonvulsants for disruptive behavior, affective instability, and EEG abnormalities. Preliminary data support the use of cholinergic and glutamergic agents for cognition. Early intervention trials for enhancing long-term development are also described. A risk/benefit ratio analysis for targeted treatments of autism is discussed.

No. 110D
NATURAL HISTORY, PROGNOSIS, AND OUTCOMES OF AUTISM SPECTRUM DISORDERS

Li-Ching Lee, Ph.D., *Department of Epidemiology, Johns Hopkins Bloomberg School of Public Health, 615 N. Wolfe St. Suite# E6032, Baltimore, MD 21205*

SUMMARY:

Literature on the natural history, prognosis, and outcome of ASD is limited. The extent and quality of prognostic data also vary considerably by subgroups on the autism spectrum. Early childhood IQ, language, and nonverbal skills appear to be significant predictors of ASD outcomes and prognosis later in life. Some individuals with ASD find work and develop social relationships, but the majority still require substantial support throughout their lives. Educational, therapeutic, and intervention programs for individuals with ASD have become increasingly available over the past two decades and have been reported as effective methods of improving autistic behaviors and social skills later in life. Factors that have an influence on outcomes of individuals with ASD will be discussed.

REFERENCES:

1. Charman T, Swettenham J, Baron-Cohen S, Cox A, Baird G, Drew A: Infants with autism: an investigation of empathy, pretend play, joint attention, and imitation. Developmental Psychopathology 1997; 33:781–789.
2. Schwartz IS, Sandall SR, McBride BJ, Boulware G: Project DATA (Developmentally Appropriate Treatment for Autism): An inclusive, School-Based Approach to Educating Young Children with Autism. Topics in Early Childhood Special Education, in press.
3. Hollander E, Phillips AT, Yeh C-C: Targeted treatments for symptom domains in child and adolescent autism. Lancet 2003; 362(9385):732–4.
4. Howlin P, Goode S. Hutton J, Rutter M: Adult outcome for children with autism. J Child Psychol Psychiatry 2004; 45(2):212–29.

SYMPOSIUM 111—HOW TO PRACTICE EVIDENCE-BASED MEDICINE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) understand what EBM is and the process of practicing EBM, (2) search the literature for different kinds of evidence, (3) Interpret commonly concepts, (4) critically appraise different kinds of studies, including randomized, controlled trials and systematic reviews.

No. 111A
INTRODUCTION TO EVIDENCE-BASED PSYCHIATRY

Bryce Templeton, M.D., *Department of Psychiatry, Drexel College of Medicine, P.O. Box 45358, Philadelphia, PA 19124-8358*

SUMMARY:

Evidence-based psychiatry (EBP) is defined as the integration of the best research evidence in psychiatry with clinical expertise and patient values (modified from the Institute of Medicine). The medical profession is exhibiting growing interest in utilizing evidence-based medicine (EBM) in order to provide our patients with the best possible care. Many clinicians feel that they have been utilizing such an approach throughout their practice. However, with improved techniques in summarizing related randomized, controlled trials and with the internet access to innovative databases, our opportunities of efficiently acquiring comprehensive summaries concerning diagnosis and treatment have substantially improved. This introduction will do the following: provide a more detailed definition of evidence-based psychiatry, describe the assets and shortcoming of EBP, and provide instruction on how to obtain ready access to the best EMP and related databases available through the internet and/or printed copy. For patients, the use of EBP can help assure correct diagnoses and the selection of optimal treatment. For the psychiatrist, the use EBP can help assure that one's practice includes the best available diagnostic and treatment guidelines and also minimizes malpractice liability.

No. 111B
REVIEW OF BASIC STATISTICAL CONCEPTS

Maju Mathews, M.D., *Department of Psychiatry, EPPI Drexel University, 4641 Roosevelt Boulevard, Philadelphia, PA 19124*

SUMMARY:

This talk will explore the various statistical concepts commonly encountered in research papers. It will explain what they mean and how to interpret them. The concepts covered will include relative risks, odds ratios, confidence intervals, predictive values, statistical and clinical significance, etc.

The emphasis will be on their interpretation and the relevance to clinical decision making.

No. 111C
CRITICAL APPRAISAL OF RANDOMIZED, CONTROLLED TRIALS

Adedapo B. Williams, M.D., *Department of Psychiatry, University of Illinois, 179 North Taylor Avenue, Oak Park, IL 60302*

SUMMARY:

Objective: This part of the symposium is designed to improve clinicians' understanding of evidence-based medicine (EBM) as regards appraising the evidence from randomized, controlled trials (RCTs), assessing their validity and clinical applicability.

Method: The presenter will give general guidelines on how to appraise randomized, controlled trials (RCTs) and do a critique of a published randomized, controlled trial, using these general guidelines.

No. 111D
CRITICAL APPRAISAL OF SYSTEMATIC REVIEWS AND META-ANALYSIS

Babatunde A. Adetunji, M.D., *Department of Psychiatry, Drexel University, 4 Transgate Boulevard, Philadelphia, PA 08009*

SUMMARY:

The symposium will involve critical appraisal of systematic reviews and meta-analysis. It will discuss what systematic reviews are and how they are combined into a meta-analysis. It will also highlight how to search for systematic reviews and how to analyze the results of meta-analysis. The concepts of heterogeneity, odds ratio or relative risk between means will be discussed as well as the interpretation of confidence intervals.

The discussion will be basic and will also emphasize how to determine whether the samples in the studies are similar to participant's patient population, and whether the magnitude of the effect weighted against the cost makes trial in the patient population worthwhile.

REFERENCES:

1. Greenhalgh T: How to Read a Paper: The Practise of EBM. BMJ Books, 2000.
2. Warner J: Clinicians' guide to reading psychiatric literature: therapeutic trials and systematic reviews. Advan Psychiatr Treat 2002; 8:73–80.
3. Lawrie S, McIntosh A, Rao S: Critical Appraisal for Psychiatry, Churchill Livingstone, 2000.
4. Clinical Evidence, Mental Health, BMJ Publishing Group, London, 2004.

SYMPOSIUM 112—TRANSLATING RISK RESEARCH INTO COMORBIDITY INTERVENTION RESEARCH
APA Council on Psychosomatic Medicine

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should know more about current NIMH-supported comorbidity research and funding opportunities.

No. 112A
EARLY IDENTIFICATION AND INTERVENTION WITH HIGH RISK, LOW BACK PAIN PATIENTS

Robert Gatchel, Ph.D., *Department of Psychology, University of Texas at Arlington, Box 19528, 501 South Nedderman Street, Arlington, TX 76019-0528*

SUMMARY:

Background: The comorbidity of mental and physical health disorders is maximally prominent in pain syndromes. This presentation will review a program for early intervention in acute low back pain (ALBP) patients in order to prevent chronic disability. An algorithm to identify those ALBP patients who are at high risk (HR) for developing chronic pain disability has been developed. We have now evaluated whether early intervention with these HR patients would significantly reduce chronic disability.

Methods: Approximately 700 ALBP patients were screened for their HR versus low risk (LR) status. HR patients were randomly assigned to one of two groups: a functional restoration early intervention group or a usual treatment group. A group of LR subjects was also evaluated. All subjects were prospectively tracked, culminating in a 12-month follow up.

Results: HR subjects who received early intervention displayed significantly fewer indices of chronic comorbid disability on a range of psychosocial, health care, medication, and work variables relative to the HR subjects not receiving early intervention (*ps* <02-.001). Economic data also revealed greater cost savings associated with the early-intervention group ($12,721 versus $21,843).

Conclusion: We now have a treatment- and cost-effective early intervention method for reducing chronic comorbid mental and pain disorders.

No. 112B
DEPRESSION AND DIABETES

Wayne J. Katon, M.D., *Department of Psychiatry, University of Washington, 1959 N.E. Pacific, Box 356560, Seattle, WA 98195-6560;* Michael Von Korff, Sc.D., Elizabeth H.B. Lin, M.D., Paul S. Ciechanowski, M.D., Gregory E. Simon, M.D., Evette J. Ludman, Ph.D.

SUMMARY:

Background: Patients with diabetes have been shown to have a higher prevalence of major depression. This presentation will describe the results of an epidemiologic study of 4,800 patients with diabetes enrolled in an HMO in Puget Sound and two randomized trials of patients with diabetes and depression/dysthymia.

Methods: A 20-page mail survey was sent to approximately 8,000 patients with diabetes. Two randomized trials of enrolled, respectively, over 400 elderly patients (age > 65) and over 300 mixed-aged patients with diabetes and depression in an intervention aimed at improving adherence to antidepressant medication or providing problem-solving therapy versus usual primary care.

Results: Patients with major depression and diabetes compared with patients with diabetes alone were found to have increased diabetic symptom burden, additive functional impairment, poor adherence to dietary and exercise regimens, poor adherence to three disease-control medications (oral hypoglycemics, antihypertensives, and lipid-lowering drugs), an increase in total medical costs of 70%, increased diabetes complications and significantly more cardiac risk factors. Over a two-year period, patients with diabetes and major depression have had an aproximately two-fold increase in mortality compared with patients with diabetes alone. In the first intervention with elderly patients with diabetes and major depression, the intervention was compared with usual care and associated with improved quality of depression care and depressive outcomes over a one-year period. The intervention was also associated with improvement in physical disability compared with usual care over the one-year period, but no change in HbA_{1c}. In the mixed-age sample, the intervention was associated with improved quality of care and outcomes of depression over a two-year period without any intervention versus control differences in HbA_{1c}.

Conclusion: Depression is a common comorbidity in patients with diabetes, is associated with adverse outcomes, and treatment and patient-level outcomes can be improved in primary care systems.

REFERENCES:

1. Gatchel RJ, Polatin PB, Noe C, Gardea M, Pulliam C, Thompson J: Treatment- and cost-effectiveness of early intervention for acute low back pain patients: a one-year prospective study. Journal of Occupational Rehabilitation 2003; 13:1–9.
2. Katon W: Clinical and health services relationships between major depression, depression symptoms, and general medical illness. Biologic Psychiatry 2003; 54:216–226.

No. 112C
COMORBIDITY OF OBESITY AND DEPRESSION

Gregory E. Simon, M.D., *Center of Health Studies-Group Health, University of Washington, 1730 Minor Avenue, Suite 1600, Seattle, WA 98101-1404;* Evette J. Ludman, Ph.D.

SUMMARY:

Background: Epidemiologic research suggests an association between obesity and depression among women, in contrast to no association or an inverse association among men. Previous studies have used cross-sectional depression measures and have lacked data to examine potential mechanisms for an association.

Methods: A population-based sample of female health plan members (n=2,292 as of 6/10/04) completed a telephone survey concerning depressive symptoms, dietary composition, and physical activity. Response rate was 61%.

Results: Prevalence of current major depressive episode was 7.5% among women with body mass index (BMI) >=30 compared with 3.7% among those with BMI <30 (Odds ratio = 2.12, 95% CI 1.38-3.26). Prevalence of lifetime depressive episode was 44.3% among women with BMI >=30 compared with 34.4% among those with BMI <30 (Odds ratio = 1.51, 95% CI 1.26-1.82). Additional analyses (data available in early 2005) will examine mechanisms for this association including: differences in dietary composition, differences in physical activity patterns, binge eating, and childhood abuse. These data will also be used to examine how depression and obesity each contribute to health-related quality of life, disability, and health care utilization.

Conclusions: Among middle-aged women, obesity is strongly associated with both current and lifetime depressive disorder.

No. 112D
DEPRESSION AND BREAST CANCER: TREATMENT RESPONSE AND HPA DYSREGULATION

David M. Spiegel, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Stanford, CA 94305-5718;* Janine Giese-Davis, Ph.D., Lisa D. Butler, Ph.D., Catherine Classen, Ph.D., Gary Norrow, M.D.

SUMMARY:

Background: Depression and cancer commonly co-occur. The prevalence of depression among cancer patients increases with disease severity and symptoms such as pain and fatigue. Depression as an indicator for psychotherapeutic intervention and a risk factor for more rapid cancer progression needs further examination.

Methods: (1) Evidence from a randomized multicenter trial of group therapy involving 353 women with primary breast cancer was examined. (2) Analysis of data is currently under way in an ongoing randomized, prospective Supportive/Expressive group therapy trial involving 125 women with metastatic breast cancer. (3) Salivary cortisol levels of 104 of these women were obtained at 8am, 12 noon, 5pm, and 9pm.

Results: (1) Initial distress, including depressive symptoms, predicted a significantly greater reduction in Profile of Mood States Questionnaire scores among treatment than control patients [$t(1.69) = 1.65$, $p = .05$]. (2) The relationship of baseline depressive symptoms to psychological response to intervention among women with metastatic breast cancer is currently being examined. (3) Cox proportional hazards analysis indicated that patients with abnormal diurnal cortisol rhythms suffered earlier mortality in the ensuing seven years ($p < .004$). The relationship between depressive symptoms and cortisol throughout the day is also being examined.

Conclusions: The evidence of these NIMH and NCI-funded studies points to a bidirectional relationship between cancer and depression, mediated by the HPA, offering new opportunities for therapeutic intervention.

REFERENCES:

1. Stunkard AJ, Faith MS, Allison KC: Depression and obesity. Biol Psychiat 2003; 54:330–337.
2. Spiegel D, Giese-Davis J: Depression and cancer mechanisms and disease progression. Biological Psychiatry 2003; 54:269–282.

SYMPOSIUM 113—POSTPARTUM MOOD DISORDERS
Collaborative Session With the National Institute of Mental Health

EDUCATIONAL OBJECTIVES:

At the end of this symposium, the participant should be able to demonstrate understanding of the risks for, and treatment of, mood disorders in the postpartum period.

No. 113A
REPRODUCTIVE HORMONES AND POSTPARTUM DEPRESSION

Catherine A. Roca, M.D., OSP, *National Institute of Mental Health, 6001 Executive Boulevard, Room 8125, Bethesda, MD 20892;* David R. Rubinow, M.D.

SUMMARY:

Mood disorders in the postpartum period occur in the context of dramatic hormonal changes. Estrogen and progesterone levels drop 50 fold and 10 fold, respectively, during the first few days post partum. While existing data do not indicate that hormonal levels *per se* differ significantly between women who experience postpartum depression and those do not, data do suggest that some women exhibit a differential sensitivity to the hormonal changes that accompany the postpartum transition. How might changes in reproductive hormones contribute to mood destabilization in these individuals? Basic studies indicate that the gonadal steroids estrogen and progesterone influence a number of neurotransmitter systems associated with the modulation of mood, e.g., serotonin, norepinephrine, and dopamine. Additionally, animal models of gonadal steroid withdrawal have demonstrated effects on the GABA inhibitory system as well as the HPA axis. Implications of these findings for future research in this area will be discussed.

No. 113B
UNCOVERING THE NATURE OF THE PUERPERAL TRIGGER: GENETIC STUDIES OF POSTPARTUM MOOD DISORDERS

Ian R. Jones, M.R.C., *Department of Psychological Medicine, University of Wales College of Medicine, Neuropsychiatric Genetics Unit, Cardiff CF144XN, Wales*

SUMMARY:

The link between childbirth and affective disorders has been made for hundreds if not thousands of years. The weight of evidence supports the hypothesis that postpartum affective episodes represent women with an affective disorder diathesis acted upon by a puerperal trigger. Childbirth is amongst the most complex of human experiences with rapid and significant chance occurring at the biological, psychological, and social levels. The nature of the trigger remains unknown but, at least for puerperal psychosis, it is likely that biological/hormonal factors play an important role and that genetic factors determine which women are vulnerable to illness at this time. We are currently genotyping large samples of bipolar and unipolar individuals (approximately 1,000 each) including in excess of 200 women who have suffered episodes of puerperal psychosis and a similar number with narrowly defined postpartum depression. In this talk, I will discuss the evidence implicating genetic factors in postpartum mood disorders and present the results of molecular genetic studies at a number of candidate genes. I will consider the pros and cons of finding susceptibility genes and consider what the future may bring if they are found.

REFERENCES:

1. Bloch M, Daly R, Rubinow DR: Endocrine factors in the etiology of postpartum depression. Comprehensive Psychiatry 2003; 44:234–246.
2. Jones I, Craddock N: Familiality of the puerperal trigger in bipolar disorder: results of a family study. American Journal of Psychiatry 2001; 158:913–917.

No. 113C
BIPOLAR DISORDER AND THE POSTPARTUM PERIOD

Adele C. Viguera, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street/WACC 812, Boston, MA 02114;* Lee S. Cohen, M.D.

SUMMARY:

Bipolar women require special consideration with respect to treatment. Several of the major mood stabilizers are known teratogens. Moreover, some anticonvulsant can have a negative impact on fertility, contraceptive efficacy, and pregnancy outcome. Despite this, in clinical practice, anticonvulsants are often used as first line-mood stabilizers in women.

Management of bipolar women who plan to conceive or those who are pregnant or puerperal poses significant challenges for clinicians that care for these patients. Recent data suggest that pregnancy is not "protective" against relapse of psychiatric disorder and that for bipolar women, specifically, relapse is common after lithium discontinuation. New prospective data on the course of bipolar disorder during pregnancy and the postpartum period will be presented.

This presentation reviews the major clinical dilemmas associated with the management of bipolar patients during the child-bearing years 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 for women trying to conceive and during pregnancy will be presented.

An algorithm for assessment of risks and benefits using older and newer antipsychotics and mood stabilizers will be presented. This presentation will review the risks/benefits decision process for managing patients during the childbearing years.

No. 113D
POSTPARTUM MENTAL ILLNESS: IMPACT AND TREATMENT

Zachary N. Stowe, M.D., *Department of Psychiatry, Emory University School of Medicine, 1635 Clifton Road, NE Suite# 6100, Atlanta, GA 30322;* Donald J. Newport, M.D., Kimberly A. Ragan, M.S.W.

SUMMARY:

Postpartum mental illness has been documented for centuries, though seldom does it reach public awareness except in the event of tragedy. Despite the long-standing documentation, the etiology of maternal mental illness during the postpartum period remains obscure. A myriad of observations and investigations over the past five decades have demonstrated potential adverse effects of maternal depression/stress/anxiety on infant well-being. Similarly, the extant literature including numerous animal species have underscored the adverse effects of maternal stress on the offspring. Recent data have noted the increased number of postpartum cases that have symptom onset in pregnancy, raising questions about the impact on infant health—pregnancy versus postpartum. Given these findings it is remarkable that few treatment studies in postpartum women have been completed. These studies have included a mixture of educational, psychosocial, psychotherapeutic, pharmacological, and preventative studies with a total combined sample size of approximately 1,300 women. These treatment data will be reviewed with respect to the development of comprehensive treatment planning for postpartum women. Such treatment is often complicated by the desire to breast feed. While antidepressants have more data than any other class of medications in the PDR, the American Academy of Pediatrics lists them as "unknown and maybe of concern." As such there remains a reluctance to aggressively treat postpartum women with antidepressants. The adverse case reports for adverse effects of antidepressants in breast feeding will be critically reviewed with an emphasis on educational issues for patients, families, and colleagues in other subspecialties.

REFERENCES:

1. Viguera AC, Baldessarini RJ, Cohen LS, Nonacs R: Managing bipolar disorder during pregnancy: weighing the risks and benefits. The Canadian Journal of Psychiatry 2002; 47(5):426–436.
2. Newport DJ, Hostetter A, Arnold A, Stowe ZN: The treatment of postpartum depression: minimizing infant exposures. Journal of Clinical Psychiatry 2002; (63)suppl 7:31–44.

MONDAY, MAY 23, 2005

WORKSHOPS

Media Workshop 1
"FIXING FRANK": THE GOOD, THE BAD, AND THE UGLY OF PSYCHOTHERAPY WITH GAY MEN

Chairperson: Petros Levounis, M.D., *Addiction Institute of New York, 1000 Tenth Avenue, Suite 8C-02, New York, NY 10019*
Participants: Ken Hanes, Michael Selditch, Jack Drescher, M.D., Francisco J. Gonzalez-Franco, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the unique psychological and cultural context of gay mental health and recognize transferential and countertransferential dynamics in the psychotherapy of gay men.

SUMMARY:

In "Fixing Frank" (2003), Frank Johnston (Andrew Elvis Miller) is a journalist who is involved in a long-term relationship with Dr. Jonathan Baldwin (Paul Provenza), a psychologist. Frank sets out to write an expose on Dr. Apsey (Dan Butler), a therapist who says he can help gay men be free of their homosexual orientation. Frank begins to see Apsey as a patient, feigning his desire not to be gay. However, Frank soon discovers Apsey is smarter (or shrewder) than he imagined; it doesn't take long for the doctor to figure out what Frank is trying to do, and as he begins to question Frank, the reason for Frank's seeing Apsey becomes blurred. As Frank's transference intensifies, his relationship with Jonathan deteriorates, and a fierce psychological tug of war erupts between the two persuasive doctors over the heart and mind of Frank.

In this media presentation, we will explore the complexities of the patient-therapist relationship from the interpersonal, cultural, and political perspectives of modern gay life. The author of the original play and screenwriter of the film, Ken Hanes, as well as the director of the film, Michael Selditch, will be on the workshop panel and participate in the discussion.

REFERENCES:

1. Drescher J: Psychoanalytic Therapy and the Gay Man. Hillsdale, NJ, Analytic Press, 1998.
2. Cabaj RP, Stein TS (eds): Textbook of Homosexuality and Mental Health. Washington, DC, American Psychiatric Press, 1996.

Media Workshop 2
POSTGENOCIDE PSYCHOLOGICAL TRAUMA IN FILM: FORBIDDEN GAMES

Co-Chairpersons: Maurice Preter, M.D., *157 East 72nd Street, Suite J, New York, NY 10021*
Harold J. Bursztajn, M.D., *Department of Psychiatry, Harvard Medical School, 96 Larchwood Drive, Cambridge, MA 02138-4639*
Participants: Leonti H. Thompson, M.D., Beata A. Zolovska, Robindra K. Paul, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants will have obtained better understanding of the developmental impact of manmade, massive traumatization on children and families in general. Implications for development of clinical skills will be explored.

REFERENCES:

1. Bowlby J: Loss: Sadness and Depression, Vol. 3. Perseus Books 1982.
2. Bloom-Feshbach J: Bloom-Feshbach S: The Psychology of Separation and Loss. Jossey-Bass, Inc. 1987.

Media Workshop 3
"SUPER SIZE ME": EXPLORING CAUSES, EFFECTS, AND SOLUTIONS TO OBESITY IN CHILDREN AND ADOLESCENTS

Co-Chairpersons: Patricia A. Daly, M.D., *Psychiatry, Dartmouth-Hitchcock Medical Center, 1 Medical Center Drive, Lebanon, NH 03756*
Lois T. Flaherty, M.D., *4 Charlesgate East, #605, Boston, MA 02215*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the psychiatric aspects of obesity in children and adolescents as well as the health risks and societal costs.

SUMMARY:

Obese individuals suffer from stigmatization and low self-esteem; overweight children and adolescents are often bullied. In addition, obesity is a factor in type II diabetes, cardiovascular diseases, and cancer. Overweight children are at risk for developing eating disorders including anorexia and bulimia. Results from the 2003 national Youth Risk Behavior Survey indiciated that 13.5% of U.S. teenagers are overwight, one-third have inadequate physical activity, and four-fifths have unhealthy diets. (Grunabum et al., 2004) With the documentary "Super Size Me" as a stimulus, this workshop will explore the U.S. food industry's contribution to the obesity epidemic in the U.S. Discussion will focus on issues relevant to psychiatrists, including the emotional costs of being overweight, as well as the health risks and societal cost. The similarity between the advertising of alcohol and tobacco with children and adolescents as targets and advertisement of calorie-dense foods will be explored. We will review interventions to increase activity levels and to promote healthy eating, as well as successful strategies to use with overweight and obese patients. There will be focus on children and adolescents, who are at ages when patterns of unhealthy eating and inadequate physical activity are laid down.

REFERENCES:

1. Grunbaum J, Kann L, Kinchenl S, et al: Youth Risk Behavior Surveillance, 2004. Atlanta, GA. Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services.
2. Zametkin AJ, Zoon C, Klein H, Munson S: Psychiatric aspects of child and adolescent obesity: a review of the past 10 years. J Am Acad Child Adolesc Psychiatry, 2004; 43:134–150.

TUESDAY, MAY 24, 2005

Media Workshop 4
"JIM IN BOLD": GAY, LESBIAN, AND TRANSGENDER TEENS ON FILM
American Academy of Child and Adolescent Psychiatry's Sexual Orientation Committee

Co-Chairpersons: Richard R. Pleak, M.D., *Department of Child Psychiatry, North Shore Long Island Jewish Health System, 400 Lakeville Road, Second Floor, New Hyde Park, NY 11042*
Sarah E. Herbert, M.D., *Department of Psychiatry, Morehouse Medical School, 41-A Lenox Pointe Northeast, Atlanta, GA 30324*
Participants: Malcolm Lazin, Susan Wheeler

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to appreciate issues that gay, lesbian, and transgender teenagers face

and understand how a family has dealt with the suicide of their gay teen son.

SUMMARY:

Gay, lesbian, and transgender teenagers face unique developmental and social issues that impact on psychiatric assessment and treatment. The coming-out process, with fear of disclosure and rejection, is very real for these teens, who face discrimination on a daily basis in their schools, families, the media, and our society. Isolation, discrimination, and suicidality are some of the problems these adolescents endure—sometimes with success, sometimes with severe consequences including suicide.

The award-winning documentary film "Jim in Bold," will be screened, followed by a discussion with the audience by child psychiatrists from AACAP's Sexual Orientation and Gender Identity Issues Committee. The film depicts the story of a gay teen, Jim Wheeler, through his family's reactions to his sexual orientation and eventual suicide, and follows three youths doing a cross-country trip interviewing isolated teenagers in memory of Jim and trying to help combat suicidality in sexual-minority adolescents. Audience members will be able to share their own experiences with sexual-minority youth and discuss ways to combat suicidality in these youths. "Jim in Bold," is a visual diary with the message of tolerance. By viewing and discussing this film, clinicians can gain a more thorough understanding of gay, lesbian, and transgender adolescents, which can lead to more effective strategies for evaluation and treatment.

REFERENCES:

1. Herbert SE, Swann SK: Ethical issues in the clinical treatment of gender dysphoric adolescents. Journal of Gay and Lesbian Social Services 1999; 10:19–34.
2. Pleak RR, Anderson DA: Observation, interview, and mental status assessment (OIM): homosexual. In: Handbook of Child and Adolescent Psychiatry, Volume 5. Edited by Noshpitz JD, New York, John Wiley & Sons, 1998, pp. 563–574.

Media Workshop 5
LONG-TERM MANAGEMENT OF SCHIZOPHRENIA IN THE FILM "OUT OF THE SHADOW"

Co-Chairpersons: Stephen M. Goldfinger, M.D., *Department of Psychiatry, State University of New York, Downstate Medical Center, 450 Clarkson Avenue, Brooklyn, NY 11203*
Susan E. Smiley, B.S., NAMI, *4156 Neosho Avenue, Los Angeles, CA 90066*
Participant: Kenneth S. Duckworth, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the vital importance of insuring reliable compliance/adherence with the treatment plan, the importance of effective collaboration between family and psychiatrists, how to distinguish between destructive and constructive communication patterns with the patient and family members, and how social stressors can impact the course of the illness.

SUMMARY:

This workshop will present a unique and acclaimed documentary film titled "Out of the Shadow," with an accompanying educational guide designed to inform mental health professionals in ways that textbooks, lectures, clinical rounds, and even years of professional practice cannot. Evidence-based practices are illuminated as viewers of the film are taken on a four-year journey inside the home, private family meetings, as well as into the hospital, to witness one patient who suffers from schizophrenia and her family. Somehow they have made sense out of chaos and ultimately learned to work together with caregivers to make recovery possible.

Maintaining continuity of care is of utmost importance. Yet too often it fails for someone living with a severe mental illness. Patients end up in a constant cycle of unfamiliar living arrangements, psychiatric wards, doctors, social workers, and worst of all, medications.

To end this cycle, collaboration is essential. Scenes from the film will be linked with discussion points in the guides, which offer information on evidence-based practices, offering new hope for patients with these treatments.

Media Workshop 6
INTERGENERATIONAL FAMILY ABUSE: A DOCUMENTARY FILM

Chairperson: Barry Herman, M.D., *277 Upper Gulph Road, Radnor, PA 19087*
Participants: Patti Obrow White, Manuel Garcia, M.D., Harold I. Eist, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the phenomenon of intergenerational family abuse and violence and to understand the need for additional research in basic science and clinical treatment, better mental health care delivery systems, and improved public policy and prevention services related to family abuse and violence.

SUMMARY:

Unique media forms have the ability to stimulate discussion about intergenerational family abuse, its etiology and treatment, and attendant social and public policy issues. The feature documentary film, "If I Could," provides attendees with a unique intergenerational time-arc perspective and offers an unprecedented look at a family deeply affected by trauma over the course of two decades. Narrated by Academy Award-winning actress Sally Field, this true story follows the life of Tracy, a young woman facing the ghosts of her troubled past in a fight to keep her son from falling prey to the same demons that nearly destroyed her. Conclusion: The film demonstrates that trauma is a multifactorial, biopsychosocial phenomenon, and treatment often requires a long-term commitment by service providers, payers, and social agencies. The film can be used as a vehicle for both public and professional discussion to promote an understanding of myriad clinical and public policy issues related to family abuse and violence.

REFERENCES:

1. Green AH: Child physical abuse, in Textbook of Child and Adolescent Psychiatry, Edited by Weiner JM. Washington, D.C., American Psychiatric Press, Inc., 1991, pp 477–485.
2. Yates A: Child sexual abuse, in Textbook of Child and Adolescent Psychiatry, Edited Weiner JM. Washington, D.C., American Psychiatric Press, Inc., 1991, pp 487–494.

MONDAY, MAY 23, 2005

Component Workshop 1
MANAGED CARE: PAST, PRESENT, AND FUTURE
APA Committee on Managed Care

Chairperson: Lawrence B. Lurie, M.D., *University of California, San Francisco, 57 Post Street, Suite 601, San Francisco, CA 94104-5023*
Participants: Kevin L. Smith, M.D., Raphael A. Rovere, M.D., Jonathan L. Weker, M.D., Jennifer R. Lee, M.D., Alan A. Axelson, M.D., David Nace, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should have a better understanding of the current health care system and will be presented with a view of the future.

SUMMARY:

The workshop, presented by members of the APA Committee on Managed Care, will look at the evolution of managed care over the past 15 years, focusing on the history, current practices, and future developments in the field.

We will discuss the lessons learned from managed care, psychiatrists' experience with managed care, and the impact of managed care on patient access to psychiatrists.

In order to think about the future of managed care, we will present a model for evaluating health care systems and describe some consumer-driven models that are surfacing and will be prominent in the next decade. A visionary, comprehensive model developed by two of our members will be presented.

Finally, we will present a view of the future through the eyes of a psychiatric resident and of two "movers and shakers" (also committee members) in developing health policy in this area.

The workshop will be moderated by the committee chair, and there will be five presentations, approximately 12 minutes in length. We anticipate 30 minutes of audience participation.

REFERENCES:

1. Alternatives to Managed Care, APA Resource Document, January 2004.
2. Redefining Competition in Health Care, Porter & Teisburg, Harvard Business Review, June 2004.

Component Workshop 2
KEEPING APA PRACTICE GUIDELINES CURRENT: ALZHEIMER'S, DELIRIUM, AND EATING DISORDERS
APA Steering Committee on Practice Guidelines

Chairperson: Jack S. McIntyre, M.D., *Department of Psychiatry, Unity Health System, 81 Lake Avenue, 3rd Floor, Rochester, NY 14608*
Participants: Ian A. Cook, M.D., Laura J. Fochtmann, M.D., Joel Yager, M.D., Peter V. Rabins, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the development process, goals, and dissemination efforts for APA practice guidelines, find brief, timely updates of APA practice guidelines online, and learn about major developments in treatment since publication of four guidelines: Psychiatric Evaluation of Adults, Alzheimer's Disease and Other Dementias of Late Life, Delirium, and Eating Disorders.

SUMMARY:

Since 1991, APA has published 13 evidence-based practice guidelines. The guidelines are increasingly used to aid clinical decision making and for continuing medical education, certification and recertification, and quality improvement. More attention is being given to the currency of guideline recommendations and the need for timely revision. To address this, the Steering Committee on Practice Guidelines has begun publishing guideline watches, brief updates summarizing major developments in the scientific literature since guideline publication that could lead psychiatrists to treat patients in a manner different from what is recommended in the guideline. Watches are authored by experts associated with the original guideline effort and are reviewed by the Steering Committee and others, but they are not formally approved by the APA Assembly and Board. To date, three watches have been published, for the guidelines on psychiatric evaluation of adults, Alzheimer's disease and other dementias of late life, and delirium. Publication of a watch for eating disorders is expected in January 2005. Workshop participants will discuss APA's process for guideline development, dissemination, review, and revision. Watch authors will review the major developments described in published watches on the above topics.

REFERENCES:

1. American Psychiatric Association: Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2004. Arlington, VA: American Psychiatric Association.
2. Cook, IA: Guideline watch: practice guideline for the psychiatric evaluation of adults. Arlington, VA: American Psychiatric Association, 2004. Available online at www.psych.org/psych pract/treatg/pg/prac guide.cfm.
3. Cook IA: Guideline watch: practice guideline for the treatment of patients with delirium. Arlington, VA: American Psychiatric Association, 2004. Available online at www.psych.org/psych pract/treatg/pg/prac guide.cfm.
4. Rabins PV: Guideline watch: practice guideline for the treatment of patients with Alzheimer's disease and other dementias of late life. Arlington, VA: American Psychiatric Association, 2004. Available online at www.psych.org/psych pract/treatg/pg/prac guide.cfm.
5. Yager J: Guideline watch: practice guideline for the treatment of patients with eating disorders. Arlington, VA, American Psychiatric Association, in press.

Component Workshop 3
WHAT NOT TO DO: THE MEDIA TALK BACK ABOUT PUBLIC AFFAIRS
APA Committee on Public Affairs

Co-Chairpersons: Marc Graff, M.D., *18040 Sherman Way, Reseda, CA 91335*
Lydia Sermons-Ward, *1000 Wilson Blvd Suite 1825, Arlington, VA 22209-3901*
Participants: Robert S. Benson, M.D., Christopher B. Peterson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand common problems in dealing with the media, from both the psychiatrist's and the reporter's perspectives.

SUMMARY:

Questions to be answered are: What are the common errors that psychiatrists make when they interact with the media? What can be done to improve communication with broadcast and print reporters?

No special background is required for this workshop—just an interest in the issues of today and how psychiatry speaks to these issues. Psychiatrists and mental health professionals who are active in public affairs, government relations, and legislative issues will find this to be particularly useful.

A panel of experts from the Committee on Public Affairs and the director of APA's Office of Communications and Public Affairs will present their "war stories" and interact with media representatives who will discuss how psychiatrists and psychiatry appear from media perspectives. Reporters will be drawn from the Atlanta media market, which includes multiple cable networks, representatives of the national media, and local print and broadcast reporters. There will be ample time for questions from the audience and general discussion of past stories as well as breaking news issues.

REFERENCES:

1. Wahl OF: Media Madness: Public Images of Mental Illness, Rutgers University Press, 1995.
2. Byrne P: Psychiatry and the Media, in Advances in Psychiatric Treatment, 2003; 9:135–143.

Component Workshop 4
PSYCHIATRIC LEADERSHIP: PUTTING OUT FIRES AND BEYOND!
APA Committee on Psychiatric Administration and Management

Chairperson: Stuart B. Silver, M.D., *Department of Mental Health, Clinical Associates, PA, 4966 Reedy Brook Lane, Columbia, MD 21044*
Participants: Christopher G. Fichtner, M.D., Sy Atezaz Saeed, M.D., Nalini Juthani, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to lead a mental health service program through an administrative nightmare; participants will develop their skills in analyzing, planning, developing interventions and managing crises in the psychiatric programs in which they participate.

SUMMARY:

Psychiatrists in administrative and leadership positions face a variety of challenges. Working within systems of care, multiple conflicting forces may come into play. Leadership involves having a vision, maintaining patient-centered priorities, and providing quality care within the context of limited resources and other systems constraints.

This workshop will take an interactive case-consultation approach in which participants are invited to share difficult and challenging cases in administrative psychiatry. Faculty, representing a broad range of administrative and leadership roles and experiences, will facilitate discussions involving case conceptualization and formulation, problem identification and analysis, and strategies for selecting effective interventions. Participants and faculty will share experiences in putting out fires and in strategies for preventing them.

The use of basic management skills in leadership and their integration with clinical principles and patient care priorities will be emphasized.

REFERENCES:

1. Reid WH, Silver, SB (eds): Handbook of Mental Health Administration and Management. New York, NY: Brunner Routledge 2003.
2. Rodenhauser P (ed): Mental Health Care Administration: A Guide for Practitioners. Ann Arbor, MI, Univ. of Michigan Press, 2000.

Component Workshop 5
EARLY CAREER PSYCHIATRISTS AS LEADERS
APA Assembly Committee of Early Career Psychiatrists

Chairperson: Adam R. Chester, D.O., *Department of Psychiatry, Flushing Hospital, 4500 Parson Boulevard, Flushing, NY 11355*
Participants: Benedicto R. Borja, M.D., Matthew W. Norman, M.D., John R. Chamberlain, M.D.

EDUCATIONAL OBJECTIVES:

After completing this workshop, participants will learn leadership strategies and opportunities achievable in the early part of their psychiatric careers.

SUMMARY:

Becoming a leader in psychiatry is a skill that develops as one's career matures. Achieving leadership as an early career psychiatrist presents more of a challenge. We propose a workshop in which early career psychiatrists discuss how to become leaders in a variety of psychiatric areas by using examples from personal experience. Leadership opportunities in academia will be discussed by Ben Borja, M.D., including professorship status, mentorship, and lecturing. Advancing in the leadership of a psychiatric department, including strategies for advancement will be discussed by Adam Chester, D.O. Community leadership will be discussed by Matt Norman, M.D. as it relates to building and maintaining a private psychiatric practice. John Chamberlain, M.D. will discuss leadership within psychiatric organizations, including fellowship status and becoming an officer. These leadership strategies will help early career psychiatrists become leaders in the field as their careers advance.

REFERENCES:

1. Mrazek DA: Leadership in child psychiatry—a perspective from a department chair. Child & Adolescent Psychiatric Clinics of North America; 11:103–112.
2. Tobin M, Edwards JL: Are psychiatrists equipped for management roles in mental health services? Australian & New Zealand Journal of Psychiatry; 2002; 36:4–8.

Component Workshop 6
CHILDREN UNDER FIRE: ENHANCING PSYCHIATRY'S GLOBAL RESPONSE
APA Corresponding Committee on Juvenile Justice Issues

Chairperson: Niranjan S. Karnik, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Stanford, CA 94305*
Participants: Shanta P. Henderson, M.D., Roxanne Dryden-Edwards, M.D., Janet A. Martin, M.D., Sandra J. Kaplan, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this session, participants should be able to understand the nature of childhood trauma and victimization in the U.S. and abroad, recognize the global similarities and differences among youth in crisis, and appreciate the role that psychiatry can play in the assessment, analysis, and treatment.

SUMMARY:

Globally, children face stressors at a level that has been unprecedented. War, terrorism, poverty, deprivation, natural disasters, and famine are but a few of the social and political processes that affect children. Psychiatry has a unique role to play in understanding and responding to these phenomena, but a general lack of understanding of these issues often prevents practitioners and researchers from realizing the role that they could play. With encouragement from the APA Council on Global Psychiatry, the Council on Children, Adolescents, and their Families was asked to develop this type of program to better educate members of APA about the dynamics of children in a global context. All of the talks in this workshop attempt to link the local and global, and act as a bridge between the international arena and the U.S. They likewise highlight issues that often lead or initiate children into lives that put them at risk for juvenile delinquency. Attention to the problems that face children and the ways that these processes function at the global level can help to enhance psychiatry's response to children under fire.

REFERENCES:

1. James A, Prout A: Constructing and Reconstructing Childhood. London, Falmer Press, 1990.
2. Small Wars: The Cultural Politics of Childhood, edited by Scheper-Hughes N, Sargent C. Berkeley, University of California Press, 1998.

Component Workshop 7
SERODISCORDANT COUPLES: ISSUES AND PSYCHODYNAMICS IN THE THIRD DECADE OF AIDS
APA New York County District Branch's AIDS Committee

Chairperson: Elizabeth V. Getter, M.D., *1 Irving Place - P26D, New York, NY 10003*
Participants: Kenneth Ashley, M.D., Mary Ann Cohen, M.D., John A.R. Grimaldi, Jr., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to identify and understand many of the complex issues encountered in doing psychotherapy with couples who have dissimilar (HIV-positive/HIV-negative) serostatus. In addition the participant will become more aware of countertransference issues potentially engendered in the therapist.

SUMMARY:

The third decade of AIDS has brought improved treatment options to HIV-infected persons living in the Western world. Highly active anti-retroviral therapy (HAART) has, for many, made a rapidly fatal illness into a chronic condition. Assisted reproduction techniques and postexposure prophylaxis offer new hope. Despite this, approximately 40,000 people in the U.S. continue to seroconvert each year. As people with HIV/AIDS (PWA) live longer, greater numbers of individuals will likely become "coupled" with someone of dissimilar (HIV-positive/HIV-negative) serostatus, and therapists will more frequently find themselves working with someone in a "serodiscordant" couple.

Whether the coupling is brief or longstanding, the interpersonal issues faced by "serodiscordant" couples are becoming more complex. Despite an uncertain future, PWAs and their partners have to consider an extended life expectancy and negotiate financial, family and career planning. The members of the NYCDB-COA will discuss some of the psychodynamic, ethical and transference issues encountered working with "serodiscordant" couples including: sexual behaviors, risk and intimacy; pregnancy in HIV+ women; concerns of the HIV– partner; and moral and legal obligations facing the therapist confronted by patient non-disclosure and partner risk. The COA will present clinical vignettes from their experiences with a northeastern urban population that illustrates the above points.

REFERENCES:

1. Cohen MA, Alfonso CA: Women, sex, and AIDS. Int J Ment Health 1997; 26:99–106.
2. Forstein M: Psychotherapy with gay male couples: loving in the time of AIDS. In Therapists on the Front Line, Psychotherapy with Gay Men in the Age of AIDS, edited by Cadwell SA, Burnham RA, Forstein M. Washington, DC, American Psychiatric Press, 1994, pp 293–315.

Component Workshop 8
TEN WAYS TO STAY OUT OF TROUBLE: ETHICS AND ETIQUETTE
APA Ethics Appeals Board

Chairperson: Spencer Eth, M.D., *Department of Psychiatry, St. Vincent's Hospital and Medical Center, 144 West 12th Street, Room 174, New York, NY 10011*
Participants: Wade C. Myers, M.D., William Arroyo, M.D., Harriet C. Stern, M.D., Scott Y. Kim, M.D., Richard D. Milone, M.D., JoAnn Macbeth, J.D., Philip T. Merideth, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize and successfully manage a variety of problematic situations involving patients and their families, financial matters, treatment challenges, and civic responsibilities that can lead to medical board and ethics complaints.

SUMMARY:

Psychiatrists often wonder whether aspects of their clinical practice could raise ethical problems. Other psychiatrists may be conducting themselves in ways that should be cause for concern, but seem unaware. This interactive workshop is designed to engage psychiatrists in an open discussion of common situations that may signal professional risk. Ten common areas include: confidentiality (e.g., complying with HIPAA and Tarasoff rules); split therapy (e.g., providing medication management for a nonphysician psychotherapist); double agent (e.g., managing dual loyalty issues in schools, prisons and the military); pharmaceutical industry relationships (e.g., accepting gifts or honoraria from drug companies); speaking to the media (e.g., the "Goldwater Rule"); self-disclosure (e.g., revealing yourself in the materials in your waiting room); boundary violations (e.g., touching patients); informed consent (e.g., telling patients about medication side effects and off-label uses); fee disputes and fee sharing (e.g., charging for a missed appointment or a lengthy phone call); and coverage arrangements. The audience will be encouraged to present their own hypothetical scenarios for consideration. The workshop panel will be composed of members of the APA Ethics Committee and Ethics Appeals Board.

REFERENCES:

1. Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry, APA.
2. Ethics Primer of the American Psychiatric Association, APA.

Component Workshop 9
U.S. RESEARCH AND SERVICES BRIDGE WITH LATIN AMERICA
APA Council on Global Psychiatry

Co-Chairpersons: Rodrigo A. Munoz, M.D., *Department of Psychiatry, University of California San Diego, 3130 Fifth Avenue, San Diego, CA 92103*
Pedro Ruiz, M.D., *Department of Psychiatry, University of Texas, 1300 Moursund Street, Houston, TX 77030*
Participants: Jose M. Caldas de Almeida, M.D., Javier I. Escobar, M.D., Gerardo Heinze, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize and utilize all current research and services links between the U.S. and Latin America. Additionally, to learn all efforts from PAHO in this regard.

SUMMARY:

Currently, the globalization process that exists worldwide has also involved Latin America. All aspects of life are impacted in this process, including health care and mental health care. While the influx of migrants in the Americas goes from south to north, the research and services influences go from north to south. The Pan American Health Organization (PAHO) and the American Psychiatric Association Council on Global Psychiatry have been actively collaborating in bridging research and services efforts between the U.S. and Latin America. In this workshop these current research and services efforts will be presented and discussed. The goal is to explore new paths of research and service collaboration and integration of the resources allocated for these purposes. Hopefully, these planning efforts will lead to an improvement in the current mental health care system, with emphasis on efficacy and cost-effective approaches. Priority will be given to initiatives focusing on the public psychiatry sector.

REFERENCES:

1. Zambrana RE, Carter-Pokras O: Improving health insurance coverage for Latino children: a review of barriers, challenges and state strategies. Journal of National Medical Association, 96: 508–523, 2004.
2. Ruiz P: Issues in the psychiatric care of Hispanics. Psychiatric Services, 48: 539–540, 1997.

Component Workshop 10
FUNDING FOR PSYCHIATRY: FROM THE IRRATIONAL AND RATIONAL
APA Council on Healthcare Systems and Financing

Chairperson: Selby C. Jacobs, M.D., *Connecticut Mental Health Center, 34 Park Street, New Haven, CT 06519*
Participants: Mantosh J. Dewan, M.D., Anita S. Everett, M.D., Edward J. Maxwell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand how burden of disease methodology could rationalize resource allocation for psychiatry. Discussion will include relative investment in psychiatric services globally; concept of burden of disease and disability adjusted life year (DALY); contribution of psychiatric disorders to burden of disease; a model for rational funding of psychiatric services.

SUMMARY:

This workshop is intended for financial decision makers and those interested in the level of financing of mental health care. The session will 1) review the current funding levels of care in the US and internationally; 2) explore the concept of using the burden of disease as a mechanism for deteremining appropriate levels of funding for care.

The psychiatric service delivery system in the U.S. has been systematically de-funded. The workshop will look at the current level of funding as it relates to the burden of psychiatric disorders and will compare that with the level of funding and burden of disease experienced in other countries. The burden of disease methodology and the use of the disability adjusted life year (DALY) metric provide psychiatry with a means to compare the funding of psychiatric services with other medical services across a range of illnesses. This information is critical to effective advocacy efforts for better funding for psychiatric services.

REFERENCES:

1. Andrews G, Issakidis C, Sanderson K, et al: Related articles, links utilising survey data to inform public policy: comparison of the cost-effectiveness of treatment of ten mental disorders. Br J Psychiatry. 2004; 184:526–33.
2. Sanderson, K, Andrews, G, Corry, J, Lapsley, H: Reducing the burden of affective disorders: is evidence-based health care affordable?. J Affect Dis. 2003; 77:109–125.

Component Workshop 11
SOMATIZATION AND STIGMA IN ASIANS: CULTURAL CHALLENGES IN PRACTICE
APA Committee of Asian-American Psychiatrists

Chairperson: John Luo, M.D., *Department of Psychiatry, University of California Los Angeles, 760 Westwood Plaza, Mailcode 175919, Los Angeles, CA 90024*
Participants: Mona H. Gill, M.D., Sabina Lim, M.D., Nang Du, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the differences in symptom presentation, barriers to access of care, diagnostic challenges, and treatment implications in the Asian-American and Pacific-Islander population.

SUMMARY:

Asian Americans and Pacific Islanders are diverse in ethnicity and in their historical experiences in the United States. Asian immigrants now account for about 4 percent of the U.S. population and are the fastest-growing racial group. It is projected that by the year 2020, the combined AA/PI population will reach approximately 20 million, or about 6 percent of the total U.S. population.

In the Asian culture, the dichotomy of mind and body is not separated, which has led to somatic presentations of mental illness. This disease presentation and the stigma of mental illness delays access to appropriate care. Recognition of mental illness in Asians is challenging in the primary care setting. Due to the various cultural backgrounds and perceptions of psychiatric illness, there are special challenges in access, diagnosis, and treatment in this population.

Participants in this workshop will learn about the differences in disease manifestation and recognition in the Asian American and Pacific Islander population. Discussion will address the barriers and issues of overcoming stigma, assessment, and treatment of mental illness in this population.

REFERENCES:

1. Lin EH, Carter WB, Kleinman AM: An exploration of somatization among Asian refugees and immigrants in primary care. Am J Public Health. 1985; 75(9):1080–4.
2. Satcher D: Mental Health: Culture, Race, and Ethnicity. Supplement to Mental Health: Report of the Surgeon General, Inventory Number: SMA-01-3613. 2001.

Component Workshop 12
BEHIND CLOSED DOORS: THE HIDDEN FAMILY: DOMESTIC VIOLENCE, CROSS-CULTURAL, AND ETHNIC INFLUENCES

APA Alliance

Co-Chairpersons: Carole L. Warshaw, M.D., *John M. Stroger Hospital, 3428 North Janssen, Chicago, IL 60657*
Cathy Tasman, *5105 Dunvegan Road, Lousiville, KY 40222*
Participants: Julia L. Perilla, Ph. D., Surinder S. Nand, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop the participants should be able to recognize cultural and ethnic influences on the diagnosis and treatment of mental health issues as they relate to family violence as well as recognize key issues for addressing domestic violence in mental health settings.

SUMMARY:

This workshop will address mental health issues related to domestic violence in cross-cultural U.S. populations, specifically Asian-American and Latino-Hispanic. Surinder Nand, M.D., will describe the unique features of domestic abuse among the South-Asian community, highlighting the accomplishments of Apna Ghar (Our Home), in Chicago. Nand will discuss the culturally sensitive and linquistically appropriate health services that are needed to deal with the variety of belief systems regarding domestic abuse among the South-Asian communities. Julia L. Perilla, Ph.D., herself a survivor, will discuss working with a community-based project for Hispanic/Latino families torn apart by domestic violence. With specific requests from the community, she developed programs for families experiencing domestic violence—one for women, one for men (which includes women participants), and one for children. Perilla will address the complications of language barriers in domestic violence shelters, as well as the impact of Latino family culture. Carole Warshaw, M.D., director of the Domestic Violence and Mental Health Policy Initiative in Chicago, and co-author of the AMA

"Guidelines on the Mental Health Effects of Family Violence," will provide both a framework and recommendations for addressing domestic violence in mental health settings, with particular attention to issues facing diverse populations. After a formal 10–15 minute presentation by each participant, there will be a discussion with the audience and the other panelists.

REFERENCES:

1. Perilla JL, Perez F: El Machismo y la Violencia: An Intervention with Latino Batterers. Proceedings from the Third Annual Symposium on Minority Health: Minority Male Interventions, 1997.
2. Abraham M: Speaking the Unspeakable: Marital Violence Among the South Asian Immigrants in the United States, Rutgers University Press.

Component Workshop 13
PRACTICAL TIPS ON HOW TO BE A SUCCESSFUL AUTHOR
American Psychiatric Publishing Inc. Editorial Board

Chairperson: Robert E. Hales, M.D., *Department of Psychiatry, University of California Davis, 2230 Stockton Boulevard, Sacramento, CA 95817*
Participants: Glen O. Gabbard, M.D., Katharine A. Phillips, M.D., John M. Oldham, M.D., Donna E. Stewart, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to list five practical strategies that will improve a person's skills to be a successful author.

SUMMARY:

The workshop is designed for psychiatrists who are interested in becoming an author or editor. The participants are all senior editors of the American Psychiatric Publishing Editorial Board and are accomplished authors and editors with extensive publishing experience. Dr. Hales will provide an overview of how book proposals and manuscripts are reviewed at APPI and provide specific guidelines to potential authors on the necessary steps to follow. Dr. Gabbard will discuss how authors may wish to develop overall themes or topics for their books and how to get feedback from more experienced authors. Dr. Phillips will provide suggestions on how to evaluate other books that have been published and how to develop a unique or novel focus. Dr. Oldham will outline strategies for editors managing the publication process of large texts. Dr. Stewart will summarize how authors may assist marketing in promoting their work, and what they may do individually to increase awareness among colleagues, trainees, and other potential readers about their work. Audience participation will be encouraged through question-and-answer sessions after each presentation and by asking attendees to provide personal anecdotes.

REFERENCES:

1. Kay J, Silberman EK, Pessar L: Handbook of Psychiatric Education and Faculty Development. Washington, DC: American Psychiatric Publishing, 1999.
2. Borus JF, Sledge WH: Psychiatric Education, in Hales RE, Yudofsky SC, Talbott JA: American Psychiatric Press Textbook of Psychiatry, Third Edition. Washington, DC: American Psychiatric Publishing, 1999.

Component Workshop 14
PSYCHIATRIC ETHICS IN THE U.S. AND THROUGHOUT THE WORLD
APA Ethics Committee

Co-Chairpersons: Spencer Eth, M.D., *Department of Psychiatry, St. Vincent's Hospital and Medical Center, 144 West 12th Street, Room 174, New York, NY 10011*
Driss Moussaoui, M.D., *University Psychiatric Center, Rue Tarik IBN Ziad, Casablanca 00210, Morocco*
Participants: Wade C. Myers, M.D., Philip T. Merideth, M.D., Ahmed M.F. Okasha, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session the participant should be able to recognize, compare, and contrast the different codes of psychiatric ethics in force throughout the world.

SUMMARY:

The APA Ethics Committee and the World Psychiatric Association Standing Committee on Ethics will jointly conduct a workshop that will compare, contrast, and discuss codes of medical ethics applicable to the practice of psychiatry that are in operation in the United States and in other countries throughout the world. Particular issues of concern will include therapeutic boundary violations, confidentiality, consent and involuntary treatment, research and human-subject protection, religious constraints on practice, psychiatric involvement in capital punishment, and the influence of religious and cultural factors on professional conduct. In addition, differing approaches to ethics education and enforcement will be highlighted. The audience will have ample opportunities to interact with the workshop presenters.

REFERENCES:

1. AMA Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry: APA.
2. Helsinki Declaration of the World Medical Association, 2000.

Component Workshop 15
THE MULTICULTURAL DIMENSION OF DEPRESSION: A CLINICAL APPROACH
APA/AstraZeneca Minority Fellows

Chairperson: Gonzalo E. Laje, M.D., *National Institutes of Mental Health, 10 Center Drive, MSC 1255 10/4N208, Bethesda, MD 20892-1255*
Participants: Angel A. Caraballo, M.D., Yolonda R. Colemon, M.D., Daniel Dickerson, D.O., Luisa S. Gonzalez, M.D., Jennifer R. Lee, M.D., Aditi M. Shrikhande, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to (1) recognize unique perceptions and expressions of depression in African-American, Chinese-American, Latino, Native American/Alaskan, and South-West Asian communities in the United States; (2) learn culturally sensitive alternatives to traditional methods of communication and treatment to improve care for minority patients.

SUMMARY:

Cultural misunderstandings between patient and clinician, clinician bias, and the fragmentation of mental health services deter minorities from accessing and utilizing care and prevent them from receiving appropriate care. The purpose of this workshop is to present a perspective on issues regarding depression in minorities. We will specifically focus on the views of African-American, Chinese-American, Latino, Native American/Alaskan, and South-West Asian communities in the United States. Currently, psychiatry is focusing on cross-cultural differences and disparities in treatment, assessment, and diagnosis in minority groups. What makes this talk unique is that

it will concentrate on how minority communities view depression, communicate symptoms, resist acceptance of mental illness, as well as genetic influences that might affect pharmacological treatment. This workshop will discuss obstacles in seeking treatment, such as cultural and language barriers, distortions of how mental illness and mental health professionals are viewed, difficulties in diagnosis due to differences in the manifestation of symptoms, difficulties in the therapeutic alliance, and difficulties in the treatment involving psychotherapeutic and pharmacotherapeutic interventions.

By the end of the talk, the participant will know how to identify cultural and biological barriers to treatment and facilitate exchange between mental health professionals and the minority community. The audience will participate through discussion with workshop presenters. With this workshop we hope to advance intervention, education, and advocacy for minority populations.

This session is geared toward residents, fellows, and clinical psychiatrists.

REFERENCES:

1. Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General, U.S. Department of Health and Human Services, 2001.
2. Parker G, Gladstone G, and Kuan TC: Depression in the planet's largest ethnic group: the Chinese. Am. J. Psychiatry, 2001; 158:857–864.

Component Workshop 16
EARLY DIAGNOSIS IN SPECIFIC MENTAL DISORDERS IN TODDLERS AND PRESCHOOLERS
APA Corresponding Committee on Infancy and Early Childhood

Co-Chairpersons: Judy S. McKay, M.D., *Department of Psychiatry, University of South Carolina School of Medicine, 3555 Harden Street, Suite 103, Columbia, SC 29203*
Harry H. Wright, M.D., *Department of Neuropsychiatry, University of South Carolina, 3555 Harden Street Extension, Suite 104, Columbia, SC 29203*
Participants: Jean M. Thomas, M.D., Joan L. Luby, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize the importance of accurate early diagnosis of selective mental disorders in young children and diagnose depression disorders, disruptive behavior disorders, and autism spectrum disorders in toddlers and preschool children.

SUMMARY:

In recent years there has been increasing interest in the assessment, diagnosis and treatment of young children with mental disorders. This workshop addresses the diagnostic challenges of evaluating toddlers and preschool children with disruptive behavior disorders, depressive disorders, and autism spectrum disorders (ASDs). The need for early diagnoses to facilitate early interventions is highlighted.

Dr. Thomas will address diagnosing disruptive behavior disorders in young children. She will describe two diagnostic patterns she is investigating in her ongoing federally funded study. Video vignettes will illustrate how the diagnostic assessment process and the diagnosis itself guide intervention and prevention strategies. Participants will be asked to help diagnose the behavioral difficulties presented.

Dr. Luby will discuss the clinical implications of her empirical data about depressive syndromes among preschool children. She will demonstrate how to assess the characteristics of depression in preschool children, taking into account age-appropriate clinical techniques.

Dr. Wright will describe the early diagnosis of ASD that follows a developmental approach. This includes historical information, direct observation, and testing in several situations over time. An evaluation procedure focusing on making early diagnosis will be provided.

Audience participation and discussion will follow the three presentations. This workshop is designed for anyone interested in working with young children.

REFERENCES:

1. The Handbook of Infant. Toddler and Pre-School Mental Health Assessment, edited by Delcarmen-Wiggins, Carter, N.Y., Oxford University Press, 2004
2. Luby JI, Heffellinger, AK, Mrakotsky C, et al: The clinical picture of depression in preschool children. JAACAP 2003; 42:340–348.

Component Workshop 17
GENDER BENDERS: PSYCHIATRIC ASPECTS OF TRANSGENDER CARE
APA New York County District Branch's Committee on Gay, Lesbian, Bisexual, and Transgender Issues

Chairperson: Serena Yuan Volpp, M.D., *Department of Psychiatry, Bellevue Hospital, 462 First Avenue, 20 West, New York, NY 10016*
Participants: Steven J. Lee, M.D., Khakasa H. Wapenyi, M.D., Daniel Garza, M.D., Ubaldo Leli, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should 1) understand the tension between medical and patient-centered models of gender identity; 2) be familiar with protocols used in psychiatric evaluations of transgender people; 3) appreciate issues that arise in psychotherapy with transgender people.

SUMMARY:

Most psychiatrists remain unfamiliar with the care of transgendered individuals. This workshop aims to introduce general practitioners to issues that arise in the evaluation and treatment of transgender people. We will start with a general discussion of the concept of gender identity. We will then speak about the development of a model transgender program at a community health clinic in New York City. The protocol used at the clinic to evaluate patients for treatment with cross-gender hormonal therapy will be outlined in detail. Clinical issues related to working with transgendered individuals who have chronic mental illness will be elaborated. The limitations of viewing gender identity as a dichotomous construct and the concepts of gender independence and androgyny as a choice will be discussed. Case examples of themes that surface in psychotherapy with transgender individuals will be provided.

REFERENCES:

1. Leli U, Drescher J: Crossing over: introduction. Journal of Gay and Lesbian Psychotherapy, 8: 1–5.
2. Tarver DE: Transgender mental health: the intersection of race, sexual orientation, and gender identity. In Mental Health Issues in Lesbian, Gay, Bisexual, and Transgender Communities, edited by Jones BE, Hill MJ. (Review of Psychiatry Series, Volume 21,

Number 4; Oldham JM and Riba MB, series editors). Washington, DC: American Psychiatric Publishing, 2002, pp. 93–108.

TUESDAY, MAY 24, 2005

Component Workshop 18
"Y" PSYCHOTHERAPY: AN INTEGRATED, EVIDENCE-BASED PSYCHOTHERAPY COMPETENCY MODEL
APA Committee on Psychotherapy by Psychiatrists

Co-Chairpersons: Eric M. Plakun, M.D., *Department of Admissions, The Austen Riggs Center, 25 Main Street, P.O. Box 962, Stockbridge, MA 01262*
Lisa A. Mellman, M.D., *Department of Psychiatry, Columbia University, 1051 Riverside Drive, New York, NY 10032*
Participants: Daniel T. Chrzanowski, M.D., Allison V. Downer, M.D., Asher B. Simon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe an approach to teaching psychotherapy that is based on existing comparative psychotherapy process research and integrates the current five residency competencies into one unified three-part structure.

SUMMARY:

Competency by residents in five types of psychotherapy has been mandated by the Accreditation Council for Graduate Medical Education, yet many residency programs lack resources to teach all five. Sample competencies derived by expert consensus to address this requirement are not consistent, use varying levels of abstraction and have areas of overlap. This workshop, from the APA Committee on Psychotherapy by Psychiatrists, is intended for residents, early career psychiatrists, and teachers in residency programs. It offers a new model that integrates the five competencies into one unified whole in a "Y-shaped" structure. Based on evidence about common factors found in all schools of psychotherapy and evidence from comparative psychotherapy process research, the stem consists of common factors and supportive, brief, and combined psychopharmacology and psychotherapy. Cognitive-behavioral therapy and psychodynamic therapy are then conceptualized as two divergent therapies that build on these basic skills with different approaches to managing therapist activity, the role of the unconscious, the therapeutic relationship, symptoms, and affects. After an introduction and review of research into common factors across therapy schools, there will be a 30-minute presentation of the model, followed by commentary from residents familiar with its development, and 30 minutes reserved for audience discussion.

REFERENCES:

1. Blagys MD, Hilsenroth MJ: Distinctive features of short-term psychodynamic-interpersonal psychotherapy: a review of comparative psychotherapy process literature. Clinical Psychology: Science and Practice; 2002; 7:167–188.
2. Blagys MD, Hilsenroth MJ: Distinctive activities of cognitive-behavioral therapy: A review of comparative psychotherapy process literature. Clinical Psychology Review 2002; 22:671–706.

Component Workshop 19
PATIENT SAFETY: EVALUATING AN ADVERSE EVENT AND IMPLEMENTING SAFEGUARDS
APA Committee on Patient Safety

Chairperson: Paul R. McHugh, M.D., *Department of Psychiatry, Johns Hopkins University, 600 North Wolfe Street, Meyer 4-113, Baltimore, MD 21287-7413*
Participants: Alfred Herzog, M.D., Geetha Jayaram, M.D., Robert A. Wise, M.D., Kathryn J. Ednie, M.D., Bruce W. Hinrichs, M.D., Carl B. Greiner, M.D., Carol B. Perez, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the basic elements of a root cause analysis of an adverse patient safety event with a psychiatric patient, and learning from the analysis, put in place safeguards in a system's protocols to prevent recurrence of the error.

SUMMARY:

The presentation will highlight the delivery of safe patient care by using the method of root cause analysis (RCA) of an case example arising from the practice of psychiatry. Participants will look at many aspects of care, including communication among caregivers, administration, and with the patient's family; monitoring of the patient; transcription of orders; administration of medications; and NQF safety standards. The review of what went wrong will include examination of errors at both a system and individual level. Most importantly, information derived from the RCA will be used to put together an action plan that will eliminate opportunities for the errors to occur again.

REFERENCES:

1. Root Cause Analysis in Health Care: Tools and Techniques, 2nd Edition, Joint Commission Resources, 2003, Oakbrook Terrace, IL.
2. Root Cause Analysis, VA National Center for Patient Safety, www.patientsafety/tools.html (accessed 9-14-04)

Component Workshop 20
CLOSING A PRACTICE: WHAT EVERY PSYCHIATRIST'S OFFICE AND HIS/HER FAMILY SHOULD KNOW
APA Corresponding Committee on Physician Health, Illness, and Impairment

Chairperson: John A. Fromson, M.D., *Massachusetts Medical Society, 860 Winter Street, Waltham, MA 02451*
Participant: Michael F. Myers, M.D., Cheryl Davenport

EDUCATIONAL OBJECTIVES:

At the end of this program participants should be able to: identify immediate steps required in the event of an emergency closing, recognize key clinical and administrative processes, identify risk-management issues arising from closing a practice, demonstrate understanding of the new APA resource kit "Closing a Practice: What Every Psychiatrist's Office and Their Family Should Know."

SUMMARY:

In the event of sudden illness, incapacity, or the death of a psychiatrist, are detailed plans in place to provide cover, organize administrative affairs, contact patients, and respond to enquiries about medical records, referrals, and prescriptions? The time to plan for this situation is, of course *before* such an emergency occurs, but where do psychiatric physicians find relevant, accurate guidance in a practical summarized format, for those who may one day need to rely upon it?

This workshop has been developed in response to inquiries from the families of APA members and APA staff, who regularly contact

district branches for advice, clearly demonstrating the need for practical and immediate guidance to help them navigate complex systems without feeling overwhelmed.

This workshop is designed to alert psychiatrists, their staff, and their family members to the myriad of clinical and administrative issues that may arise in their absence and indicate how checklists, policies, and documentation prepared in advance can provide peace of mind and continuity of service for their practice and their patients. The workshop will provide an overview of an essential new APA "toolkit," which is specific to psychiatry and offers a new member benefit in risk management.

REFERENCES:

1. APA Resource Kit: "Closing a Practice: What Every Psychiatrist's Office and Their Family Should Know": APA Corresponding Committee on Physician's Health and Impairment and APA District Branch and State Associations Executive Directors Committee, 2005.

Component Workshop 21
NOVEL CAREERS IN PSYCHIATRY: WOMEN WHO HAVE MADE THEIR OWN WAY
APA Committee on Women

Co-Chairperson: Melva I. Green, M.D., *Department of Psychiatry, Johns Hopkins University Hospital, 109 Persimmon Circle, Reisterstown, MD 21136*
Carrie L. Ernst, M.D., *Department of Psychiatry, Cambridge Health Alliance, 1493 Cambridge Street, Cambridge, MA 02139*
Participants: Catherine A. Roca, M.D., Francine Cournos, M.D., Cassandra F. Newkirk, M.D., Mary Jane England, M.D.

EDUCATIONAL OBJECTIVES:

To identify and appreciate creative solutions to professional challenges from the perspectives of pioneers who have built unique careers in psychiatry.

SUMMARY:

In training, psychiatrists are exposed to a limited number of career options. Mentors typically represent traditional choices such as academics, private practice, or public sector psychiatry. And yet, those who have established nontraditional paths may have knowledge that could help guide colleagues through diverse career challenges. In this interactive roundtable discussion, innovative psychiatrists who have had unusual careers will be interviewed regarding challenges they faced as well as successful strategies they developed. The personal exploration of their experience, including triumphs and mistakes, may offer insights to psychiatrists at all levels.

REFERENCES:

1. A Resident's Guide to Surviving Psychiatric Training. Edited by Foreman-El Masri T, Dickstein L. APA, 2003.
2. Helm P, Golant S: Hardball for Women: Winning at the Game of Business.

Component Workshop 22
REVERSING THE CRIMINALIZATION OF THE SERIOUSLY MENTALLY ILL
APA Corresponding Committee on Jails and Prisons

Chairperson: Henry C. Weinstein, M.D., *Department of Psychiatry, New York University School of Medicine, 1111 Park Avenue, New York, NY 10128*
Participants: Tom Hamilton, H. Richard Lamb, M.D., Erik Roskes, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this forum the participant should be able to appreciate the causes and the extent of the criminalization of the seriously mentally ill in the criminal justice system, that it is more cost effective to treat the mentally ill in the community, and the efforts that APA in partnership with other advocacy groups is making to keep the mentally ill out of the criminal justice and juvenile justice systems.

SUMMARY:

The criminalization of the seriously mentally ill is a major public policy scandal that resulted from the rapid deinsitutionalization of the seriously mentally ill and the concomitant failure to adequately fund the community mental health system. The seriously mentally ill are now significantly overrepresented in jails, prisons, and juvenile detention facilities. In addition to humanitarian concerns there are economic issues. The seriously mentally ill are more expensive to incarcerate than other inmates and are better served by treatment in their communities. Just as deinstitutionalization was, in large part, driven by state budgetary concerns, APA, in partnership with NAMI and other advocacy organizations, is compiling data to prove the economic, budgetary, and business advantages of decriminalizing the mentally ill.

The presenters will first describe the development of this situation. Then, a number of specific programs to "uncriminalize" the mentally ill—and prevent rearrest and recidivism, will be briefly described including diversion programs, mental health courts, and discharge into a system of mental health care that welcomes patients released from correctional facilities. Finally, the participants will be asked to discuss and comment on an APA advocacy effort by which legislators and their constituents—the taxpayers—will be persuaded that they can avoid misspending resources and that it is more cost efficient to treat and maintain these patients in the community mental health system than in the juvenile or criminal justice system.

REFERENCES:

1. NAMI and Public Citizen's Health Research Group: Criminalizing the Seriously Mentally Ill: The Abuse of Jails as Mental Hospitals; 1992.
2. American Psychiatric Association: Psychiatric Services in Jails and Prisons, 2nd Edition: Task Force to Revise the APA Guidelines on Psychiatric Services in Jails and Prison (Rep. No. 2). Washington, DC, American Psychiatric Association, 2000.

Component Workshop 23
DISASTER PSYCHIATRY: CHALLENGES AND NOVEL STRATEGIES FOR RESIDENCY TRAINING
APA Committee on Psychiatric Dimensions of Disaster

Co-Chairpersons: Diane E. McLean, M.D., *Columbia University, 1051 Riverside Drive, Box 81, New York, NY 10032*
Anthony T. Ng, M.D., *Uniformed Services University of the Health Sciences, Bethesda, MD 20892*
Participants: Davin A. Agustines, M.D., Holly V. MacKenna, M.D., Roman R. Snihurowych, M.D., Molly J. Hall, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize training needs for residents in disaster psychiatry, identify available resources and strategies, recognize regional differences in training needs, and be able to identify training needs associated with specific types of disasters.

SUMMARY:

The role of disaster mental health has grown significantly in the past several years. While there has been greater emphasis and training for psychiatrists in disaster psychiatry, such emphasis has not existed for postgraduate psychiatry training, and it is more likely than ever that psychiatric residents will be called upon to provide that care.

Residency programs are increasingly faced with the difficulty of incorporating additional topics that residents must learn into an already full curriculum. New topics can be mandated through new certification requirements or may develop out of resident or faculty interests. Incorporation of training in disaster preparedness poses unique challenges, yet it is of both local and national importance and likely to be only more so in the future. This workshop will address specific challenges faced by residency programs, regional approaches to specific types of disasters, case examples of how programs have incorporated training in disaster preparedness, and strategies and material that programs can draw on to create training opportunities for residents in disaster psychiatry.

REFERENCES:

1. Katz CL, Pellegrino L, Pandya A, et al: Research on psychiatric outcomes and interventions subsequent to disasters: a review of the literature. Psychiatry Research. 2002; 110:201–17.
2. Ursano RJ, Fullerton CS, Norwood AE: Terrorism and Disaster: Individual and Community Mental Health Interventions. Cambridge, UK, Cambridge University Press, 2003.

Component Workshop 24
ETHNICITY, CULTURE, AND RESPONSE TO DISASTER AMONG HISPANICS
APA Committee of Hispanic Psychiatrists

Chairperson: Eugenio M. Rothe, M.D., *Department of Psychiatry, University of Miami, 275 Glenridge Road, Key Biscayne, FL 33149-1311*
Participant: Daniel Castellanos, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to demonstrate an understanding of the cultural and ethnic factors associated with disasters and Hispanics, and recognize the various coping strategies and psychopathology associated with disasters and Hispanics.

SUMMARY:

Over the past decade the United States has suffered several natural disasters (hurricanes, floods, earthquakes, etc.) as well as manmade disasters (September 11, forced migrations). When disasters occur, all ethnic groups in the United States are affected. Differences in the impact and response to disasters may result as a consequence of cultural or socioeconomic differences among these groups. In this regard, Hispanic Americans present unique characteristics. This presentation examines the different cultural and ethnic factors among Hispanics that have been impacted by disasters and how these contribute to their psychological reactions. Our current understanding of how these disasters have impacted on the population of Hispanic Americans is discussed. Various coping strategies, adaptation styles, and resulting psychopathology are also examined. Postdisaster interventions relevant to Hispanics are discussed. Case vignettes will be utilized to illustrate these concepts and facilitate audience participation.

REFERENCES:

1. Perilla JL, Noris FH, Lavizzo EA: Ethnicity culture and disaster reponse: identifying and explaining ethnic differences in PTSD six months after Hurricane Andrew. J Soc Clin Psychol. 2002; 21:20–45.
2. Kaniasty K, Norris FH: Help-seeking comfort and receiving social support: the role of ethnicity and context of need. Am J Community Psychol. 2000; 28:545–581.

Component Workshop 25
SUICIDE AMONG ETHNIC ELDERS
APA Committee on Ethnic Minority Elderly

Co-Chairpersons: Iqbal Ahmed, M.D., *Department of Psychiatry, University of Hawaii, 1356 Lusitana Street, 4th Floor, Honolulu, HI 96813*
Warachal E. Faison, M.D., *Medical University of South Carolina, 5900 Core Road, Suite 203, N. Charleston, SC 29406*
Participants: Carl I. Cohen, M.D., Mia J. Robinson, M.D., Yolonda R. Colemon, M.D., Cynthia I. Resendez, M.D., Nhi-Ha T. Trinh, M.D., Ronald Brenner, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate knowledge about the risk factors and protective factors for suicide in the major ethnic minority groups in the U.S., and apply this knowledge in the care of patients.

SUMMARY:

There is a higher rate of suicide in the elderly, constituting about 20% of all completed suicides, though they are only 13% of the population in the U.S. However, the ethnic elderly tend to have lower completed suicide rates, with the possible exception of Chinese and Japanese men older than 75. This may reflect a cohort effect. Immigration laws in the early part of the 20th century did not allow Chinese men to bring in families. As a result, many Chinese men are now old and alone without any family support. With Japanese elderly males the rates of suicide are not dramatically different from the Caucasian population. However, the factors influencing the suicide in these groups may be different. Japanese men may commit suicide to avoid being a burden on the family, but Caucasian men may commit suicide due to retirement leading to lowered sense of self worth and social isolation as a result of widowhood and loss of work-related social networks. Diminishing health and alcohol abuse may also be contributory. Elderly women, especially African-American women appear to have strong social bonds and low rates of suicides. Our presentation will consider the overall risk of suicide in the elderly, with a particular focus on medical comorbidity, as well as consider some of the other risk factors and protective factors in the ethnic elderly. This may help in developing preventive strategies in reducing overall suicide risk in the elderly.

REFERENCES:

1. Baker EM: Suicide among ethnic elders. In Suicide and Depression in Late Life: Critical Issues in Treatment, Research, and Public Policy. Edited by Kennedy G.J. Publication series of the Department of Psychiatry, Albert Einstein College of Medicine of Yeshiva University, No. 13. New York, John Wiley & Sons, pp. 51–79.
2. Conwell Y, Pearson J.L: Suicidal behaviors in older adults, theme issue. American Journal of Geriatric Psychiatry, 10 (4).

Component Workshop 26
USING THE HIV DEMENTIA SCALE IN THE CLINICAL SETTING
APA Committee on AIDS

Chairperson: Karl Goodkin, M.D., *Department of Psychiatry, University of Miami School of Medicine, 1400 NW 10th Avenue, Room 803A, Dom Tower, Miami, FL 33136*
Participants: Francisco Fernandez, M.D., Stephen J. Ferrando, M.D., Giovanni Caracci, M.D., Marshall Forstein, M.D.

EDUCATIONAL OBJECTIVES:

To appreciate and understand the diagnostic work-up for cognitive impairment, in particular HIV-associated dementia; identify practical

strategies for evaluating mental status; review the implications for using the HIV dementia scale including its limitations; review the use of the HIV dementia scale through clinical case discussions.

SUMMARY:

Diagnosing cognitive impairment in people living with HIV/AIDS is increasingly complex. Cognitive impairment eventually develops in 30% of people with AIDS, and dementia develops in about 15% of people with AIDS. HIV-associated dementia is considered the overarching disorder that categories cognitive impairments. The HIV dementia scale has been proven to be successful in identifying people with HIV-associated dementia. Presenters will review the use of the HIV dementia scale focusing their discussion on demonstrating the use of the HIV dementia scale and offering information on its implications and limitations. This session is intended to be highly interactive. Time will be allotted for discussion on this topic throughout the workshop. A case discussion will also be presented.

REFERENCES:

1. Dougherty R, et al: Progression of HIV-associated dementia treated with HAART. AIDS Read 2002; 12:69–74.
2. Henraya F, et al: Assessing HIV-associated dementia: modified HIV dementia scale versus the grooved pegboard. AIDS Read 2002; 12:29–38.

TUESDAY, MAY 24, 2005

Component Workshop 27
BENZODIAZEPINES AND OPIATES IN THE ELDERLY: USE, MISUSE, AND ABUSE
APA Committee on Access and Effectiveness of Psychiatric Services for the Elderly

Chairperson: Allan A. Anderson, M.D., *Shoreline Behavioral, 300 Bryn Street, Cambridge, MD 21613*
Participants: Julian Offsay, M.D., Colleen J. Northcott, M.D., James A. Greene, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to make better informed decisions about the use of these agents. Participant will be in a stronger position to appraise the literature and to prescribe more safely and appropriately.

SUMMARY:

Benzodiazepine and opiate use in the elderly raises valid concerns. At times, these concerns lead to extreme positions of phobic avoidance in terms of prescribing. Conversely, clinicians are sometimes unaware of the real dangers and pitfalls.

This workshop will provide a rational framework for practicing clinicians to knowledgeably prescribe these medications when appropriate. We will present the latest literature to address the above issues. The vulnerability and needs of the elderly well be emphasized, but in fact these issues are of broad professional interest across psychiatry and other areas.

There will be one speaker to discuss benzodiazepines and a second to discuss opiates. Each presenter will address the problems associated with use of these agents. Side effects, addiction potential, and legal and ethical matters will be included. Relevant geriatric pharmacologic principles will be mentioned. The risks and limitations of alternative agents will be discussed. This material, along with other clinical considerations, will provide a valid rationale for choosing benzodiazepines and opiates in some clinical situations. Guidelines for safe and effective use will be provided.

Because this topic arouses strong opinions, we expect a lively debate. We will encourage open discussion to facilitate an honest sharing of experience, concerns, and information on this topic.

REFERENCES:

1. Cutson, TM: Management of pain in the older adult. Clin. Fam. Pract. 2001; 3:667–681.
2. Fingerhood M: Substance abuse in older people. J Am Geriatric Soc 2000; 48:985–995.

Component Workshop 28
RE-ENGINEERING CLINICAL RESEARCH TRAINING: THE NPTC
APA Council on Research

Co-Chairpersons: John F. Greden, M.D., *Department of Psychiatry, University of Michigan Medical Center, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0999*
James F. Leckman, M.D., *Child Study Center, Yale University, 230 South Frontage Road, New Haven, CT 06520*
Participants: Michael H. Ebert, M.D., Joel J. Silverman, M.D., Michele T. Pato, M.D., Michelle B. Riba, M.D., Paul C. Mohl, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will be well-informed about progress in the current effort to reduce the obstacles and increase the opportunities for including a range of clinical research training options in psychiatry residency programs.

SUMMARY:

In 2001, NIMH and the APA Council on Research joined forces to review the magnitude and causes of the steadily decreasing number of psychiatrists pursuing clinical research careers. A subsequent IOM study recommended a plan of action, and NIMH Director Tom Insel created the National Psychiatry Training Council (NPTC) to develop a detailed vision for implementing the IOM recommendations. The NPTC strategy, in turn, has been to develop a new roadmap by spring 2005 through the efforts of nine task forces, each addressing issues critical to actualizing the IOM recommendations. Considerable progress is being made, and this workshop will report on the work to date. Greden will present an overview of the NPTC goals; Leckman will describe proposed model programs including innovative child-adolescent possibilities; Ebert will summarize regulatory revisions that might be implemented and their impact upon departments and residency training; Pato will describe strategies to enhance research literacy; and Riba will describe APA involvement and support. Roberts will discuss responses from the academic community. NPTC recommendations hold potential impact for academicians, clinicians, and researchers; participant input will be encouraged throughout the presentations as well as during the question-and-answer period.

REFERENCES:

1. Abrams MT, Patchan KM, Boat TF (eds.): Research Training in Psychiatry Residency: Strategies for Reform. Washington, DC, The National Academies Press, 2003
2. Yager J: The Institute of Medicine's report on research training in psychiatry residency: strategies for reform: background, results and followup. Academic Psychiatry 2004; Winter

Component Workshop 29
I DO, BUT I CAN'T: MENTAL HEALTH ISSUES AROUND GAY MARRIAGE
APA Committee on Gay, Lesbian, and Bisexual Issues

Chairperson: Serena Yuan Volpp, M.D., *Department of Psychiatry, Bellevue Hospital, 462 First Avenue, 20 West, New York, NY 10016*
Participants: Jack Drescher, M.D., Kimberly A. Arlinghaus, M.D., Kent E. Dunn, M.D., Daniel W. Hicks, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the impact of homophobia and discrimination on the mental health of the gay, lesbian, and bisexual population; identify the psychological issues related to legal recognition of same-sex relationships.

SUMMARY:

The debate around gay marriage has generated a great deal of controversy and distress. In this workshop, we aim to stimulate discussion about the mental health consequences of homophobia and discrimination and how this relates to the issue of gay marriage. A short video clip will show an example of the emotional harm caused by nonrecognition of same-sex relationships. A review of the literature on the impact of prejudice and social stress on the gay and lesbian population will be presented. We will detail the contrasts between civil unions and marriage and discuss the psychological differences. Participants will be encouraged to share their clinical experiences and opinions on how these issues have impacted their patients.

REFERENCES:

1. Cabaj R, Purcell D: On the Road to Same-Sex Marriage: A Supportive Guide to Psychological, Political, and Legal Issues. San Francisco, Jossey-Bass, 1998.
2. Gilman SE, Cochran SD, Mays VM, et al: Risks of psychiatric disorders among individuals reporting same-sex sexual partners in the National Comorbidity Survey. American Journal of Public Health 2001; 91: 933–939.

Component Workshop 30
QUOTES AND MISQUOTES: RESIDENT PHYSICIANS WORKING WITH THE MEDIA
APA Committee of Residents and Fellows and the APA Office of Communications and Public Affairs

Co-Chairpersons: William C. Wood, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC-812, Boston, MA 02114*
Hilarie Turner, *APA, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901*
Participant: Nada L. Stotland, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to identify how different journalism media formats (newspaper, television, and radio) approach physicians for expert information, how to best prepare oneself for these media formats, and how to make sure that the scientific and caring basis of psychiatry is accurately portrayed during a media interview.

SUMMARY:

The news media represent one of the most powerful means available for psychiatrists to educate the public about mental illness and to influence mental health policy. Successful communication to the public through newspapers, television, radio, and other formats can influence how people perceive mental illness. This, in turn, has tremendous bearing on issues such as stigmatization of psychiatric patients, funding for mental health services, and support for research and education in the field of mental health. In this workshop, cosponsored by the APA Committee of Residents and Fellows and the APA Office of Communications and Public Affairs, we will focus on how to convey your message in the news accurately and effectively. A distinguished panel of reporters representing newspaper, television, and radio have been invited to respond to the question, "What does a young psychiatrist need to know in order to be most effective when working with your news media format?" After hearing the reply from each reporter, a senior psychiatrist with extensive media experience will share personal anecdotes of her work. The audience will then be invited to engage the panel of experts to further their understanding of how to work most effectively with the news media.

REFERENCES:

1. Kutner L, Beresin EV: Reaching out: mass media techniques for child and adolescent psychiatrists. J Am Acad Child Adol Psychiatry 2000; 39: 1452–1454.
2. Salzman J: Making the News: A Guide for Nonprofit Activists. Boulder, CO, Westview Press, 1998.

Component Workshop 31
PRACTICING REWARDING PSYCHIATRY IN JAILS AND PRISONS: A PRACTICUM
APA Caucus of Psychiatrists Working in Correctional Settings

Chairperson: Henry C. Weinstein, M.D., *Department of Psychiatry, New York University School of Medicine, 1111 Park Avenue, New York, NY 10128*
Participants: Kathryn A. Burns, M.D., Kenneth G. Gilbert, M.D., Annette L. Hanson, M.D., Cassandra F. Newkirk, M.D., John S. Zil, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop the participants should appreciate and understand the basic, practical, issues of practicing psychiatry in jails and prisons.

SUMMARY:

The experience of practicing in a jail or a prison can be interesting and satisfying, rewarding as well as remunerative. This interactive workshop on correctional psychiatry, a presentation of the APA Caucus of Psychiatrists Practicing in Criminal Justice Settings, will focus on the practical realities of working in correctional settings—from basic and simple to complex and perplexing. Topics to be discussed will include the challenges presented by the unique rules and routines of a correctional environment, how the correctional psychiatrist can work within such constraints, and how new practitioners should be oriented to these issues. This workshop will also cover various types of careers in correctional psychiatry (e.g., part time versus full time), the legal context of correctional psychiatry, psychopharmacology in correctional settings, special populations and "burnout." If the participants so wish, this workshop may cover more advanced topics such as systems issues in correctional facilities, (e.g., integrating medical and mental health services,) managed care issues, accreditation issues, cross-training with security personnel, cultural competency issues, and ethical issues in correctional psychiatry. The faculty for this course are all members of the executive board of the caucus.

REFERENCES:

1. American Psychiatric Association, Psychiatric Services in Jails and Prisons, Second Edition, Washington DC, American Psychiatric Press, 2000.
2. Wettstein R (Editor): Treatment of Offenders with Mental Disorders, Guilford, New York, 1998.

Component Workshop 32
THE VOICE OF APA PAST AND PRESENT: CONSIDERATIONS FOR AN ORAL HISTORY PROJECT
APA Corresponding Committee on History and Library

Chairperson: Avram H. Mack, M.D., *Division of Forensic Psychiatry, Medical University of South Carolina, 67 President Street, PO Box 250861, Charleston, SC 29425*
Participants: Joel T. Braslow, M.D., John A. Talbott, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize some of the uses of oral histories (in a variety of settings) and the possible mechanisms by which such histories could be collected and made available to the membership.

SUMMARY:

The American Psychiatric Association and American psychiatry have changed dramatically over the past four decades. Our current membership is composed of practitioners who have trained in a variety of venues with a range of philosophies. One of our greatest potential resources in the history of psychiatry lies in the histories of our individual members. We propose to begin an oral history project to capture these stories, from those of academic leaders to those of rank-and-file community practitioners.

This workshop will begin with an introduction to oral history, with a review of relevant scholarship in this area. We will then proceed to a discussion of the psychiatric, teaching, and historical uses of oral history. We will conclude with a discussion of the mechanisms for generating and maintaining an oral-history archive, including issues of selecting participants, methods of conducting interviews, assessing the role of the state psychiatric societies in their local histories, and reviewing possible funding sources to support an archive.

REFERENCES:

1. Kandel ER: A new intellectual framework for psychiatry. Am J Psychiatry. 1998; 155:457–69.
2. Sabshin M: Turning points in twentieth-century American psychiatry. Am J Psychiatry 1990; 147:1267–74.

Component Workshop 33
WHEN IT'S NOT ALL IN YOUR HEAD: HEALTH, MENTAL ILLNESS, ETHNICITY, AND RECOVERY
APA Council on Social Issues and Public Psychiatry

Co-Chairpersons: Robert P. Cabaj, M.D., *Mental Health Services, San Francisco Community Mental Health Services, 1380 Howard Street, 5th Floor, San Francisco, CA 94103*
Matthew O. Hurford, M.D., *332 West Mount Airy Avenue, Philadelphia, PA 19119*
Participants: Gloria Pitts, D.O., Joy D. McQuery, M.D., Stephen M. Thielke, M.D., Gail L. Daumit, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the significance of untreated physical illness in recovery-model approaches to seriously mentally ill persons especially with ethnic and cultural considerations.

SUMMARY:

The public sector is increasingly embracing the recovery model in its approach to the seriously and persistently mentally ill person. The model emphasizes partnerships with health care providers in achieving the highest level of functioning possible, instilling hopefulness, and finding the most effective way to manage symptoms. The psychiatrist is a key member of this partnership, but—considering the great prevalence and incidence of physical health problems in the seriously mentally ill population, as well as the under-recognition and treatment of such condition—the primary care provider must be an integral part of the partnership. Both consultative and direct care of the person with both physical and mental health problems are helpful in achieving the highest level of functioning possible—the major goal of the recovery model. A special concern arises when considering the ethnic and cultural influences at play for a person who needs to address both physical and mental health problems, and this workshop will also focus on these aspects when working with people whose problems "are not all in their heads."

REFERENCES:

1. JM Meyer, HA Nasrallah (Eds): Medical Illness and Schizophrenia. American Psychiatric Publishing Inc., Washington, DC, 2003.
2. WS Tseng, J Streltzer (Eds): Cultural Competence in Clinical Psychiatry. American Psychiatric Publishing Inc., Washington, DC, 2002.

WEDNESDAY, MAY 25, 2005

Component Workshop 34
A BITTER PILL? TAILORING MEDICAL TRAINING TO FIT OUR CONTEMPORARY PRACTICE
APA/GlaxoSmithKline Fellows

Co-Chairpersons: Steve Sugden, M.D., *Department of Psychiatry, University of California Davis, 2230 Stockton Boulevard, Sacramento, CA 95817*
Lara R. Fuchs, M.D., *22 East 31st Street, Apartment 1C, New York, NY 10016*
Participants: Tiffany R. Farchione, M.D., Marisa A. Giggie, M.D., Prakash K. Thomas, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this session, the participant should be able to recognize the challenges facing contemporary psychiatrist due to the complex effects of psychotropic medications and evaluate critically the current residency training model.

SUMMARY:

Traditionally, psychiatric residency training encompassed a year-long internship of general medicine. This model, however, has been revised to include two months of neurology and only four months of internal medicine, typically spent on inpatient wards. The recently issued Consensus Statement on recommended laboratory monitoring for atypical antipsychotics illustrates the numerous potential medical complications of psychotropic medications. Since many psychiatric patients have more contact with their psychiatrist than with their primary care providers, it is unclear whether the current emphasis in training on inpatient medicine appropriately prepares residents to monitor and treat their patients.

This workshop will evaluate the adequacy of the current model of internal medicine training received during residency as it pertains to these challenges, review relevant literature and trends in psychiatric training curricula, and present survey data regarding residents' and residency training directors' views on this type of training. Additionally, prominent innovators in psychosomatic medicine and clinical practice, as well as residency training directors, will critically examine this issue. Group discussion will explore optimal models to address the complexities of contemporary practice.

REFERENCES:

1. Rubin EH, Zorumski CF: Psychiatric evaluation in an era of rapidly occurring scientific advances. Academic Medicine, 78:351–354.

2. Melkersson K, Dahl ML: Adverse metabolic effects associated with atypical antipsychotics: literature review and clinical implications. Drugs 2004; 64:701–723.

Component Workshop 35
ROADMAP TO RECERTIFICATION: LIFELONG LEARNING
APA Council on Medical Education and Lifelong Learning

Co-Chairpersons: Richard Balon, M.D., *2543 Elm Brook Court, Rochester Hills, MI 48309-4077*
Sheldon I. Miller, M.D., *Northwestern University Medical School, 222 East Superior, Chicago, IL 60611-3015*
Participants: Deborah J. Hales, M.D., Joan M. Anzia, M.D., Lowell D. Tong, M.D., Trish Tivnan

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the rationale and process of recertification, discuss the use of APA and APPI Web-based and journal modalities to facilitate lifelong learning and preparation for recertification, and discuss how APA can assist members with lifelong learning and the recertification process.

SUMMARY:

Lifelong learning is increasingly important in the rapidly expanding field of psychiatry. Recognizing this, APA has strengthened its commitment and resources to effective, accessible educational materials for psychiatrists. This workshop, presented by the APA Council on Medical Education and Lifelong Learning, will provide an overview of the road to lifelong learning in psychiatry, with a specific focus on board recertification. This interactive workshop will begin with Dr. Sheldon Miller providing the rationale for recertification. Dr. Lowell Tong will present how lifelong learning now begins in medical school and residency. Dr. Joan Anzia will discuss the perspective of the recent recertification examinees. Dr. Debbie Hales will review what APA is doing to promote lifelong learning for psychiatrists through periodicals and interactive tools. She will also discuss the self-assessment exam that APA has prepared as a lifelong learning tool. Dr. Hales will also demonstrate APPI's development of Web-based learning tools and resources for psychiatrist. The audience will be invited to suggest additional ways in which APA can help its members in the lifelong learning and recertification process.

REFERENCES:

1. Scheiber S, Kramer T, Adamowski S: Core Competencies for Psychiatric Practice: What Clinicians Need to Know. Washington, DC, American Psychiatric Press Inc., 2003.
2. Andrews LB, Burruss JW: Core Competencies for Psychiatric Education: Defining, Teaching, and Assessing Resident Competence. Washington, DC, American Psychiatric Press Inc., 2004.
3. Shore JH, Scheiber SC: Certification, Recertification, and Lifetime Learning in Psychiatry. Washington, DC, American Psychiatric Press Inc., 1994.

Component Workshop 36
CPT CODING AND DOCUMENTATION UPDATE
APA Committee on RBRVS, Codes, and Reimbursements

Chairperson: Chester W. Schmidt, Jr., M.D., *Department of Psychiatry, Johns Hopkins Bayview Medical Center, 4940 Eastern Avenue, A4C, Baltimore, MD 21224-2735*
Participants: Tracy R. Gordy, M.D., Edward Gordon, M.D., Napoleon B. Higgins, Jr., M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the workshop the participants will be 1) knowledgeable about current Medicare and CPT coding changes, 2) updated about Medicare reimbursement concerns, and 3) have their individual questions about coding, documentation, and reimbursement answered.

SUMMARY:

The goals of the workshop are to inform practitioners about changes in the RBRVS Medicare physician reimbursement system, modifications in CPT coding, and current issues associated with documentation guidelines. This year's workshop will focus on 1) updating participants as to current issues related to CPT coding, 2) a review of current Medicare reimbursement issues and concerns, and 3) discussion of documentation guidelines for psychiatric services as well as the evaluation-and-management service codes. Time will be reserved for questions and comments by the participants about the above topics as well as issues and problems faced by the participants in their practices.

REFERENCES:

1. CPT. American Medical Association, Chicago, IL, 2004.
2. Schmidt CW: CPT Handbook for Psychiatrists, 3rd edition, American Psychiatric Press, Washington, DC, 2004.

Component Workshop 37
SSRIS AND SUICIDE: LESSONS LEARNED AND IMPLICATIONS FOR FUTURE TREATMENT GUIDELINES
APA Council on Children, Adolescents, and Their Families

Chairperson: Graham J. Emslie, M.D., *University of Texas Southwestern Psychiatry, 5323 Harry Hines, Dallas, TX 75235*
Participants: John S. March, M.D., David Fassler, M.D., Jennifer K. Cheng, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: gain a greater understanding of the data available regarding SSRI safety and efficacy in the child and adolescent population and integrate this knowledge into a clinically applicable and evidence-based approach to their own practice.

SUMMARY:

The possible relationship between suicide and suicidal ideation and the use of antidepressants, especially selective serotonin reuptake inhibitors, has been an ongoing controversy. Despite increasing awareness and analyses of the data, many questions still remain. How was suicidal ideation defined in these studies? Does a class effect exist or is this relationship observed solely with Paxil? How do the numerous unpublished negative studies affect our credibility as a field?

This workshop will review the data available regarding the possible relationship between the use of antidepressants and suicide or suicidal ideation and how it may guide our future treatment guidelines. Dr. Graham Emslie will present an overview of the data and its implications. Dr. John March will discuss the Treatment of Adolescent Depression Study (TADS) and its implications for the treatment of adolescent depression. Dr. David Fassler will discuss the policy implications of these studies from a public perspective. A case study will be presented by Dr. Jennifer Cheng Shannon, and workshop participants will be encouraged to discuss their clinical considerations with a panel discussion to follow. Participants will also be asked to discuss their opinions regarding the possible relationship between antidepressants and suicide as well as how they feel it impacts their practice and treatment guidelines.

REFERENCES:
1. Jick H, Kaye JA, Jick SS: Antidepressants and the risk of suicidal behaviors. JAMA, 2004; 292:338–343.
2. March JS, et al: The Treatment for Adolescents with Depression Study (TADS). JAMA, 2004; 807–820.

Component Workshop 38
TO DOSE OR NOT TO DOSE: PSYCHOPHARMACOLOGY IN THE DEVELOPMENTALLY DISABLED
APA Committee on Developmental Disabilities

Chairperson: Bryan H. King, M.D., *Dartmouth Hitchcock Medical Center, One Medical Center Drive, Lebanon, NH 03756*
Participants: Joel D. Bregman, M.D., John DeFigueiredo, M.D., Lee Combrinck-Graham, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the steps involved in completing a comprehensive psychopharmacologic evaluation of a developmentally disordered individual.

SUMMARY:

Access to quality health care for people with developmental disabilities has been of concern for at least 30 years. As many as a third of this population receives psychiatric medications, yet a significant number are not assigned a psychiatric diagnosis. Given that millions are affected by developmental disabilities, medical and mental health professionals need to be knowledgeable about appropriate psychopharmacological assessment of these individuals. During this program, Lee Combrinck-Graham, M.D., will present a case of a man with mental retardation and sexual obsessions to illustrate challenges involved in evaluating and treating the developmentally disabled. Joel Bregman, M.D., will present a case of an adult with an autism spectrum disorder. John deFiguierdo, M.D., will discuss special considerations involved in treating geriatric individuals with developmental disabilities. Moderator Bryan King, M.D., will generate discussion by asking questions regarding evaluation and treatment of this population with psychiatric medications. The presentation is approximately 60 minutes in length, allowing about 30 minutes for the audience to ask questions and engage in discussion with the panel. This session is designed for psychiatrists, psychiatric nurses, other medical professionals, as well as psychologists, social workers, and other mental health professionals.

REFERENCES:

1. Lewis MA, Lewis CE, Leake B, et al: The quality of health care for adults with developmental disabilities. Public Health Reports 2002; 117:174–184.
2. Longitudinal prescribing patterns for psychoactive medications in community-based individuals with developmental disabilities: utilization of pharmacy records. Journal of Intellectual Disability Research 2004; 48:563.

Component Workshop 39
FROM CRADLE TO GRAVE: THE IMPACT OF INCARCERATION ON AFRICAN-AMERICAN FAMILIES
APA Committee of Black Psychiatrists

Co-Chairpersons: Michelle O. Clark, M.D., *10921 Wilshire Boulevard, #405, Los Angeles, CA 90024*;
N. Kalaya Okereke, M.D., *2500 Johnson Avenue, #2-J, New York, NY 10463-4926*
Participants: Rahn K. Bailey, M.D., Cassandra F. Newkirk, M.D., William M. Womack, M.D., Nancy Boyd-Franklin, Ph.D.

EDUCATIONAL OBJECTIVES:

Upon completing this session the participants will have had an opportunity to hear a review of the pertinent literature on this subject and to dialogue with experts in this area so as to improve their clinical knowledge and skills in treating African Americans.

SUMMARY:

African Americans are overrepresented in the criminal justice systems in the United States. Almost no family in this community is exempt from the experience of arrest, trial, and incarceration. This reality creates special, stressful circumstances for the community and significantly impacts the mental health of all family members. From infants to grandparents, the "loss" caused by removal of a family member is a situation they must manage. Our discussants will review the literature and discuss their work with patients and the families involved.

REFERENCES:

1. Boyd-Franklin N: Black Families in Therapy, Second Edition: Understanding the African American Experience. New York, Guilford Press, 2003.

Component Workshop 40
DOCTOR, YOUR CHILD IS CALLING
APA Corresponding Committee on Psychiatry in the Workplace

Co-Chairpersons: Jacquelyn B. Chang, M.D., *University of California San Francisco, 1838 El Camino Real, #205, Burlingame, CA 94010*
Andrea G. Stolar, M.D., *Department of Psychiatry, Case Western Reserve University, 16011 Chadbourne Road, Shaker Heights, OH 44120*
Participant: Marcia A. Scott, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify work-family conflict, contributors to worker fatigue, and risk factors for workplace impairment; recognize potential transference and countertransference re: work-family conflict; distinguish between psychological stress and psychiatric illness; identify positive adaptive strategies.

SUMMARY:

High-achieving professionals can find themselves in an untenable position trying to balance responsibilities that are potentially unending. For example, as women have come to make up 50 percent of psychiatric trainees and medical students, new demands have been placed on these professionals and on the institutions they serve. What happens when coping strategies fail? When does stress become disease? Using a real-life disability case example of a high-achieving physician whose limited emotional reserves were sapped by unexpected home pressures, this session will explore the work-family conflict, personal and professional reactions to perceived workplace impairment, and potential adaptive responses. We will discuss the concept of illness versus the failure of adaptation and the psychological conflicts that contribute to the work-family struggle among this generation of professionals. Finding balance in one's life and recognizing one's limitations are crucial to successfully intertwining the numerous stressors of the parent-professional, whether physician or executive. The session will conclude by offering personal and environmental adaptive strategies for both patients and providers to maintain their high-quality productivity in the office and at home.

REFERENCES:

1. Jansen NW, Kant I, Kristensen, TS, Nijhuis, FJ: Antecedents and consequences of work-family conflict: a prospective cohort study.

Journal of Occupational and Environmental Medicine 2003; 45:479–491.
2. Levinson W, Tolle SW, Lewis C: Women in academic medicine, combining career and family. New England Journal of Medicine 1989; 321:1511–1517.

Component Workshop 41
PSYCHOSOMATIC MEDICINE: AN UPDATE ON A NEW SUBSPECIALTY
APA Council on Psychosomatic Medicine

Co-Chairpersons: Philip R. Muskin, M.D., *Department of Psychiatry, Columbia University, 622 West 168th Street, MB 427, New York, NY 10032-3874*
Carol L. Alter, M.D., *87 Audubon Lane, Princeton, NJ 08540*
Participants: Peter A. Shapiro, M.D., James L. Levenson, M.D., Constantine Lyketsos, M.D., David Gitlin, M.D., Stephen C. Scheiber, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the requirements for subspecialty certification in order to take the ABPN exam, start a fellowship program, and provide clinical services in the general medical setting.

SUMMARY:

Psychosomatic medicine is not a new endeavor. Benjamin Rush initiated integrated teaching of psychiatry and medicine to medical students more than 200 years ago. In 1902 the first psychiatric unit in a general hospital opened in the Albany Hospital. In the 1930s both Dunbar and Henry published research on psychological aspects of patients with physical illness. Numerous consultation/liaison services opened in hospitals throughout the United States after World War II and C/L is a required component of training for all psychiatric residents. Psychosomatic medicine became the newest psychiatric subspecialty in 2003, with the first certification examination to take place in June 2005. This component workshop will review the status of the field, the development of the subspecialty examination, initiatives to strengthen research at the interface of psychiatry and medicine, and how APA will collaborate with other groups to address a crucial barrier to access to care, i.e., funding for psychiatric services in the general medical setting.

Philip Muskin, M.D., will introduce the workshop as chair of the APA Council on Psychosomatic Medicine. David Gitlin, M.D., will discuss the implications that the new subspecialty status will have on residency training and the process of obtaining accreditation for fellowship training from the ACGME. Constantine Lyketsos, M.D., and Peter Shapiro, M.D., will address issues of research, focusing on the NIH portfolio, future directions for the field examining specific disease-focused priorities (cardiovascular, cancer, diabetes, and neurologic disease), and efforts to create psychosomatic medicine research networks for large-scale trials. James Levenson, M.D., and Stephen Scheiber, M.D., will discuss subspecialty certification by the ABPN and how certification examinations are prepared. Carol Alter, M.D., will discuss the state of access to and reimbursement of psychiatric care for medically ill patients and review efforts aimed at addressing these barriers, both within APA and more broadly in the public health community.

The workshop will encourage audience participation to discuss how this new subspecialty will impact on psychiatrists in academic and nonacademic settings.

REFERENCES:

1. Lipowski ZJ: Consultation-liaison psychiatry: the first half century. General Hospital Psychiatry 1986; 8:305–315.
2. Kornfeld DS: Consultation-liaison psychiatry: contributions to medical practice. Am J Psychiatry 2002; 159:1964–1972.

Component Workshop 42
IMPROVING DIAGNOSTIC AND THERAPEUTIC SKILLS: A CROSS-CULTURAL PERSPECTIVE
APA Committee on International Medical Graduates

Chairperson: Sanjay Dube, M.D., *Eli Lilly & Company, Lilly Corporate Center, Indianapolis, IN 46285*
Participants: Nalini Juthani, M.D., Francis M. Sanchez, M.D., Oscar E. Perez, M.D., Michelle B. Riba, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: understand the role of cultural factors in the manifestation of psychopathology and diagnosis of disease, incorporate cultural formulations into a psychodiagnostic understanding and comprehensive therapeutic intervention, understand key elements of psychodynamic factors underlying disease states in ethnic minorities.

SUMMARY:

Diagnostic nomenclature is only as good as the accurate interpretation of the observed clinical phenomenon. Cultural influences are known to influence expression of mental illness, quality of the patient-doctor interaction, and outcome. This workshop will be an interactive discussion using case vignettes to discuss the role of cultural factors in illness manifestation in three ethnic communities. The impact of race and gender of the patient and the psychiatrist on the dynamics of the patient-doctor relationship will be discussed. Special emphasis will be given to highlighting key areas where cultural factors will influence better diagnosis and therapeutic interventions. These include: ''psychotic''-like symptoms, depression and anxiety, sexuality, religion, psychosomatics, stereotypes, psychodynamic factors (guilt/hostility, autonomy), stigma, and use of medications. Role of family and appropriate boundaries will also be discussed. The workshop will be moderated from the viewpoint of American culture and recognition of these influences in enhancing the quality of care.

REFERENCES:

1. Gaw A: Psychiatric care in Filipino Americans. In: Culture, Ethnicity and Mental Health (edited by A. Gaw). APPI, Washington D.C., 1993.
2. Doorway Thoughts: Cross-Cultural Health Care for Older Adults, Jones and Barlett Publishers, 2004.
3. Diagnostic and Statistical Manual for Mental Disorders, 4th Edition. APA, Washington DC, 1994.

Component Workshop 43
SAME SEX MARRIAGES: MENTAL HEALTH AND PERSONAL PERSPECTIVES
APA Northern California Psychiatric Society's Committee on Lesbian, Gay, Bisexual, and Transgender Issues

Co-Chairpersons: Gene A. Nakajima, M.D., *CSP 1700 Jackson Street, San Francisco, CA 94109*
Ellen Haller, M.D., *Department of Psychiatry, University of California San Francisco, Box F-0984/401 Parnassus Avenue, San Francisco, CA 94142*
Participants: Dan H. Karasic, M.D., John S. Kruse, M.D., Marshall Forstein, M.D.

EDUCATIONAL OBJECTIVES:

Participants will understand changing ideas of marriage and its mental health implications and understand that same-sex marriage does not harm opposite-sex marriages.

SUMMARY:

Married (or nearly married) gay and lesbian psychiatrists will discuss mental health issues concerning same-sex marriages (SSM). John Kruse, M.D., Ph.D., will describe how his celebration at San Francisco City Hall demonstrated that validation from various communities counters the corrosive effects of stigmatization on mental health. Dan Karasic, M.D. who also married in San Francisco, will discuss SSM in historical, social, and political contexts. Ellen Haller, M.D., had an appointment to be married; however, just four days before her wedding, the California Supreme Court ruled against SSM. She will describe the difficulty explaining these legalities to her 7-year-old son. Gene Nakajima, M.D., was married in Vancouver several months before marriages were allowed in the U.S., and he will discuss the emotional journey traveling to another country for marriage. Marshall Forstein, M.D., will explore the history of obtaining the legal right for same-sex marriage in Massachusetts and some of the emotional experiences that he and his family and other same-sex couples with children report. This workshop is for general psychiatrists who will be encouraged to describe their own and their patients' reactions and experiences to SSM.

REFERENCES:

1. Cabaj RP: History of gay acceptance and relationships. In On the Road to Same-Sex Marriage: A Supportive Guide to Psychological, Political, and Legal Issues, edited by Cabaj RP, Purcell DP, San Francisco, Josey-Bass, 1998.
2. Townsand M: Mental health issues and same-sex marriage. In On the Road to Same-Sex Marriage: A Supportive Guide to Psychological, Political, and Legal Issues, edited by Cabaj RP, Purcell DP, San Francisco, Josey-Bass, 1998.

WEDNESDAY, MAY 25, 2005

Component Workshop 44
MENTAL STATUS AFTER CABG: IMPLICATIONS FOR PSYCHIATRISTS' COMPETENCE
APA Lifers

Co-Chairpersons: Abram M. Hostetter, M.D., *250 Pantops Mountain Road, Apartment 5409, Charlottesville, VA 22911*
Sheila Hafter Gray, M.D., *Uniform Services University of the Health Sciences, PO Box 0612, Palisades Station, Washington, DC 20016-0612*
Participants: Margaret O'Connor, Ph.D., Alberto M. Goldwaser, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss changes in mental status after CABG that may adversely affect psychiatrists' skills; select a method of testing for defects and identifying those that may improve with neuropsychological rehabilitation; work effectively with a physician assistance committee when there are concerns about one's capacity to practice safely.

SUMMARY:

Coronary artery bypass graft (CABG) carries known risks for postoperative deterioration of mental status. Some defects may persist and pose a special risk for psychiatrists, and particularly for medical psychotherapists whose memory is their primary treatment tool. In this workshop we will delineate the problem and offer recommendations for evaluating and treating mental symptoms after CABG. We shall focus on what psychiatrists may do to assure that they practice safely and effectively and offer recommendations for working with their physician-assistance committee in the event that they or others are concerned about their competence. Questions for consideration include: (1) Why is psychiatric competence at special risk for deterioration after CABG? How do we evaluate cognitive changes after CABG and try to remedy identified defects? (2) Why is taking care of oneself the best way to take care of one's patients? Are psychiatrists able to self-evaluate? What do we know from the literature and from clinical experience? What lessons may we learn from a physician-assistance committee? An interactive discussion with the speakers will be moderated by Abram Hostetter, M.D.

REFERENCES:

1. Clark RW: The Pope's confessor: a metaphor relating to illness in the analyst. J American Psychoanalytic Association, 1995; 43:137–149.
2. Newman MF, Kirschner JL, Phillips-Bute B, et al: Longitudinal assessment of neurocognitive function after coronary-artery bypass surgery. New England Journal of Medicine 2001; 344:395–402.

Component Workshop 45
CURRENT ISSUES IN PSYCHIATRY AND LAW AT APA
APA Council on Psychiatry and Law

Chairperson: Paul S. Appelbaum, M.D., *Department of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, MA 01655*
Participants: Richard Bonnie, J.D., Howard V. Zonana, M.D., Jeffrey L. Metzner, M.D., Patricia R. Recupero, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to review current important issues in law and psychiatry with which the Council on Psychiatry and Law is involved on behalf of APA.

SUMMARY:

The Council on Psychiatry and Law addresses major legal issues on behalf of APA. This workshop presents a selection of the issues currently on the council's agenda. Richard Bonnie, J.D., will describe collaborative efforts with the American Bar Association and American Psychological Association to develop a recommended policy on application of the death penalty to people with severe mental illnesses. Jeffrey Metzner, M.D., will discuss a related issue: the use of the death penalty for persons who are juveniles at the time of their crimes, a matter currently under consideration by the U.S. Supreme Court. Howard Zonana, M.D., will present the council's exploration of issues related to national security work by psychiatrists and the ethical questions that this raises about the proper limits of a physician's role. Finally, Patricia Recupero, M.D., J.D., will talk about the cutting-edge issue of cybermedicine and the legal problems that it may create for psychiatrists. Other current issues will be addressed during the discussion period.

REFERENCES:

1. Roper v. Simmons, No. 03-633, U.S. Supreme Court.
2. Ewing CP, Gelles MG: Ethical concerns in forensic consultation regarding national safety and security. J Threat Assessment 2003; 2:95–107.

Component Workshop 46
THE CONFLICTING WORLDVIEWS OF SIGMUND FREUD AND C.S. LEWIS
APA Corresponding Committee on Religion, Spirituality, and Psychiatry

Chairperson: John R. Peteet, M.D., *Department of Psychiatry, Brigham and Women's Hospital, 75 Francis Street, Boston, MA 02115*
Participants: Dan G. Blazer II, M.D., Armand M. Nicholi, Jr., M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize divergent perspectives on life of the two major world

views and factors that influence an individual's choice of a world view.

SUMMARY:

This workshop, which follows the 2005 APA Oskar Pfister Award Lecture, provides an opportunity to discuss the importance of patients' and clinicians' worldviews. The secular world view of Sigmund Freud and the spiritual worldview of the Oxford and Cambridge scholar C.S. Lewis offer contrasting perspectives on basic human concerns such as the nature of transcendent experience, the source of ethics, pain and human suffering, happiness and the reason unhappiness prevails, human sexuality, and the problem Freud called "the painful riddle of death." What do these two influential lives demonstrate about how one chooses a worldview? How does an understanding of a patient's worldview inform a clinician's approach? What is the significance of a clinician's own worldview? After Dr. Dan Blazer comments on the exploration by Dr. Nicholi of these areas, the session will emphasize discussion with members of the audience of their responses to the material.

REFERENCES:

1. Nicholi AM: The Question of God. C.S. Lewis and Sigmund Freud Debate God, Love, Sex and the Meaning of Life. Free Press, 2002.
2. Blazer D: Freud vs. God. How Psychiatry Lost its Soul and Christianity Lost its Mind. InterVarsity Press, 1998.

Component Workshop 47

HOW TO LEAD AN EFFECTIVE TREATMENT TEAM

APA Caucus of State Hospital Psychiatrists

Chairperson: Beatrice Kovasznay, M.D., *Forensic Services, New York State Office of Mental Health, 44 Holland Avenue, Albany, NY 12203*
Participants: Joel S. Feiner, M.D., Pamela A. Weinberg, M.D., Yad Jabbarpour, M.D.

EDUCATIONAL NOBJECTIVES:

At the conclusion of this session, the participant should be able to understand helpful techniques for bringing together a treatment team to provide effective treatment.

SUMMARY:

Treatment of patients in the public sector usually involved multidisciplinary treatment teams. Psychiatrists often receive little formal training in how to work effectively with a treatment team. Consequently, they may end up relegated to a peripheral role, mainly as prescribers of medications. Resentment of this role can lead to further disengagement from the team and its mission. Alternatively, a psychiatrist can chose to become the driving force behind bringing the treatment team together to do its best for the patient. Not only is it better patient care, it is also a lot more enjoyable!

Three seasoned public sector psychiatrists will share their experiences in developing and working with treatment teams.

REFERENCES:

1. Rodenhauser P: Psychiatrists as treatment team leaders: pitfalls and rewards. Psychiatry Q 1996; 167:11–31.
2. Corrigan PW, Lickey SE, Campion J, Rashid F: Mental health team leadership and consumers satisfaction and quality of life. Psychiatr Serv 2000; 51:781–5.

Component Workshop 48

WHY BUSINESS NEEDS QUALITY CARE FOR DEPRESSION, ANXIETY, AND SUBSTANCE-USE DISORDERS

APA Committee on APA/Business Relationships

Chairperson: Norman A. Clemens, M.D., *Department of Psychiatry, Case Western Reserve University, 1611 South Green Road, Suite 301, Cleveland, OH 44121-4128*
Participants: Jeffrey P. Kahn, M.D., Alan Langlieb, M.D., Herbert S. Peyser, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the impact of depression, anxiety, and substance use disorders on America's workforce and the role psychiatrists have in providing quality care.

SUMMARY:

Employers are a fundamental component in our health care system. With health care costs rising, many employers are focusing more attention on the cost of illness and related expenditures of disability and lost productive time as a means of putting the brakes on a system that is choking the American economy. Moreover, many employers of the new information/technology economy are placing a heightened focus on the impact of depression, anxiety, and substance-use disorders. This new awareness raises important questions: How many employees suffer from depression, anxiety and/or substance-use disorders? What impacts do depression, anxiety, and substance-use disorders have on other physical illnesses and on worker productivity? How can employers ensure that their employees are receiving the best treatment, and how can they measure the advantages? What is the role for psychiatrists to address and manage these concerns?

This workshop will address these concerns by focusing on the three areas: (1) the prevalence of depression, anxiety, and substance-use disorders in the workplace; (2) the social and economic costs as a result of depression, anxiety, and substance-use disorders; and (3) how quality mental health care can help reduce the social and economic burdens resulting from these diseases.

REFERENCES:

1. Kahn JP, Langlieb AM (eds.): Mental Health and Productivity in the Workplace: A Handbook for Organizations and Clinicians. San Francisco, Jossey-Bass/Wiley, 2003, p. 330.
2. Goetzel R, Ozminkowski R, Sederer L, et al: The business case for quality mental health services: why employers should care about the mental health and well-being of their employees. Occup Environ Med: 2002; 44:320.

Component Workshop 49

COME AND COMPLAIN: DO PSYCHIATRISTS HAVE A ROLE IN ACCREDITATION? A DEBATE

APA Committee on Standards and Survey Procedures

Chairperson: Steven I. Altchuler, M.D., *Department of Psychiatry and Psychology, Mayo Clinic, 200 First Street, SW, Rochester, MN 55905-0001*
Participants: Marlin R.A. Mattson, M.D., Dennis J. Milke, M.D., Albert V. Vogel, M.D.

EDUCATIONAL OBJECTIVES:

By the end of this session, attendees will be aware of the benefits and purposes of outside accreditation and be aware of how to participate in the development of accreditation standards.

SUMMARY:

Psychiatrists are finding issues related to accreditation affecting many areas of their practice: documentation, admission and dismissal criteria, care utilization. There are multiple accrediting groups involved: JCAHO accredits hospitals and health care facilities; URAC accredits health plans. APA represents its members as these organizations develop standards. Using a debate format, with members of the audience participating in the debate, we will explore the advantages and disadvantages of the accreditation process and what role psychiatrists can have in it. We will specifically examine ways in which psychiatrists can help influence the development and revision of standards.

REFERENCES:

1. Comprehensive Accreditation Manual for Hospitals: The Official Handbook. Oakbrook Terrace, Joint Commission on Accreditation of Healthcare Organizations, 2004.
2. Case Management Standards. Washington DC, URAC, 2004.

Component Workshop 50

INDIAN HEALTH SERVICE MENTAL HEALTH UPDATE AND PLANNING FOR THE FUTURE

APA Committee of American Indian, Alaska Native, and Native Hawaiian Psychiatrists

Chairperson: Frank Brown, M.D., *1841 Clifton Road, NE, Atlanta, GA 30329*
Participants: Jon Perez, Ph.D., Brian T. Benton, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate a knowledge of the current mental health roles of the Indian Health Service and the plans for future mental health care of Native Americans.

SUMMARY:

Native Americans are known to have high prevalence of certain mental illnesses. The mental health needs of Native Americans remain as a priority area of the Indian Health Service. The Indian Health Service provides a wide range of services throughout the United States especially in the Southwest. Discussion will focus on the current mental health operations of the Indian Health Service and plans for the provision of mental health care over the next few years. The director of Division of Behavioral Health of the Indian Health Service will present an overview of what the Indian Health Service has achieved over the last decade, the current emphasis on identification, prevention, and treatment of mental illness, and plans for mental health services in the Indian Health Service clinics and hospitals. Discussion will also center on the obstacles that hinder optimal mental health care of Native Americans and how the Indian Health Service is addressing these issues. The audience will be able to address specific questions to the director of Division of Behavioral Health.

REFERENCES:

1. U.S. Department of Health and Human Services: Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD, R.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General, 2001.
2. Indian Health Service Behavioral Health Website: www.ihs.gov/medicalprograms/behavioral

Component Workshop 51

NEED AN OXYCONTIN FIX? THE ROLE OF BUPRENORPHINE IN THE OUTPATIENT TREATMENT OF PRESCRIPTION NARCOTIC PROBLEMS

APA Corresponding Committee on Treatment Services for Patients with Addictive Disorders

Chairperson: George F. Kolodner, M.D., *Georgetown University School of Medicine, 6th Floor Kober-Cogan, 3800 Reservoir Road, Washington, DC 20007-2197*
Participants: Marianne T. Guschwan, M.D., John Renner, M.D., Samuel M. Silverman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the advantages of using buprenorphine and be able to do so more effectively.

SUMMARY:

In 2002 the APA Committee on Treatment Services for Patients with Addictive Disorders began a series of workshops on ambulatory detoxification in order to provide a forum for discussion and learning by clinicians who wanted to know more about how to deliver these services outside of traditional inpatient settings. Focusing initially on alcohol, the series moved last year to opioids. With the introduction of buprenorphine in October 2002, outpatient detoxification from opioids as well as opioid maintenance treatment has become a option for the outpatient practitioner. However, with any new treatment, there is a learning curve that may serve as an impediment to using it. Representatives from both the Committee on Treatment Services for Patients with Addictive Disorders and the Committee on Training and Education in Addiction Psychiatry will review the pharmacology of buprenorphine, effective buprenorphine dosing for detoxification and maintenance, several common pitfalls in using this medication, and present cases to educate psychiatrists on how to use buprenorphine in their practices. The audience will have the opportunity to question the presenters about the details of using buprenorphine as well as to discuss cases.

REFERENCES:

1. Fudala PJ, Bridge TP, Herbert S, et al.: Office-based treatment of opiate addiction with a sublingual-tablet formulation of buprenorphine and naloxone. New Engl J Med 2003; 349:949–958.
2. SAMHSA Treatment Improvement Protocol #40: Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction, 2004.

MONDAY, MAY 23, 2005

Issue Workshop 1

TREATING PTSD: COMBINING PSYCHOTHERAPY AND PHARMACOTHERAPY

Co-Chairpersons: Lewis A. Opler, M.D., *Department of Psychiatry, New York University School of Medicine, 765 Gramattan Avenue, Mt. Vernon, NY 1055*
Kristina H. Muenzenmaier, M.D., *Department of Psychiatry, Bronx Psychiatric Center, 1500 Waters Place, Bronx, NY 10461*
Participants: David B. Albert, Ph.D., Michaela Mendelsohn, Ph.D.

EDUCATIONAL OBJECTIVE:

To better understand how combining pharmacotherapy with individual, group, and family psychotherapy can lead to better outcomes for persons with PTSD.

SUMMARY:

This workshop is for clinicians, administrators, and policy makers interested in sharing experiences about the treatment of persons with histories of trauma and with posttraumatic stress disorder (PTSD). Faculty will describe their work in different settings, including presenting how individual, group, and family psychotherapy has been utilized effectively in treating adolescents and adults with PTSD. Next, there will be a presentation on the pharmacotherapy of PTSD. After these presentation, and for more than half of the workshop, participants will join in an interactive discussion of issues that have emerged or that are anticipated in treating persons with PTSD comprehensively and holistically, with an emphasis on issues related to combining pharmacotherapy with psychotherapy to optimize outcomes in treating persons with PTSD.

REFERENCES:

1. Wilson JP, Friedman MJ, Lindy JD (eds): Treating Psychological Trauma and PTSD. New York, NY, Guilford Press, 2001.
2. Yehuda R (ed.): Treating Trauma Survivors with PTSD. Washington, DC, American Psychiatric Publishing Inc., 2002.

Issue Workshop 2

ORAL BOARDS BOOT CAMP UPDATED

Co-Chairpersons: Elyse D. Weiner, M.D., *State University of New York at Downstate, 113 University Place, Suite 1010, New York, NY 10003*
Eric D. Peselow, M.D., *Department of Psychiatry, New York University School of Medicine, 550 First Avenue, New York, NY 10016*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session the participant should be able to begin forming a personal, comprehensive strategy for studying and taking the oral boards exam in psychiatry.

SUMMARY:

Oral Boards Boot Camp is a comprehensive, interactive approach to making oneself into an attractive oral boards candidate. This in-depth strategy for oral boards preparation has been updated and improved. Consistent with the Oral Boards Boot Camp long-term approach, we invite all future candidates, no matter how early in their training, to begin to work on the important process of refining their diagnostic interview. The workshop will include all aspects of oral boards preparation including a study timeline, how to practice, the interview, and fielding questions. This presentation will be detail oriented and will include tips such as relating to both patients and examiners, making the travel experience more comfortable, video preparation, boards courses, how to dress, day of the exam, and reasons for failure.

Anonymous advice for future candidates from recent successful diplomates will be presented. As in the past, diplomates are invited to attend the workshop to share their stories. Candidates will start developing their individual long-term training strategy, which they can further expand prior to taking the boards, thus increasing confidence and decreasing anxiety. Oral Boards Boot Camp will provide a structured setting with lively discussion for future examinees to make themselves into effective oral boards candidates.

REFERENCES:

1. Morrison J, Munoz RA: Boarding Time: A Psychiatry Candidate's New Guide to Part II of the APBN Examination, Third Edition. Washington DC, American Psychiatric Press, 2003.
2. Strahl NR: Clinical Study Guide for the Oral Boards in Psychiatry. Washington DC, American Psychiatric Press, 2001.

Issue Workshop 3

COGNITIVE THERAPY FOR PERSONALITY DISORDERS

Chairperson: Judith S. Beck, Ph.D., *Cognitive Therapy & Research Department, The Beck Institute, 1 Belmont Avenue, Suite 700, GSB Building, Bala Cynwyd, PA 19004-1610*

EDUCATIONAL OBJECTIVE:

To conceptualize personality disorder patients according to the cognitive model; recognize therapeutic alliance issues in treatment of personality disorders; set goals and plan treatment for patients with characterological disturbance; combine pharmacotherapy and cognitive therapy for personality disorder patients.

SUMMARY:

Cognitive therapy, a short-term, structured, problem-solving-oriented psychotherapy, has been shown in more than 120 trials to be effective in treating Axis I disorders. In the past 10 years, cognitive therapy methods have been developed for Axis II disorders, and outcome research has verified the efficacy 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 used. Questions and clinical material from participants will be encouraged throughout, and a final segment will instruct 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, 2004.
2. Beck JS.: Cognitive approaches to personality disorders. In American Psychiatric Press Review of Psychiatry, Vol. 16, edited by Dickstein L, Riba M, Oldham J. Washington, D.C.: American Psychiatric Press, 1997.

Issue Workshop 4

DOCTOR, WHY DO I STILL HAVE THIS PAIN? THE PHYSICIAN'S PSYCHOSOMATIC DILEMMA

Co-Chairpersons: Don R. Lipsitt, M.D., *Harvard Medical School, 25 Shattuck Street, Boston, MA 02115*
Malkah T. Notman, M.D., *Department of Psychiatry, Harvard Medical School, 54 Clark Road, Brookline, MA 02445*
Participants: Donald Jay Meyer, M.D., Robert C. Joseph, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to appreciate and apply skills essential to an integrated psychosomatic approach to medical treatment.

SUMMARY:

Eighty percent of the symptoms patients present to their primary physicians are somatic. Studies show that 50% or more of these symptoms may have an underlying psychological etiology or accompanying reaction. Physicians who adhere to an either-soma-or-psyche approach to their patients' complaints may be unable to respond to

patients whose emotions manifest themselves in the experience of physical symptoms. Psychiatrists are often called into this conceptual breach to consult. This workshop, an outgrowth of an ongoing work/study group on "somatization," addresses conceptual steps for the psychiatrist working in a medical setting who seeks to facilitate an integrated treatment of somatizing patients. Discussion of these steps will focus on how to understand and incorporate into treatment: 1) the interpersonal and intrapsychic dynamics of somatization as manifested in the patient-physician relationship; 2) a tolerance for the negative affect generated by "psychosomatic" patients; and 3) supportive approaches and techniques of psychosocial interviewing. Ways in which the physician can act as a "change agent" with "troublesome" patients and how psychiatrists, in their consultative role with medical colleagues, can know what psychological content to include and exclude will be addressed. Clinical vignettes and a videotape will serve as a basis for discussion and a stimulus for audience participation.

REFERENCES:

1. Lipsitt DR: The patient-physician relationship in the treatment of hypochondriasis. In Hypochondriasis: Modern Perspectives on an Ancient Malady, edited by Starcevic V, Lipsitt DR. New York, Oxford University Press, 2001, pp 265–290.
2. Lipsitt DR: Psyche and soma: struggles to close the gap. In American Psychiatry After World War II, edited by Menninger RW, Nemiah JC. Washington, DC, American Psychiatric Press, 2000, pp 152–185.

Issue Workshop 5
RISK MANAGEMENT ISSUES IN PSYCHIATRIC PRACTICE

Chairperson: Alan I. Levenson, M.D., 75 *North Calle Resplendor, Tucson, AZ 85716-4937*
Participants: Ellen R. Fischbein, M.D., Martin G. Tracy, J.D., Jacqueline M. Melonas, J.D., Donna Vanderpool, J.D.

EDUCATIONAL OBJECTIVE:

To recognize the major psychiatric professional liability risks that lead to malpractice lawsuits, discuss emerging practice trends that increase malpractice risk and use risk management strategies to decrease major professional liability risk including those related to suicide, prescribing psychotropic medication, supervision, cybermedicine, HIPAA, etc.

SUMMARY:

Malpractice suits pose a significant problem for psychiatrists in all practice settings. At least 8% of practicing psychiatrists are sued each year. It is important for psychiatrists to understand the sources of malpractice lawsuits and the malpractice risks they face as clinicians, teachers, and administrators. This workshop will present data from the APA-endorsed Psychiatrists' 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 high-exposure liability cases. Specific risk-management strategies will be discussed for reducing such high-liability exposure. In particular, the workshop will focus on lawsuits related to patient suicide and adverse events due to prescribing psychotropic medications—two frequent sources of malpractice lawsuits against psychiatrists. Current trends in professional liability risks will also be discussed, e.g., collaborative treatment relationships, "cyberpsychiatry," and HIPAA. Attendees will have an opportunity to participate in the workshop by discussing malpractice case studies, which will be distributed for review, and through an ample question-and-answer period.

REFERENCES:

1. American Psychiatric Association Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors. Am J Psychiatry 2003; 160: Supplement.
2. Hickson GB, Federspiel CF, Pichert JW et al: Patient complaints and malpractice risk. JAMA 2002; 287:2951–2957.

Issue Workshop 6
MANAGING DISTRESS AND PSYCHIATRIC DISORDER AFTER TERRORISM
Collaborative Session With the National Institute of Mental Health

Co-Chairpersons: Farris Tuma, Sc.D., *National Institute of Mental Health, 6001 Executive Boulevard, Room 6200, Bethesda, MD 20892*
Anthony T. Ng, M.D., *Uniform Services University of the Health Sciences, Bethesda, MD 20892*
Participants: Carol S. North, M.D., Sandro Galea, M.D., Matthew Friedman, M.D., Robert J. Ursano, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be familiar with evidence on the extent and nature of distress and psychopathology experienced after a major terrorist attack; unique and common circumstances and issues raised by different types of events, including bioterrorism; and potential roles for clinicians in facilitating recovery and providing evidence-based care for patients.

SUMMARY:

The purpose of this workshop is to orient attendees to the clinical and public health implications of a major terrorist event; unique and common circumstances and issues raised by different types of events, including bioterrorism; and research-based knowledge that will help clinicians appreciate their potential role and to provide good care for their patients. This will be accomplished with three scientific presentations by leading research clinicians followed a discussant with ample time for open discussion. Psychiatry has an important role to play in facilitating individual and community recovery in the aftermath of major traumatic events. Valuable and practical skills include: using what is known from research to recognize and address distress (in addition to disorder); educating other physicians; treating complex posttraumatic conditions (grief/bereavement); knowing state-of-the-art intervention for PTSD, ASD, MDD, and other conditions.

REFERENCES:

1. Galea S, Vlahov D, Resnick H, et al: Progression of posttraumatic stress disorder symptoms among adults in New York City after the September 11 terrorist attacks. American Journal of Epidemiology. 2003; 158:514–524.
2. Smith EM, North CS, et al: Trauma related to disasters of natural and human origin. Wilson, John Preston (Ed); Raphael, Beverley (Ed). International Handbook of Traumatic Stress Syndromes. The Plenum Series on Stress and Coping. New York, Plenum Press, 1993, pp. 405–525.

Issue Workshop 7
THE PSYCHIATRIC CONSEQUENCES OF THE WORLD TRADE CENTER ATTACK IN DISASTER RELIEF WORKERS
Collaborative Session With the National Institute of Mental Health

Chairperson: JoAnn Difede, Ph.D., *Department of Psychiatry, Weill Medical College of Cornell University, 525 East 68th Street, Box 200, New York, NY 10021*
Participants: Jennifer Roberts, Ph.D., Pamela Leck, Ph.D., Margaret Altemus, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, participants will have a better understanding of the empirical literature on PTSD and disaster relief workers. They will learn how to design and implement a screening program for PTSD. They will be able to describe effective treatments for PTSD in disaster relief workers.

SUMMARY:

In this workshop we share our experience establishing both clinical and research programs targeted towards two groups of disaster relief workers (DRWs): employees of Consolidated Edison and the New York City Fire Department (FDNY), following September 11th.

We will begin with a review of the literature on DRWs and then present empirical findings from our evaluation of 3,800 Con Edison workers deployed to work at WTC site. We will include discussion on the challenges and considerations specific to developing a large screening program within an occupational health department.

We will then share our experience treating more than 400 Con Edison and FDNY employees utilizing brief treatment protocols involving prolonged imaginal exposure therapy and virtual reality exposure therapy, which were developed via NIMH treatment grants. These treatment protocols were based on first-line therapies for PTSD and included three major components: exposure therapies, cognitive restructuring, and anxiety-management techniques. We will also discuss innovations in the medical management of PTSD.

This workshop will further address the public health issues involved in the assessment and treatment of DRWs as well as suggestions about educational programs to better prepare DRWs in coping with the psychiatric consequences of disasters.

REFERENCES:

1. Difede J, Roberts J, Jayasinghe N, Leck P: (In Press, 2004) Evaluation and treatment of emergency services personnel following the World Trade Center attack. In September 11, 2001: Treatment, Research and Public Mental Health in the Wake of a Terrorist Attack, edited by Nerin Y, Gross P, et al. New York: Cambridge University Press.
2. Marmar CR, Weiss DS, Metzler TJ, et al: Longitudinal course and predictors of continuing distress following critical incident exposure in emergency services personnel. Journal of Nervous and Mental Disease, 1999; 187:pp. 15–22.

Issue Workshop 8
MENTAL HEALTH OF PHYSICIANS: WHOSE BUSINESS IS IT?

Chairperson: Jeffrey L. Clothier, M.D., *Department of Psychiatry, University of Arkansas for Medical Sciences, #4 Black Bear Court, Little Rock, AR 72223*
Participants: Laura W. Roberts, M.D., Linda L.M. Worley, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) describe the definition of physician impairement, 2) compare current licensure application disclosure practices, 3) list risk factors that contribute to suboptimal health practices of physicians, 4) describe interventions for medical students/trainees, 5) describe the ethical dilemma facing medical boards and physicians.

SUMMARY:

Physician impairment is defined by the presence of any condition that interferes with the ability to practice medicine competently and safely. This workshop will explore the definition of impairment related to medical practice and layers of protection of the public. Three layers of protection are identified. These correspond to primary, secondary, and tertiary prevention models. The seeds of impairment may be sown early in the context of a rigorous training period. Attention to student mental health processes at this time are important. The licensing process is an attempt to identify impaired physicians. Recently the attention to impairment as the result of mental illness has become an issue during the licensing process. A basic assumption is that a mental health diagnosis is equivalent to some level of impairment. This creates an ethical dilemma for the individual physician. The final layer of protection is with the process of peer reporting. The ethical principles of confidentiality and autonomy conflicts directly with the duty to protect the public. Physicians have an affirmative duty to protect the public from impaired physicians. Practical implications of training, treatment, and the culture of silence will be explored in the context of current licensing practices.

REFERENCES:

1. Worley LLM: Instilling happiness into medical school. J Ark Med Soc. 1998; 94:391–393.
2. Roberts LW, Warner TD, Rogers M, et al: Medical student illness and impairment: a vignette-based survey study involving 955 students at 9 medical schools.
3. Pitt E, Rosenthal MM, Gay TL, Lewton E: Acad Med. 2004; 79:840–4.

Issue Workshop 9
PHYSICIAN SUICIDE: WHAT CAN BE DONE?

Chairperson: Thomas E. Hansen, M.D., *Department of Psychiatry, Veterans Administration Medical Center, 3710 SW US Veterans Hospital Road, Portland, OR 97239*
Participants: Henry J. Grass, M.D., Carla Fine, M.S., Michael F. Myers, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to recognize the risk and great costs of physician suicide and to use this information personally and to intervene with colleagues.

SUMMARY:

This workshop will address the serious problem of physician suicide, reviewing outbreaks in Oregon and direct personal experiences, and discussion of interventions.

Dr. Hansen will present a brief overview, noting that physicians kill themselves at higher than expected rates (the rate for male physicians matches the older male high-risk group, the rate for women is much higher than for comparably aged females).

Dr. Grass, chair of the OPA Physician Assistance Committee, will present his experience as a field interviewer in a joint AMA-APA study prompted by an epidemic of physician suicide in 1977–78, as well as information about an apparent recent rash of suicides in Oregon. This has led the OPA-PAC to initiate efforts to increase awareness and include mental illness in Oregon's BME Diversion program.

Dr. Myers and Carla Fine (survivor and author of the book, "No Time to Say Goodbye") will share their work with raising awareness about physician suicide. The audience will view a segment of their videotape, "When Physicians Commit Suicide."

We plan for 35 minutes of audience response to the material and proposals for interventions. The material and discussion will benefit individual physicians, physicians' therapists, and administrators interested in physician well being.

REFERENCES:

1. Center C, Davis M, Detre T, et al: Confronting Depression and Suicide in Physicians: A Consensus Statement. JAMA 2003; 289:3161–3166.
2. Council on Scientific Affairs: Results and Implications of the AMA-APA Physician Mortality Project. JAMA 1987; 257:2949–2953.

3. Myers M, Fine C: Suicide in physicians: toward prevention. MedGenMed 2003; 5:11.

Issue Workshop 10
JEALOUS DELUSIONS, GUMMAS, AND EEG TRACINGS

Co-Chairpersons: Sherri M. Simpson, M.D., *Baylor College of Medicine, 6655 Travis Street, Suite 700, Houston, TX 77030*
James N. Flack, M.D., *Menninger Department of Medicine, Baylor College of Medicine, 6655 Travis Street, Suite 700, Houston, TX 77030*
Participant: Katie Coerver, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, each participant should be able to demonstrate a broader understanding of psychosis and mood lability as part of atypical presentations of neurological disorders.

SUMMARY:

Psychiatric presentations of neurological disorders have long been identified both as diagnostic and treatment challenges. However, psychological and cognitive symptoms recognized as part of the symptomatology for some neurological disorders are consistently overlooked, and all too often, misdiagnosed. Affective dysregulation, psychosis, and depression in patients (without definitive neurological findings) contribute to misdiagnoses of neuropsychiatric diseases such as SLE, MS, and various forms of epilepsy. When the capacity for emotional regulation (and preseveration of normal thought organization) are compromised by disease or injury, the impact on individuals and their families may be considerable, both with regard to psychological well-being and social and occupational functioning.

This workshop seeks to reexamine the presenting symptoms, diagnostic strategies, and subsequent treatment intervention of two cases with atypical, behavioral presentations—neurosyphilis and post-herpetic meningitis. A neurologist will discuss the neurobiology of the aforementioned disease processes including kindling, long-term potentiation, EEG tracings, and localized, cerebral gumma deposition. The facilitators will lead an interactive exchange among attendees to discuss medication and other management challenges inherent in the aberrant presentations of the above neuropsychiatric disorders.

REFERENCES:

1. Arciniegas DB, Topkoff J: The neuropsychiatry of pathologic affect: an approach to evaluation and treatment. Semin Clin Neuropsychiatry. 2002.
2. Wilson LG: Viral encephalopathy mimicking functional psychosis. Am J Psychiatry. 1976

Issue Workshop 11
PSYCHIATRISTS' INVOLVEMENT IN WORKPLACE SAFETY

Chairperson: Marie-Claude Rigaud, M.D., *P.O. Box 2816, Aurora, IL 60507*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: become familiarity with factors involved in workplace safety, discuss workers' psychiatric conditions likely to compromise safe workplace behaviors, and develop skills in assessing fitness for "safe" duty and make appropriate workplace recommendations to enhance safety.

SUMMARY:

Workplace safety is a multidimensional concept, encompassing direct as well as indirect environmental, individual, and group conditions. At the individual level, behavioral safety involves individual workers' ability to perform their job in a safe manner, without intentionally or unintentionally hurting themselves or others. The Americans With Disabilities Act addresses issues of direct threat. The National Institute of Occupational Safety and Health (NIOSH) has studied issues related to workplace violence and its prevention. Violence prevention activities are now routine for human resource departments and schools, with the development and implementation of zero tolerance policies. As treaters or independent examiners, psychiatrists have a major role in identifying and managing individual workers' factors and conditions. That role requires psychiatrists to be aware of and assess workers' conditions and behaviors affecting safety and to issue recommendations for job accommodations or other dispositions as indicated.

The concept of safety will be defined as it relates to the field of psychiatry, and general issues concerning workplace safety will be discussed. A presentation and discussion of clinical aspects of workers' mental/psychological conditions that can alter safe workplace behavior will follow. The workshop will conclude with a presentation of procedures for clinical evaluation of fitness for (safe) duty and a discussion of recommendations beneficial to individual workers and the workplace.

REFERENCES:

1. Miller L: Workplace violence: prevention, response, and recovery. Psychotherapy 1999; 36:160–169.
2. Beck JC, Schoulen R: Workplace violence and psychiatric practice. Bulletin of the Menninger Clinic 1999; 64:36–48.
3. Geller ES: People-based safety. Professional Safety Dec 2003; 48:33–43.

Issue Workshop 12
ISSUES AND CHALLENGES IN INTEGRATING INTERPERSONAL PSYCHOTHERAPY INTO PSYCHIATRY DEPARTMENTS

Chairperson: Heather Flynn, Ph.D., *Department of Psychiatry, University of Michigan, 2101 Commonwealth Road, Ann Arbor, MI 48105*
Participants: Scott Stuart, M.D., Jonathan E. Lichtmacher, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, participants should be aware of key issues in integrating an evidenced-based treatment into training and clinical care in psychiatry departments and will be equipped with specific recommendations for meeting the challenges involved.

SUMMARY:

Interpersonal psychotherapy (IPT) is a brief, evidence-based treatment specific for major depression. Psychiatry departments vary widely in their integration of IPT into training and clinical care. This workshop will highlight key issues and challenges faced by faculty developing IPT programs at three psychiatry departments in the U.S.: the University of Iowa, University of Michigan, and University of California, San Francisco. The discussion will emphasize educational and organizational issues including the importance of department and faculty leadership, philosophical/cultural obstacles, and logistical issues. In the first half of the workshop, a brief overview of the three models will be presented, followed by a summary of the unique and shared issues and challenges that have been confronted. The role of resident training in light of the newly formed National Psychiatry Training Council Task Force will be discussed. The second half will be devoted to audience discussion of relevant experiences in learning,

teaching, or otherwise incorporating IPT into academic psychiatry departments. It is hoped that residents, faculty, and clinicians from a variety of disciplines and at all levels of IPT experience will participate. Based on the discussion, recommendations on how to meet challenges will be outlined.

REFERENCES:

1. Weissman M, Markowitz J, Klerman G: A Comprehensive Guide to Interpersonal Psychotherapy. Basic Books, New York, 2000.
2. Hamilton S, Mellman LA, Gabbard GO: Psychotherapies in residency training. J Psychother Pract Res. 1999; 8:302–13.

Issue Workshop 13
DIAGNOSTIC ISSUES FOR INFANCY AND EARLY CHILDHOOD: A WHITE PAPER FOR *DSM-V*

Chairperson: Michael S. Scheeringa, M.D., *Tulane University, 1440 Canal Street, TB 52, New Orleans, LA 70112*
Participants: Joan L. Luby, M.D., Helen L. Egger, M.D., William E. Narrow, M.D.

EDUCATIONAL OBJECTIVE:

To understand the empirical database, recent developments, and unique developmental challenges that are salient for diagnosing young children.

SUMMARY:

As part of the planning process for DSM-V, the APA Office of Research convened a group to create a developmentally sensitive white paper on infancy and early childhood issues. This represents the first APA panel charged to review the database that has grown over the past 20 years. Three members of that group will review the main recommendations and focus on three areas to illustrate the empirical database, recent developments, and unique developmental challenges that are salient for diagnosing psychopathology in this age group. First, Michael Scheeringa, M.D., will give an overview, of the review process and how this effort has built upon a previous national effort that developed the Research Diagnostic Criteria-Preschool Age. Second, Joan Luby, M.D., will discuss the recommendations for major depression disorder as an example of a disorder that has been relatively well studied. Third, Dr. Scheeringa will discuss the recommendations for reactive attachment disorder as an example of a disorder that is still being conceptualized prior to extensive data gathering. Fourth, Helen Egger, M.D., will discuss the conceptual and measurement issues of functional impairment that are unique to this age group. Audience members will be encouraged to discuss these recommendations.

REFERENCES:

1. Task Force on Research Diagnostic Criteria: Infancy and Preschool Age, research diagnostic criteria for infants and preschool children: the process and empirical support. J Am Acad Child Adolesc Psychiatry 2003; 42:1504–1512.
2. Kupfer DJ, First MD, Regier DA: A research agenda for DSM-V. Washington, DC, American Psychiatric Association, 2002.

Issue Workshop 14
ETHNICITY AND PSYCHOPHARMACOLOGY: RESEARCH AND CLINICAL IMPLICATIONS

Co-Chairpersons: Pedro Ruiz, M.D., *Department of Psychiatry, University of Texas, 1300 Moursund Street, Houston, TX 77030*
Key-Ming Lim, M.D., *Harbor-University of California Los Angeles, 1000 West Carlson Street, Torrence, CA 90509*
Participants: William Lawson, M.D., Edmond H.T. Pi, M.D., Ricardo P. Mendoza, M.D., Tarek A. Okasha, M.D.

EDUCATIONAL OBJECTIVE:

To recognize the interrelationship between ethnicity and psychopharmacology, and understand its clinical implications among the ethnic minority populations in the U.S.

SUMMARY:

During the last several decades, the United States has become a multiethnic and pluralistic society. As such, all aspects of life in this country have been influenced and impacted by this pluralistic rainbow, including health care and mental health care. In this respect, major emphasis has been given to research efforts on the interrelationship between ethnicity and psychopharmacology. This has resulted in new knowledge being created in this area of research, as well as in its clinical applications, particularly with respect to the ethnic minority populations who reside in this country. These applications have also expanded to the racial and cultural aspects of these ethnic population subgroups. Thus, in this presentation, a series of research areas will be addressed and discussed, pertaining to the major ethnic minority groups who live in this nation. Additionally, future research perspectives will be also addressed as a way of focusing attention on this area. The discussion will have teaching and educational implications as well.

REFERENCES:

1. Ruiz P: Ethnicity and Psychopharmacology. Washington, D.C., American Psychiatric Press, Inc., 2000.
2. Mendoza R, Wan YY, Poland RE, et al.: CYP2D6 polymorphism in a Mexican-American population. Clinical Pharmacology & Therapeutics 2001; 70:552–560.

Issue Workshop 15
MAKING IT HAPPEN: IMPLEMENTING PRACTICE GUIDELINES IN EVERYDAY PRACTICE

Chairperson: Rory P. Houghtalen, M.D., *Unity Health System, 81 Lake Avenue, Rochester, NY 14608*
Participants: Jack S. McIntyre, M.D., Jeffrey Mothersell, C.S.W., Joel Yager, M.D.

EDUCATIONAL OBJECTIVE:

To recognize how practice guidelines can aid a health system in improving clinical practices and patient outcomes; identify one performance measurement tool for assessing practice guideline adherence; describe a process and methods for practice guideline implementation in a behavioral health setting.

SUMMARY:

Despite the wide dissemination of APA practice guidelines for the evaluation and treatment of mental disorders, adherence to guideline recommended practices is generally poor, and processes to improve adherence to guideline recommendations in everyday practice have not been clearly defined. This workshop provides an overview of a systematic effort to implement the APA practice guidelines in a community behavioral health system that provides mental health and substance use services in urban, suburban, and rural areas. We will present the process and methods that we are using to effect a cultural change in everyday practice that includes cultivation of administrative support, marketing the value of guideline implementation, creation of tool kits to train staff in the application of guidelines, decision-support tools and documentation aids that encourage the display of best practices, and a quality-improvement process to monitor and provide feedback about progress with guideline implementation. Implementation of the practice guideline for major depressive disorder will serve as a focal example. Initial data that illustrate baseline adherence to guideline recommended practices and progress toward guideline-adhering practices will be presented. This workshop will be relevant for clinicians and clinical administrators inter-

ested in enhancing guideline-adhering practices in their practice settings.

REFERENCES:

1. McIntyre J: Usefulness and limitations of treatment guidelines in psychiatry. World Psychiatry, 2002; 1:186–199. Physician Consortium for Performance Improvement. (2003). Clinical Performance Measure.
2. Major Depressive Disorder. (American Medical Association), Washington, DC. www.ama-assn.org/ama/pub/category/4837.html accessed 8/20/04.

Issue Workshop 16
PRACTICAL CLINICAL TRIALS COMPARING PSYCHOPHARMACOLOGICAL TREATMENTS

Co-Chairpersons: Sandra L. Tunis, Ph.D., *Health Outcome Department, Eli Lilly and Company, 940 South East Street, Dock 88, Indianapolis, IN 46285*
Don Buesching, Ph.D., *Eli Lilly and Company, Lilly Corporate Center, Indianapolis, IN 46285*
Participants: Douglas E. Faries, Ph.D., Kurt Kroenke, M.D., Wayne J. Katon, M.D.

EDUCATIONAL OBJECTIVE:

To recognize some key advantages, limitations, and opportunities in the design and conduct of practical clinical trials comparing psychopharmacological treatments.

SUMMARY:

The practical clinical trial (PCT) is gaining momentum in psychiatry and other areas of medicine as a vehicle for providing payers, clinicians, policymakers, and patients evidence for the "added value" of new treatment technologies. The Centers for Medicare and Medicaid Services is developing incentives for the conduct of PCTs as part of an evidence-based reimbursement initiative. The objective of this workshop is to provide an interactive forum to discuss benefits but also potential pitfalls of PCTs for answering questions on the effectiveness of competing psychopharmacological treatments within "real-world" practice settings. Design and implementation "best practices" will be presented by researchers who have spearheaded antidepressant and antipsychotic PCTs. Analytic issues will be addressed, including the limitations of traditional intent-to-treat approaches for detecting differences on primary effectiveness endpoints. To illustrate, the frequent use of medication switching by physicians may provide optimal treatment for individual patients, but may drive therapy arms to "equivalence" from an analytical perspective. Innovative techniques are needed to address the extent to which comparative pharmacotherapies contribute to improvements in clinical or functional endpoints of the PCT. As more of these resource-intensive studies are contemplated, the field will benefit from discussing their advantages, limitations, and opportunities for innovation.

REFERENCES:

1. Tunis SR: Practical clinical trials: increasing the value of clinical research for decision making in clinical and health policy, JAMA 2003; 290:1624–1632.
2. Tunis SL, et al: Designing naturalistic prospective studies of economic and effectiveness outcomes associated with novel antipsychotic therapies, Value in Health 2000; 3:232–242.

Issue Workshop 17
SPLIT THERAPY PSYCHOTHERAPY AND PHARMACOTHERAPY: PROCEDURES AND STRATEGIES

Chairperson: Malkah T. Notman, M.D., *Department of Psychiatry, Harvard Medical School, 54 Clark Road, Brookline, MA 02445*
Participants: Carl P. Malmquist, M.D., Brenda C. Solomon, M.D., Amit D. Rajparia, M.D.

EDUCATIONAL OBJECTIVE:

Upon completion of this workshop participants will have an understanding of the clinical, forensic, ethical, and training issues related to split therapy and become familiar with strategies for managing these.

SUMMARY:

Although many psychiatrists believe that pharmacotherapy and psychotherapy are most effectively done by the same individual, this is increasingly rare. Managed care restrictions, other economic pressures, and shifts in training and expectations have led to split therapeutic roles for the psychiatrist. Psychotherapy is often done only by nonpsychiatrists, leaving the psychiatrist to have primarily a psychopharmacology role with short and widely spaced visits. The dynamically oriented psychiatrist often looks to the psychopharmacologist for prescribing medication. Each sees the patient in different ways, for different periods of time, with different views of the patient. This may have benefits such as an additional perspective on the patient but can create problems because of differences in skills, orientation, understanding, and diagnostic formulations. Role conflict can occur in the psychiatrist who sees some patients psychotherapeutically and some psychopharmacologically. Conflict between the therapists, competition, poor information sharing, and splits in the transference with manipulations affect the treatment. Understanding these issues and developing strategies to address them can avoid therapeutic and forensic pitfalls. They will be discussed from several positions: Dr. Amit Rajparia, a PGY-4 resident, will discuss training issues and role differences; Dr. Notman will discuss clinical problems; Dr. Brenda Solomon will present ethical considerations; Dr. Carl Malmquist will raise the forensic issues. Audience participation will be invited.

REFERENCES:

1. Klein DF: Studying the respective contributions of pharmacotherapy and psychotherapy. In Psychiatry in the New Millenium. Edited by Weissman S, Sabashin M, Eist H: APPI, 1999, pp. 217–235.
2. Busch FN, Auchincloss EL: The psychology of prescribing and taking medications. In Psychodynamic Concepts in General Psychiatry, edited by Schwartz H, Bleiberg E, Weissman S. Washington, APA, 1995, pp. 401–416.

Issue Workshop 18
TREATMENT OF DEPRESSION DURING PREGNANCY

Co-Chairpersons: Janet A. Martin, M.D., *Department of Psychiatry, Cedars-Sinai Medical Center, 17846 Palora Street, Encino, CA 91316-3620*
Neil Silverman, M.D., *Cedars-Sinai Medical Center, 8730 Alden Drive, Los Angeles, CA 90048*
Participants: Leo L. Gallofin, M.D., Syed S.A. Naqvi, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand the risks and benefits of antidepressant treatment during pregnancy and identify specific antidepressant medications that are safe during pregnancy.

SUMMARY:

Based on research diagnostic criteria, depression is estimated to affect 9% of women during pregnancy and 10% to 15% of women in the three months postpartum. Many women who do not necessarily plan on becoming pregnant while being treated for depression discover they are pregnant after several weeks of exposing the fetus to medications. Research is limited in understanding the effects of antidepressant medication during pregnancy and while breastfeeding, thus making it challenging for physicians to make clear recommendations for treatment of their pregnant patients. Prospective studies in recent years have examined the effects of various tricyclic antidepressants and SSRIs on factors such as maternal weight gain, intrauterine fetal death, morphologic and behavioral teratogenicity, growth impairment, and neonatal toxicity. Identified risks found in some studies include direct medication effects and withdrawal syndromes in neonates, which differed depending on trimester of exposure, and reduced maternal weight gain associated with fluoxetine. This workshop will present information from the scientific literature and clinical experience to clarify the identified risks and benefits of treatment of depression during pregnancy and enable physicians to provide more definitive information to patients with depression who plan to become pregnant and provide appropriate treatment for pregnant women who have depression.

REFERENCES:

1. Laine K, Heikkinen T, Ekblad U, Kero P: Effects of exposure to selective serotonin reuptake inhibitors during pregnancy on serotonergic symptoms in newborns and cord blood monoamine and prolactin concentrations. Arch Gen Psychiatry 2003; 60:720–726.
2. Wisner KL, Gelenberg AJ, Leonard H, et al: Pharmacologic treatment of depression during pregnancy. JAMA 1999; 282:1264–1269.

Issue Workshop 19
BINGE-EATING DISORDER IN OBESITY AND IMPLICATIONS FOR BARIATRIC SURGERY

Co-Chairpersons: Jennifer L. McLain, M.D., *Department of Psychiatry, Cedars-Sinai Medical Center, 8730 Alden Drive, Thalians W-101, Los Angeles, CA 90048*
Edi Cooke, Psy.D., *Department of Psychiatry and Mental Health, Cedars-Sinai Medical Center, 8730 Alden Drive, Room W101, Los Angeles, CA 90048*
Participant: Alexander H. Fan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand binge-eating disorder in the obese population and its treatments including considerations for bariatric surgery.

SUMMARY:

In 1971 obesity affected 14.5% of Americans, but today over one-third of Americans are obese. Morbid obesity is associated with higher rates of type 2 diabetes, liver disease, heart disease, stroke, arthritis, hypertension, and gallstones, as well as colon, breast, and endometrial cancers. Approximately 400,000 individuals die from obesity-related illnesses each year. Bariatric surgery is the current gold-standard treatment for morbid obesity. On average, bariatric patients lose 50% of their excess body weight by five years post surgery. However, little is known about individuals who do not successfully lose or maintain weight loss. It is likely that individuals with disordered eating and untreated psychopathology largely comprise this group of less successful and unsuccessful bariatric surgery patients. Binge-eating disorder (BED), a proposed diagnosis in the DSM-IV-TR, is present in up to 30% of potential candidates for bariatric surgery. Both the disorder itself and its frequent psychiatric comorbidities may lead to higher risk for postoperative medical complications, continued disordered eating, and reduced weight loss after surgical treatment in these individuals. This workshop will review what we know about BED and bariatric surgery, examine what is not known about this patient population, and open discussion about future directions in this important area.

REFERENCES:

1. Fairburn C, Wilson T: Binge Eating: Nature, Assessment, and Treatment. New York, Guilford Press, 1993.
2. Kalarchian M, et al: Binge eating among gastric bypass patients at long-term follow-up. Obesity Surgery 2002; 12(2):270–75.

Issue Workshop 20
DUAL-CAREER COUPLES: MULTIPLE ROLES, INNOVATIVE SOLUTIONS
Association of Women Psychiatrists

Chairperson: Silvia W. Olarte, M.D., *Department of Psychiatry, New York Medical College, 25 East 83rd Street, 9D, New York, NY 10028*
Participants: Linda H. Chaudron, M.D., Ana E. Campo, M.D., Mary Kay Smith, M.D.

EDUCATIONAL OBJECTIVE:

To recognize the stress inherent in the lives of dual-career couples, evaluate creative solutions and demonstrate their positive effect in the well-being of parents and children alike.

SUMMARY:

Women currently comprise up to 50% of some first-year medical school classes. This follows the general trend in the U.S., where over 75% of mothers of toddlers work outside of their home. Balancing multiple roles continues to be a great concern for women of all socioeconomic and educational levels. With the steady increase in the earning power of women, the traditional working dyad in which the man's income is the main economic source of the household has began to change. Among professional couples there has been a steady equalization of income power and with increasing frequency even a reverse on the traditional earning power distribution. This different earning power distribution fosters changes within relationships including changes in the distribution of the multiple roles needed to succeed in providing for professional, family, and personal needs. What in the 1980s was innovative among dual-earner couples, that is, both working outside of the home with hired help providing for home support under the main supervision of the woman of the house, has in 2004 become a more traditional solution. Other arrangements are being tried as innovative, carrying with them a new set of psychological stressors. This workshop will review data on multiple career and family roles for professional women psychiatrists and present innovative experiences of dual-career couples experimenting with different patterns of shared responsibilities.

REFERENCES:

1. Spurlock J: Multiple roles of women and role strains. Health Care Women Int 1995; 16:501–508.
2. Luecken LJ, Suarez EC, Kuhn CM, et al: Stress in employed women: impact of marital status and children at home on neurohormone output and home strain. Psychosom Med 1997; July/Aug: 352–359.

Issue Workshop 21
PRACTICE RESTRICTIONS ON PHYSICIANS: DISABILITY, ADA, AND FUTURE EMPLOYMENT

Co-Chairpersons: Andrea G. Stolar, M.D., *Department of Psychiatry, Case Western Reserve University, 16011 Chadbourne Road, Shaker Heights, OH 44120*
Marilyn Price, M.D., *12 Dorothy Road, Newton, MA 02459*
Participant: Marcia A. Scott, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand what constitutes disability of a physician with a psychiatric illness and licensing requirements that may apply; to understand what kind of documentation can best serve both patient and insurance professional; to clarify the roles and address confidentiality issues for the treating physician, coworker, employer, and their legal representatives.

SUMMARY:

"Dr. Doe" never missed a martini after work; it was "only one" but always one. Then managed care took hold, his schedule tightened, and the department chair kept talking about the "bottom line." His wife complained he was drinking more. When he cut back he found that several Xanax steadied his hands. He used his prescribing privileges to get by, but eventually the state medical board was alerted. Dr. Doe underwent a board-mandated psychiatric evaluation and was advised of license restrictions. Fortunately, he had disability insurance and applied for benefits to keep him afloat during treatment, until he could reinstate his license.

But was Dr. Doe disabled? Is a substance abuser restricted from the appropriate use of the abused substance due to the risk of triggering a relapse? Are practice restrictions a valid focus for a treatment plan? What if his substance of choice is a material part of his daily practice, such as could happen with an addicted anesthesiologist? What kind of accommodation is he entitled to under ADA?

A panel including insurance insiders and a medical-board evaluator will address the predicament of the psychiatrically impaired professional and the roles of clinician, third-party evaluator, legal counsel, and insurance evaluators.

REFERENCES:

1. Boisaubin EV, Levine RE: Identifying and assisting the impaired physician. Am J Med Sci 2001; 322:31–36
2. Brent NJ: Protecting physicians' rights in disciplinary actions by a medical board: a brief primer. J Med Prac Manag 2002; 18:97–100

Issue Workshop 22
RESEARCH TRAINING AND CAREER DEVELOPMENT: NIMH OPPORTUNITIES
Collaborative Session With the National Institute of Mental Health

Co-Chairpersons: Della M. Hann, Ph.D., *National Institute of Mental Health, 6001 Executive Boulevard, Bethesda, MD 20892*
Joseph R. Calabrese, M.D., *Department of Psychiatry, University Hospital Cleveland, 11400 Euclid Avenue, Suite 200, Cleveland, OH 44106*
Participants: Mark Chavez, Robert L. Findling, M.D., Omar Elhaj, M.D.

EDUCATIONAL OBJECTIVE:

The participant will learn about 1) current NIMH priorities for research training and career development; 2) the range of NIMH funding mechanisms available to pursue training in research across the professional life cycle, including Training (T) Awards, the Loan Repayment Program (LRP), Career (K) Awards, and Mental Health Research Education Grants (R25s), and 3) the critical elements of highly successful research training fellowship.

SUMMARY:

Although the need for highly trained physician scientists in psychiatry is critical, the number of those pursuing active research careers appears to be declining. The aim of this workshop is to: 1) increase the awareness of the field's urgent need for young research-oriented investigators, 2) discuss the incentives and priorities for a research-oriented career, 3) familiarize the audience with the available NIMH funding mechanisms, 4) provide helpful guidelines on how to initiate a research project and to submit an application for a grant to the NIMH. The format is an interactive workshop where the speakers will each briefly present their respective segments, followed by an open forum for questions and answers, moderated by the workshop chairs. The audiences for this workshop are: 1) general adult psychiatry residents intending to start a research fellowship at or after PGY-3 level, 2) child psychiatry residents intending to start a research fellowship at or after PGY-4 level.

REFERENCES:

1. http://www.nimh.nih.gov/researchfunding/training.cfm. NIMH Research Training and Development Timetable.
2. http://www.iom.edu/project.asp?id=3893. Institute of Medicine Report on the Incorporation of Research Into Psychiatry Residency Training.

Issue Workshop 23
COLLABORATIVE CARE MODELS FOR DEPRESSION IN PRIMARY CARE

Chairperson: Ann Marie T. Sullivan, M.D., *Elmhurst Hospital, 79-01 Broadway, Elmhurst, NY 11373*
Participants: Steven A. Cole, M.D., Joslyn Levy R.N., Karneya J. Ancselovits, M.D. Martin H. Maurer, M.D.

EDUCATIONAL OBJECTIVE:

Participant will understand the different models that have been utilized for development of integrated depression care and recognize the challenges, impediments, and the necessary components to successfully integrate care.

SUMMARY:

It is well known that there is a high prevalence of major depression in primary care populations (6%–10%) as well as a low detection and treatment rate. Since Katon's seminal research was published in 1995, many other studies establishing the efficacy of the collaborative care model for the treatment of depression in primary care have been published. Collaborative care models for depression share many similarities with Wagner's six-component "chronic illness care" model for chronic illness. All presenters have been involved in provider collaboratives focused on development of integrated care models for treatment of depression within primary care. These collaboratives (NYC Department of Health and Mental Hygiene, 200 federally qualified health centers, and Institute for HealthCare Improvement) all have used adaptations of Wagner's and Katon's model with many ethnically diverse underserved populations in both urban and rural areas. Discussion will focus on implementation in diverse settings. Outcome data across numerous sites will be presented. The function and implementation of care management and role of psychiatry in the model will be discussed and related to depression outcome data.

Target audience: clinicians and administrators looking at improving care of depressed primary care patients.

REFERENCES:
1. Katon W, Von Korff M, Lin E, et al: Collaborative management to achieve treatment guidelines: impact on depression in primary care. JAMA 1995; 273:1026–1031.
2. Kilbourne A, Rollman B, Schulberg H, et al: A clinical framework for depression treatment in primary care. Psychiatric Annals 2002; 32:545–553.

Issue Workshop 24
COMPARING CAREGIVING ISSUES OF AGING PATIENTS WITH SCHIZOPHRENIA AND DEMENTIA

Co-Chairpersons: Sheila M. Loboprabhu, M.D., *Department of Psychiatry, Veterans Administration Medical Center, 116 Gero, 2002 Holcombe Boulevard, Houston, TX 77030*
Michael D. Jibson, M.D., *University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0016*
Participant: Theron C. Bowers, Jr., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, participants should be able to appreciate the caregiving needs of schizophrenia vs. dementia patients, assess patients' functional skills, and tailor treatment in an age-specific and situation-specific manner to the needs of both patient and caregiver.

SUMMARY:

Caregiving for the elderly poses many demands and challenges. In this workshop, we compare caregiving for aging schizophrenia and dementia patients and discuss the similarities and differences. Existing systems support younger caregivers with aging parents. However, the aging schizophrenia population involves older parents facing their own end-of-life issues, while worrying about who will care for their disabled adult children. Caregivers of patients with dementia are commonly their elderly spouses and adult children. Dementia patients progressively decline in memory and functional skills. They may use the full spectrum of caregiving: aging in place, assisted living, and nursing home placement. Caregivers must adapt based on formal vs. informal caregiving, the patient's functional skills, and location of care. In contrast, patients with schizophrenia may live at home with their parents, independently, or in group homes. Concomitant substance abuse may lead to homelessness or staying in halfway houses or shelters. Elderly parents should anticipate changes in caregiving for their adult children with schizophrenia. Early involvement of siblings or other relatives can provide reassurance of continued care for these disabled patients. The geriatric psychiatry team can help with financial and social planning to ease the transition for adults with schizophrenia upon the death of their parents.

REFERENCES:

1. Thompson K. Stigma and public health policy for schizophrenia. Psychiatry Clin North Am 2003; 26:273-94.
2. Mace N, Rabins P: The 36-hour day: a family guide to caring for persons with Alzheimer's disease, related dementing illnesses, and memory loss in later life. Baltimore, John Hopkins Press, 1999.

Issue Workshop 25
THE PSYCHIATRY RESIDENT AS EDUCATOR: IMPLEMENTATION OF A CURRICULUM

Co-Chairpersons: Ruth M. Lamdan, M.D., *Department of Psychiatry, Temple University School of Medicine, 1316 West Ontario Street, Jones Hall, Philadelphia, PA 19140*
Autumn Ning, M.D., *Temple University Hospital, 1316 Ontario Street, Philadelphia, PA 19140*
Participants: Roya Lewis, M.D., Diane B. Gottlieb, M.D., Edward A. Volkman, M.D., Robert L. Boyd, M.D., Elton Smith, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to discuss the existing medical education literature on the role of residents as teachers. They will have the opportunity to critique a proposed curriculum and plan a curriculum to enhance the skills and effectiveness of resident educators at their institutions.

SUMMARY:

The literature shows that residents spend approximately 20% of their time teaching medical students and junior house staff. The ACGME, in addition to the skills and attributes outlined in the core competencies, has developed guidelines requiring that psychiatry residents have "teaching opportunities: residents must be instructed in appropriate methods of teaching and have ample opportunity to teach students in the health professions." The standards, process, and outcome measures by which this is to be accomplished remain unclear.

The workshop faculty and residents will present a series of brief talks that will include the role of residents in the education of undergraduate and graduate trainees in the literature and the curriculum that we have developed for them in our institution. Topics include 1.) Introduction to adult learning theory 2.) Individual supervision and modeling 3.) Residents teaching pre-clinical medical students and clinical clerks 4.) Residents teaching residents, 5.) Role of the chief resident for education and limitations of residents as teachers.

Remaining time will be used to discuss the educational role of residents at their institutions. We will attempt to gain a consensus on an educational curriculum for all psychiatry residents as well as a critique of our approach.

REFERENCES:

1. Morrison EH, Jafler JP: Yesterday a learner, today a teacher too: residents as teachers in 2000. Pediatrics 2000; 105:238–241.
2. Kaji A, Moorehead JC: Residents as teachers in the emergency department. Annals of Emergency Medicine 2002; 39:316–318.

Issue Workshop 26
MEETING THE CHALLENGES OF CORRECTIONAL MENTAL HEALTH RESEARCH
Collaborative Session With the National Institute of Mental Health

Chairperson: Robert L. Trestman, M.D., *Department of Psychiatry, University of Connecticut Health Center, 263 Farmington Avenue, MC 1410, Farmington, CT 06030*
Participants: Humberto Temporini, M.D., Philip Candillis, M.D., Joel M. Silberberg, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to discuss critical aspects of correctional mental health research; learn fundamentals of core research issues including coercion, voluntariness, collaboration with custody administration, infrastructure and oversight standards, design pragmatics, sources of funding, and dissemination of findings.

SUMMARY:

Correctional environments challenge traditional approaches for determining practice and treatment needs. With more than 300,000 mentally ill inmates in our nation's jails and prisons on any given day, departments of corrections (DOC) across the country struggle to provide effective care in environments where safety, and not treatment, is the driving factor. Due to many factors, there is a dearth of both primary research in correctional mental health and of the subsequent translation of research knowledge into clinical applications and evidence-based treatment approaches that are valid in correctional settings. Dr, Trestman will expand on the reasons for, and

justification of, correctional mental health research as well as the importance of collaboration between researchers and DOC staff. Dr. Silberberg will address the ethical considerations that arise from doing research in such an environment, such as issues of competence and coercion. Dr. Candilis will elaborate on recent trends in research oversight and accreditation, including the potential costs of future research review. Finally, Dr. Temporini will discuss the pragmatics of research in corrections, including sources of funding and application and dissemination of findings. Audience participation includes working through selected real-world examples, with facilitated solution of such issues as collaboration, access, ethics, design, and oversight.

REFERENCES:

1. Earthrow M, O'Grady J, Birmingham L: Providing treatment to prisoners with mental disorders: development of a policy. Br J Psychiatry 2003; 182:299–302.
2. Moser DJ, Arndt S, Kanz JE, et al: Coercion and informed consent in research involving prisoners. Compr Psychiatry 2004; Jan-Feb; 45:1-9.

TUESDAY, MAY 24, 2005

Issue Workshop 27
ARE THERE LIMITS TO BOUNDARY LIMITS?

Chairperson: Malkah T. Notman, M.D., *Department of Psychiatry, Harvard Medical School, 54 Clark Road, Brookline, MA 02445*
Participants: Carl P. Malmquist, M.D., Linda M. Jorgenson, J.D., Elissa P. Benedek, M.D., Lawrence B. Inderbitzin, M.D.

EDUCATIONAL OBJECTIVE:

The participant in this workshop will have an opportunity to better evaluate and implement appropriate boundary limits for a range of psychiatric experiences including consultations, psychopharmacology relationships, and intensive psychotherapy.

SUMMARY:

During psychotherapy the boundary limits about certain kinds of relationships are not always clear. Having a sexual relationship during therapy is one area that is considered unethical. Business relationships are not always that clear, although they can involve unethical exploitation. Previous presentations by this group have considered the dilemmas created when therapist and patient are in the same small community where overlapping relationships may be difficult to avoid. The differences between patient-doctor relationships in intensive treatment such as psychoanalysis and those in diverse treatments such as medication visits, cognitive-behavioral treatment, counseling, or consultations, have not been widely explored. The post-termination boundaries and their ethical and clinical implications have been addressed even less and are even less clear. The concept "once a patient always a patient" has been a cornerstone of APA ethics.

In this workshop we will present several vignettes on videotape representing different post-termination relationships from two psychiatric experiences. Each presenter will discuss these boundary issues representing a continuum of positions from the most strict interpretation of "once a patient always a patient" to a less constricted view, depending on the type of therapy and the transactions in question. Audience participation will be invited.

This is a repeat of a workshop we presented last year. It has been very successful. We barely succeeded in getting beyond the first vignette since the discussion was so lively. There was interest expressed in having an opportunity for further discussion.

REFERENCES:

1. Appelbaum PS, Jorgenson LM: Psychotherapist-patient sexual contact after termination of treatment: an analysis and a proposal. Am J Psych 1991; 148:1466–1473.
2. Gabbard G, Lester E: Boundary Violations in Psychoanalysis. Basic Books, 1995 (chapter on transference.)

Issue Workshop 28
CHILDREN OF PSYCHIATRISTS: LISTEN AND LEARN

Co-Chairpersons: Leah J. Dickstein, M.D., *Department of Psychiatry, University of Louisville School of Medicine, 3006 Dunraven Drive, Louisville, KY 40202*
Michelle B. Riba, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0295*
Participants: Sarah Sharfstein, Cory Butterfield, India Primm-Spencer, Sudepta Varma, MD

EDUCATIONAL OBJECTIVE:

To understand unique and universal issues children of psychiatrist may experience in their personal home lives and in their lives beyond this actual and perceived unique relationship.

SUMMARY:

This unique workshop offers all attendees opportunities to hear first-hand experiences of children of all ages whose parents are psychiatrists. Speakers describe individual home lives, dispelling myths and decreasing stigma surrounding their professional parents. Beyond their personal relationships with their parents, they relate benefits to others who see their parents in their roles.

Ample time will be allowed for discussion between the audience and panelists as well as between panelists, the chair and cochair.

REFERENCES:

1. This Side of Doctoring: Reflections From Women in Medicine, edited by Eliza Lo Chin, Sage Publishers, Inc., 2002.
2. Health Awareness Workshop Reference Text, edited by Dickstein L, Proactive Press 1998.

Issue Workshop 29
ABPN AND APA PERSPECTIVES ON MAINTENANCE OF CERTIFICATION

Chairperson: Stephen C. Scheiber, M.D., *American Board of Psychiatry and Neurology, 500 Lake Cook Road, Suite 335, Deerfield, IL 60015-5249*
Participants: Victor I. Reus, M.D., Deborah J. Hales, M.D., David B. Mallott, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to describe the ABPN's and APA's efforts related to maintenance of certification.

SUMMARY:

The purpose of this workshop is to present information on the ABPN's evolving Maintenance of Certification (MOC) program and on the APA's related efforts on behalf of its members. As mandated by the American Board of Medical Specialties, the ABPN is in the process of developing a MOC program that will add two new components (evidence of self-assessment and lifelong learning and evidence of performance in practice) to the current recertification requirements (licensure and a multiple-choice examination) for specialists and subspecialists. Evidence of self-assessment and lifelong learning is currently scheduled for implementation for diplomates

applying for the 2007 recertification examinations. Evidence of practice performance will be required at a future data. As of 2005, the examinations will be administered in a nationwide network of computer test centers, and the new test administration procedures will be delineated. Representatives of APA will outline the programs and services the organization has developed to meet the needs of psychiatrists who will be participating in recertification/MOC.

REFERENCES:

1. Shore JH, Scheiber SC (Eds.): Certification, Rectification, and Lifetime Learning in Psychiatry. Washington, DC, American Psychiatric Press, Inc., 1994.
2. Scheiber SC, Kramer TAM, Adamowski S (Eds.): Core Competencies for Psychiatric Practice: What Clinicians Need to Know. Washington, DC, American Psychiatric Press, 2003.

Issue Workshop 30
HOW TO LAUNCH A SUCCESSFUL PRIVATE PRACTICE, PART 1

Co-Chairpersons: William E. Callahan, Jr., M.D., *7700 Irvine Center Drive, Suite 530, Irvine, CA 92618*
Keith W. Young, M.D., *10780 Santa Monica Boulevard, Suite 250, Los Angeles, CA 90025-4749*
Participants: Jacqueline M. Melonas, J.D. Martin G. Tracy, J.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to know 10 key tips to avoiding lawsuits and malpractice; to know the three most frequent reasons why psychiatrists are successfully sued; to understand different types of malpractice insurance.

SUMMARY:

This is part one in a three-part comprehensive course that provides you all the information you need to launch a successful private practice. It is composed of two workshops and one symposium all on one day and has been offered for the last seven years. Even if you are not in private practice this course will offer lots of useful information that will assist you in launching your career. Our material is constantly updated with up-to-the-minute solutions from our faculty with thriving practices.

In part one we focus on risk management, avoidance of malpractice suits, ways to maximize quality, and high-risk issues that you must address in your practice. Drs. Callahan and Young are joined by experts in the field Jackie Melonas, J.D., vice president, risk management, Professional Risk Management Services; Martin Tracy, J.D., president/CEO, Professional Risk Management Services; and Donna Vanderpool, J.D., Professional Risk Management Services. Other sessions cover coding for maximum billing, marketing, office location and design, streamlining a practice, and business/financial principles.

REFERENCES:

1. Molloy P: Entering the Practice of Psychiatry: A New Physician's Planning Guide, Roering and Residents, 1996.
2. Practice Management for Early Career Psychiatrists, APA Office of Healthcare Systems and Financing, 1998.

Issue Workshop 31
PAIN MANAGEMENT OF THE CHEMICALLY DEPENDENT PATIENT

Chairperson: Jeffrey A. Berman, M.D., *Department of Psychiatry, New Jersey Medical School/UMDNJ, 30 Bergen Street ADMC 1507, Newark, NJ 07107*
Participants: Christine E. Skotzko, M.D., Elena Volfson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to 1) recognize that the need to treat pain and chemical dependency may coexist in the same patient, 2) demonstrate how to document the key elements of a pain history, and 3) discuss the differences between pseudoaddiction and substance use disorders.

SUMMARY:

Pain management of chemically dependent patients poses unique challenges. Inadequate management of chronic pain is widespread, despite the availability of safe, easily administered medications. The prevalence of chronic pain in the American population is 18% (26 million), with 56% of all individuals with chronic moderate to severe pain suffering for more than five years. Pain that was severe enough to interfere significantly with level of function and quality of life was common as was the incidence of anxiety and depression (four times greater than in the non-pain cohort).

Chronic pain interferes with the following activities: sleep, exercise, sexual activity, concentration, and job attendance. Individuals who are, or have been diagnosed with DSM-IV substance use disorders (SUD) (including alcohol), account for 8%-13% of the population. Treatment of pain in these individuals requires a special understanding of the elements of diagnosis and approaches to management.

Skills to be developed by clinicians will include: 1) assessment of the chemically dependent patient with pain, 2) medication prescription that does not worsen the SUD, 3) assessment for aberrant behaviors, suggestive of an existing or emerging SUD related problem, 4) regulatory issues mandated by JCAHO, the DEA, and state licensing boards when treating this challenging population.

REFERENCES:

1. Breitbart W, Rosenfeld BD, Passick SD, et al: The undertreatment of pain in ambulatory AIDS patients. Pain 1996; 65:239–245.
2. Merskey H, Bogduk N: Classification of Chronic Pain, 2nd Edition. Seattle, WA, IASP Press, 1994.

Issue Workshop 32
STRATEGIES FOR SUCCESS FOR EARLY CAREER ACADEMIC PSYCHIATRISTS, PART 1: WRITING FOR PUBLICATION
Collaborative Session With the National Institute of Mental Health

Chairperson: Laura W. Roberts, M.D., *Department of Psychiatry, Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, WI 53226*

EDUCATIONAL OBJECTIVE:

To improve participants understanding of peer review journal publication process, to identify personal strengths as a writer, and to provide information about roles of editors, authors, reviewers in publication.

SUMMARY:

This workshop is a down-to-earth, hands-on introduction to the essential skills of writing manuscripts for publication in peer-reviewed academic medical journals. In helping participants to build their writing skills, the course will involve presentation of valuable and detailed information on the framework of empirical and conceptual manuscripts and of specialized format papers, such as annotated bibliographies, review papers, brief reports. Participants will be introduced to the process of getting a paper published, including manuscript preparation, submission, editorial review, peer-review, revision and resubmission, editorial decision-making, and publication production. This process will be discussed in a step-by-step fashion, giving insights from the perspective of writers, reviewers, and editors. Specific strategies for assessing one's strengths and motivations as a writer and collaborator, for choosing the "right" target journal for a paper, for selecting the "right" presentation of the content, for responding to reviewers' concerns, and for working with editors will be addressed. I will also cover important but seldom discussed

considerations related to collaboration with co-authors, authorship "ethics," and scientific integrity issues. This workshop will involve interactive learning and Q-and-A formats, and it will have a tone of warmth and collegiality. It is aimed at enhancing the skills of early and middle career academic psychiatrists, but will be valuable for more senior faculty who serve as mentors, senior authors, and guest editors. Up-to-date resource materials will be provided to all participants.

REFERENCES:

1. Kay J, Silberman EK, Pessar L. (eds): Handbook of Psychiatric Education and Faculty Development. Washington, D.C., American Psychiatric Press, 1999.
2. Roberts LW, Coverdale J, Edenharder K, Louie A: How to review a manuscript: a 'down to earth' approach. Academic Psychiatry 2004; 28:81–87.

Issue Workshop 33
DECISIONAL CAPACITY IN THE CONSULTATION/ LIAISON SETTING: CONTROVERSIES AND DIFFICULTIES

Chairperson: Ramaswamy Viswanathan, M.D., *Department of Psychiatry, State University of New York, Downstate Medical Center, 450 Clarkson Avenue, Campus Box 127, Brooklyn, NY 11203-2098*
Participants: Paul S. Appelbaum, M.D., Barbara K. Schindler, M.D., Scott Y. Kim, M.D., Laura B. Dunn, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize nuances in decisional capacity assessments in complex medical situations, learn how to balance competing ethical and legal principles in difficult situations, and learn how to optimize decision making when information available is limited.

SUMMARY:

We will explore some practical difficulties and controversies in decisional-capacity assessments in the medical-surgical setting, and the need to re-examine some concepts. While competence is technically a judicial determination, because of the urgency of situations and difficulties in getting judicial determination, the opinion of the consulting psychiatrist often becomes the determining event. When nonpsychotic factors influence decision making, reasonable physicians can disagree on capacity determination. What does one do when craving for cigarettes or illicit drugs drives a patient in a coronary care unit to want to leave? A claustrophobic patient refuses an MRI or surgery? Fear of needles, unarticulated or exaggerated fear of invasive procedures, or anxiety-driven minimization result in treatment refusals? Can we risk substantial harm to a patient by respecting his autonomy, when he refuses to cooperate with our examination, and as a result we are unable to find clear and convincing evidence of mental impairment to override his autonomy? We will also explore the applicability to the medical-surgical setting of legal decisions made for psychiatric settings. We will depict some case scenarios, get the panelists' and the audience's opinions on them, and open up the workshop to other issues or situations.

REFERENCES:

1. Ganzini L, Volicer L, Nelson W, Derse A: Pitfalls in assessment of decision-making capacity. Psychosomatics, 2003; 44:237–243.
2. Grisso T, Appelbaum PS, Hill-Fotouchi C: The MacCAT-T: a clinical tool to assess patients' capacities to make treatment decisions. Psychiatr Serv, 1997; 48:1415–1419.

Issue Workshop 34
PSYCHIATRIC HOSPICE ON AN ACT TEAM: WHEN MENTAL ILLNESS IS TERMINAL

Co-Chairpersons: Curtis N. Adams, Jr., M.D., *PACT Team, 630 West Fayette Street, 4 East, Baltimore, MD 21201*
Ann L. Hackman, M.D., *Programs Assertive Community Treatment, University of Maryland Medical Center, 630 West Fayette Street, 4 East, Baltimore, MD 21201*

EDUCATIONAL OBJECTIVE:

Participants will recognize opportunities to apply techniques of psychiatric hospice in an outpatient setting.

SUMMARY:

The idea of a psychiatric hospice facility for individuals unable to succeed in the community has been suggested, and a palliative care approach is often used with psychiatric illness such as dementia. However the literature does not address the possibility of a hospice approach to outpatient treatment. This workshop describes our experience at the University of Maryland's Assertive Community Treatment (ACT) team in working with a small subgroup of patients whose diseases including severe mental illnesses, substance use disorders, and somatic illnesses, which, despite the most intensive efforts, are treatment refractory. Psychiatric hospice is an approach to care that acknowledges that some diseases are terminal. Hospice treatment involves a more supportive, less aggressive approach to the patient that changes and often reduces expectations for both staff and patient. It may improve the therapeutic relationship by recasting the illness as the enemy and allowing the patient and staff to join together in coping with their powerlessness over the illness. The panel will briefly consider the literature, describe their experience with psychiatric hospice including modifications in the ACT model and the impact of the approach for both patients and staff. Then with the audience we will explore the clinical and ethical issues involved with psychiatric hospice.

REFERENCES:

1. Craun MJ, Watkins M, Hefty A: Hospice care of the psychotic patient. Am J Hospice Palliat Care 1997: July–Aug; 14:205–8
2. Levin SM, Feldman MB: Terminal illness in a psychiatric patient—issues and ethics. S Afr Med J 1983:63:492–4.

Issue Workshop 35
DETECTION OF MALINGERING IN DISABILITY EVALUATIONS

Chairperson: Roger Z. Samuel, M.D., *Boca Raton Psychiatric Group, 7284 W Palmetto Park, Suite 201, Boca Raton, FL 33433-3439*
Participants: Tom McLaren, Ph.D., Lawrence Gordon

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize and diagnose malingering in disability applicants/ claimants.

SUMMARY:

One of the more difficult conditions to assess is malingering, especially in civil disability cases, yet this is frequently requested by referral sources. The panel consists of a psychiatrist, a forensic psychologist, and a plaintiff attorney who focuses on disability litigation. The psychiatrist will present factors that suggest malingering. A scale to measure this will be proposed. The neuropsychologist will present psychological tests used to assess malingering. The attorney will discuss how such assessments might be refuted by opposing counsel and will discuss how claimants' attorneys buttress

their cases and discredit opposing psychiatrists' evaluations and testimony. Discussion and questions by the audience will be encouraged.

REFERENCES:

1. Clinical Assessment of Malingering and Deception, 2nd Ed, Richard Rogers, Guilford Press (1997).
2. Mittenberg, W., Patton, C., Canyock, E & Condit D: Base rates of malingering and symptom exaggeration. Journal of Clinical and Experimental Neuropsychology 2002.

Issue Workshop 36
TEACHING PSYCHOSOMATIC MEDICINE FOR PRIMARY CARE PHYSICIANS: WHAT, HOW, AND WHERE?

Chairperson: Hoyle Leigh, M.D., *Department of Psychiatry, University of California, 445 South Cedar Avenue, Fresno, CA 93702*
Participants: Don R. Lipsitt, M.D., Seth M. Powsner, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize the role of the consultation-liaison psychiatrist in the education of the primary care physician in various settings and venues.

SUMMARY:

This workshop will explore, the role of the consultation-liaison psychiatrist in the education of the primary care physician. The moderator of this workshop (HL) will briefly present the findings of a survey of directors of training of primary care residencies demonstrating their perceived need for training of psychosomatic medicine in their curriculum—somatoform disorders, psychological factors affecting physical illness, physical factors affecting emotions/behavior, eating disorders, bereavement and grief, and the dying patient. Dr. Lipsitt will discuss the perceived needs and practice of primary care physicians in caring for medically unexplained symptoms, based on primary care physician focus groups. Dr. Powsner will discuss and demonstrate the effectiveness of the emergency room setting for the teaching of psychiatry and psychosomatic medicine in a multimedia presentation. Presentations will be limited to 45 minutes, with 45 minutes for discussion with the audience. The discussion is expected to stimulate consultation-liaison psychiatrists and psychiatric educators to develop a set of minimal competencies in psychosomatic medicine for primary care physicians and to generate ideas that will lead to the development of more effective and efficient curricular models.

REFERENCES:

1. Hodges B, Inch C, Silver I: Improving the psychiatric knowledge, skills, and attitudes of primary care physicians, 1950-2000: a review. Am J Psychiatry 2001; 158:1579–1586.
2. Leigh H (Editor): Biopsychosocial Approaches in Primary Care: State of the Art and Challenges for the 21st Century. Plenum Press, New York, 1997.

Issue Workshop 37
SHAKESPEARE, PSYCHIATRY, AND PSYCHOPATHOLOGY

Chairperson: Steven E. Pflanz, M.D., *Department of Psychiatry, McGuire Air Force Base, 4348 Prestwick Road, McGuire AFB, NJ 08641*
Participant: Charles R. Joy, M.D.

EDUCATIONAL OBJECTIVE:

To understand that Shakespeare's works are windows into the human unconscious that can be examined to better understand the difficult life issues that both psychiatrists and their patients grapple with.

SUMMARY:

The enduring popularity of William Shakespeare's plays over the past 400 years speaks to his unique ability to capture the issues that vex and inspire the human condition. Through the theater, Shakespeare opened windows into the emotions and impulses that populate the human unconscious. This workshop examines the role of drama in both the professional and personal lives of psychiatrists. The themes explored in Shakespeare's theater help us understand from a different perspective the difficult issues that our patients grapple with in therapy. The plays that we find most gripping or poignant tell us something about our own unconscious world and help us reach a greater degree of self-understanding. Throughout his works, Shakespeare created vivid characters suffering from mental illness and/or personality pathology. In this workshop, the audience will listen to readings of short scenes from Shakespeare, discussing each piece as it is presented. The material will be chosen from such plays as Macbeth, Hamlet, King Lear, Othello, Richard III, and Julius Caesar. The coup de grace will be a short performance of a classic Shakespeare scene by the facilitators. Throughout the workshop the audience will participate in a lively discussion exploring the connection between the theater and the unconscious for both ourselves and our patients.

REFERENCES:

1. Shakespeare W: Macbeth. New York, Washington Square Press, 1992.
2. Shakespeare W: Richard III. New York, Washington Square Press, 1996.

Issue Workshop 38
UNCOVERING MEDICAL CAUSES OF FUNCTIONAL DECLINE IN THE DEVELOPMENTALLY DISABLED

Chairperson: Stephen M. Soltys, M.D., *Southern Illinois University, 3605 Branonshire Drive, Springfield, IL 62704*
Participants: Rodney C. Curtis, M.D., Klara I. Curtis, M.D., Steven L. Thornton, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize commonly missed causes of functional decline in the developmentally disabled.

SUMMARY:

When evaluating patients with developmental disabilities who present with a deterioration in cognitive, behavioral, or motor functioning, psychiatrists must keep in mind that many medical conditions may present with functional decline. Often these medical conditions are missed by internists or other physicians who are not used to working with the developmentally disabled. In this highly interactive workshop, four psychiatrists with expertise in developmental disabilities will help participants to recognize these conditions. Dr. Klara Curtis will provide an overview of somatic disorders and their manifestations in the developmentally disabled population. Dr. Steve Thornton will focus on uncontrolled seizure as a cause of behavior decline, and Dr. Rod Curtis will talk about undiagnosed spinal cord compromise. Dr. Soltys will talk about general principles of consultation with the developmentally disabled population. Ample time will be provided for discussion among workshop participants.

REFERENCES:

1. Curtis R, et al. Spinal cord compromise: an important but underdiagnosed condition in people with mental retardation. Public Health Rep 2004; 119:396–400.

2. What do you do when they grow up? approaches to seizures in developmentally delayed adults. Epilepsia 2002; (Suppl 3):71–79.

Issue Workshop 39
DRUG COMPANIES IN TRAINING CLINICS: ECONOMIC NECESSITY VERSUS UNDUE INFLUENCE

Co-Chairpersons: Edward A. Volkman, M.D., *Temple University School of Medicine, 1316 West Ontario Street, Philadelphia, PA 19140*
Ruth M. Lamdan, M.D., *Department of Psychiatry, Temple University School of Medicine, 1316 West Ontario Street, Jones Hall, Philadelphia, PA 19140*
Participants: Roya Lewis, M.D., Robert L. Boyd, M.D., Autumn Ning, M.D., Darryl Atherholt, Diane B. Gottlieb, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize the complexities of the relationships among the pharmaceutical industry, the medication needs of clinic patients, the housestaff's educational needs, and the administrative responsibilities of training programs. (S)he should be able to formulate a policy that ethically resolves these competing interests to the maximum benefit of the interested parties.

SUMMARY:

The pharmaceutical market has become increasingly competitive, and drug companies are being subjected to ever greater scrutiny with respect to both their marketing devices and their reporting of clinical trials. In this context the prescribing practices of physicians and soon-to-be physicians are crucial to the drug companies.

As the availability of breakthrough drugs leading to blockbuster sales diminishes, the importance of delineating drug differences within a category that will lead to preferential prescribing of a particular drug based on those differences becomes critical. Residents form a group of special interest from a marketing point of view both because prescribing habits formed in residency tend to persist into practice, and because they are unusually open to influence by dint of their career stage and relative inexperience.

We will present brief outlines of how this environment is perceived by a pharmaceutical representative, four residents with varying educational and administrative responsibilities in a training clinic, two faculty charged with running the clinic, and a training director. The workshop will stimulate discussion among the participants with the goal of producing a consensus on what policy, if any, a training clinic ought to have with regard to resident contact with pharmaceutical representatives.

REFERENCES:

1. Watkins RS, Kimberly J Jr: What residents don't know about physician-pharmaceutical industry interactions. Academic Medicine 2004; 79:432-7.
2. Chakrabarti A, Fleisher WP, Staley D, Calhoun L: Interactions of staff and residents with pharmaceutical industry: a survey of psychiatric training program policies. Annals of the Royal College of Physicians & Surgeons of Canada 2002; 35(8 Suppl.):541–6.

Issue Workshop 40
DRIVING MISS DAISY

Co-Chairpersons: Theron C. Bowers, Jr., M.D., *Veterans Administration Medical Center, 2002 Holcombe Boulevard, Houston, TX 77030*
Sheila M. Loboprabhu, M.D., *Department of Psychiatry, Veterans Administration Medical Center, 116 Gero, 2002 Holcombe Boulevard, Houston, TX 77030*
Participants: Jeffrey Lindeman, Psy. D., Kelly C. Anderson

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, participants will be able to evaluate and manage driving risks in those living with dementia.

SUMMARY:

Driving is an issue that always arises at sometime during the course of a patient's dementia. Sometimes families may manage driving issues without professional involvement. However, clinicians caring for patients with dementia are often faced with concerns about driving. Clinicians also often must educate the families about potential risks. This workshop will focus on issues involving driving, such as automobile accidents among seniors and driving with early dementia. Office-based evaluation of driving will also be reviewed, as will legal issues regarding confidentiality and liability. Additional use of consultations in the driving evaluation will also be discussed. A psychologist will review how neuropsychological testing can identify specific cognitive problems related to driving. A kinesiotherapist will also present information about driver evaluation by direct observation. The workshop will also review the importance of driving in the lives of the elderly and helping patients cope with the loss of driving ability. The audience will participate during a question-and-answer session at the end of the presentation.

REFERENCES:

1. Dobbs BM, Carr DB, Morris JC: Evaluation and management of the driver with dementia. Neurologist 2003; 8:61–70.
2. Dubinsky RM, Stein AC, Lyons K: Practice parameter: risks of driving and Alzheimer's disease (an evidence-based review): report of the quality standards subcommittee of the American Academy of Neurology. Neurology 2000; 54:2205–2211.

Issue Workshop 41
PSYCHIATRISTS INTERVENING UPSTREAM: GOOD PRACTICES FOR PREVENTING VIOLENCE IN CHILDREN, YOUTH, AND FAMILIES
Collaborative Session With the National Institute of Mental Health

Chairperson: Guiseppe Raviola, M.D., *Department of Psychiatry, Massachusetts General Hospital, 15 Parkman Street, WACC-812, Boston, MA 02114*
Participants: Carl C. Bell, M.D., W. Rodney Hammond, Ph.D., Fran Henry, M.B.A., Mark L. Rosenberg, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand violence in children, youth and families as behavior that can be prevented. Participants will incorporate this understanding into their clinical practice, learning how to address specific types of violent behavior in the psychiatric setting with patients and families.

SUMMARY:

The past decade has seen the creation of effective programs for the prevention of youth violence as a result of the efforts of researchers, health care professionals, and school and community officials. Bringing together clinicians with researchers from the Division of Violence Prevention, Centers for Disease Control, and child advocates, this workshop aims to change the way participants think about the treatment and prevention of violence in youth and to propose best practices in treatment and preventive intervention from a psychiatric perspective. Psychiatrists have a critical role to play in addressing risk factors leading to interpersonal violence and in increasing the number of protective factors for the child, the parent-child environment, and the wider environment. At the conclusion of this workshop participants will be able to describe the developmental pathways of violent behavior, the context within which these behaviors occur, and the intervenable risk factors for these behaviors; they will know

why they should ask patients about these risk factors; they will know how to ask patients about risk factors for violence and will know what to suggest for patients when these risk factors are present; and they will not be reluctant to ask about these risk factors when present.

REFERENCES:

1. Dahlberg LL, Potter LB: Youth violence: developmental pathways and prevention challenges. American Journal of Preventive Medicine 2001; 20:3–14.
2. Committee on Preventive Psychiatry, Group for the Advancement of Psychiatry: Violent behavior in children and youth: preventive intervention from a psychiatric perspective. Journal of the American Academy of Child and Adolescent Psychiatry 1999; 38:235–41.

Issue Workshop 42
CULTURAL COMPETENCE IN THE CLINICAL ENCOUNTER: IRMA BLAND AND EVELYN LEE

Chairperson: Francis G. Lu, M.D., *Department of Psychiatry, San Francisco General Hospital, 1001 Potrero Avenue, Suite 7M, San Francisco, CA 94110*
Participant: Harriett Koskoff

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand cultural issues related to interpersonal communication and professionalism when working with African Americans and Asian Americans.

SUMMARY:

This workshop will explore cultural issues as they relate to the interpersonal communication and professionalism as experienced in the clinical encounter. Two new training videotapes will be shown, each 19 minutes in length, that consist of interviews of Irma Bland, M.D., and Evelyn Lee, Ed.D., speaking about African-American and Asian-American issues, respectively. Both were pioneering spirits for cultural competence who passed away prematurely in 2003. The American Psychiatric Association has established the Irma Bland Award for Excellence in Teaching Residents to begin in 2005. Dr. Bland was clinical professor of psychiatry at LSU, and Dr. Lee was clinical professor of psychiatry at UCSF. The videotapes were co-directed by filmmaker Harriet Koskoff and Francis Lu, the same team that created the training videotape "The Culture of Emotions," shown at the 2004 APA Annual Meeting. Brief case vignettes and patient scenarios will also be presented to illustrate the speakers' discussion about communication, respect, and relationships (including transference and countertransference). These issues will also be linked with the DSM-IV-TR Outline for Cultural Formulation, a concise clinical tool to bring cultural issues into clinical practice.

REFERENCES:

1. Gaw A: The Concise Guide to Cross-Cultural Psychiatry. American Psychiatric Publishing Inc., Washington, DC, 2001.
2. Group for the Advancement of Psychiatry: Cultural Assessment in Clinical Psychiatry. Washington, DC, American Psychiatric Publishing Inc, 2002.

Issue Workshop 43
A NEW MODEL FOR THE TREATMENT OF RELATIONAL DISORDERS

Co-Chairpersons: Glenn N. Siegel, M.D., *Elmhurst Healthcare, 183 North York Road, Elmhurst, IL 60126*
Mary Pittman, M.S., *Elmhurst Healthcare, 183 North York Road, Elmhurst, IL 60126*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to describe the values-based model in the treatment of personality disorders, implement the use of this model in his/her own clinical setting, address severe destructive behaviors in patients according to this values-based model.

SUMMARY:

The presenters' extensive experience in the programmatic treatment of personality disorders has led them to reconceptualize this diagnostic category as disorders of relationship. The common denominator in all relational disorders is varying degrees of disconnection from self and others. This state of disconnection is expressed through psychiatric symptoms, interpersonal disruption, and self-destructive behaviors. An innovative treatment model based on relational values has been developed and successfully implemented to guide individuals with relational disorders toward developing authentic connection to self and others. The model will be discussed in depth, with an example of case-history application. The simplicity of the paradigm to be presented demystifies the therapeutic process and creates a culture of collaboration between patient and therapist(s). The content of this workshop is expected to stimulate discussion and re-evaluation of traditional therapeutic approaches to the treatment of personality disorders.

REFERENCES:

1. Jordan J, Kaplan A, et al: Empathy, mutuality, and therapeutic change: clinical implications of a relational model. In Women's Growth in Connection. New York, Guilford Press.
2. Gilligan C, Lyons N, Hanmer T: Making Connections. Cambridge, Harvard University Press, 1990.

TUESDAY, MAY 24, 2005

Issue Workshop 44
TOPICS IN PSYCHOSOMATIC MEDICINE: FATIGUE IN CANCER AND AIDS
Collaborative Session With the National Institute of Mental Health

Co-Chairpersons: William Breitbart, M.D., *Department of Psychiatry, Memorial Sloan Kettering Hospital, 1242 Second Avenue, Box 421, New York, NY 10021-6007*
Andrew J. Roth, M.D., *Department of Psychiatry, Memorial Sloan-Kettering, 1242 2nd Avenue, New York, NY 10021*
Participant: William Pirl, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to differentiate fatigue from depression in cancer and AIDS; to manage fatigue pharmacologically and nonpharmacologically.

SUMMARY:

The workshop participants will have the opportunity to share their experiences in the management of fatigue in cancer and AIDS patients and interact with the presenters. The workshop will focus on the following: William Breitbart M.D.: *Overview of Fatigue in Cancer and AIDS.* An overview of the assessment and management of fatigue in cancer and AIDS will be presented. A comprehensive approach to the management of fatigue in cancer and AIDS will be presented. William Pirl, M.D.: *The Feasibility of Screening for Fatigue in a Thoracic Oncology Clinic.* A total of 342 patients in a thoracic oncology clinic were screened for fatigue with a one-item measure recommended by the National Comprehensive Cancer Network. The feasibility of routine screening for fatigue in a clinical setting will be described. Andrew Roth, M.D.: *Psychostimulants for Fatigue in Prostate Cancer.* Fatigue is a distressing symptom in up to 67% of prostate cancer patients. We are conducting an NIH-funded, double-blind, randomized, placebo-controlled trial evaluating the relative benefits and risks of methylphenidate in the treatment

of fatigue in ambulatory prostate cancer patients. The impact of psychostimulant treatment on fatigue, depressive symptom severity, and overall quality of life will be discussed.

REFERENCES:

1. Cella D, Davis K, Breitbart W, Curt G: Cancer-related fatigue: prevalence of proposed diagnostic criteria in a US sample of cancer survivors. Journal of Clinical Oncology 2001; 19:3385–3391.
2. Breitbart W, Rosenfeld B, Kaim M, et al: A randomized, double-blind, placebo-controlled trial of psychostimulants for the treatment of fatigue in ambulatory patients with HIV disease. Arch Internal Med 2001; 161:411–420.

Issue Workshop 45
HOW TO LAUNCH A SUCCESSFUL PRIVATE PRACTICE, PART 2

Co-Chairpersons: William E. Callahan, Jr., M.D., *7700 Irvine Center Drive, Suite 530, Irvine, CA 92618*
Keith W. Young, M.D., *10780 Santa Monica Boulevard, #250, Los Angeles, CA 90025-4749*
Participants: Tracy R. Gordy, M.D., Chester W. Schmidt, Jr., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand the use of codes for insurance to accurately reflect your work with patients; understand documentation requirements consistent with the codes you use; know where to go to get updated information on coding throughout your career.

SUMMARY:

This is part two in a three-part comprehensive course that provides you all the information you need to launch a successful private practice. It is composed of two workshops and one symposium all on one day. Offered for the last seven years and directed by faculty who have succeeded using this information. Even if you are not in private practice, this course will offer lots of useful information that will assist you in launching your career. Our material is constantly updated with up-to-the-minute solutions from our faculty with thriving practices. In part two, we focus on the complexities of using the insurance industry's procedure codes to accurately reflect your work with patients. Even if you intend to have a fee-for-service, cash-based practice, many patients will require "superbills" for insurance so they can get reimbursed. There are documentation requirements for each code, and not understanding them and following them can leave you prosecuted for fraud. Drs. Callahan and Young are joined by the two nationally recognized experts on coding who work with APA and AMA to make these codes and guidelines work. Chester Schmidt, M.D., and Tracy Gordy, M.D., will present and answer questions.

Early career psychiatrists, residents, and psychiatrists currently in or thinking about starting a private practice should benefit.

REFERENCES:

1. Practice Management for Early Career Psychiatrists, APA Office of Healthcare Systems and Financing, 1998.
2. Logsdon L: Establishing a Psychiatric Private Practice. Washington, D.C., American Psychiatric Press Inc., 1985.

Issue Workshop 46
STRATEGIES FOR SUCCESS FOR EARLY CAREER ACADEMIC PSYCHIATRISTS, PART 2: PROMOTION
Collaborative Session With the National Institute of Mental Health

Chairperson: Laura W. Roberts, M.D., *Department of Psychiatry, Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, WI 53226*

EDUCATIONAL OBJECTIVE:

To provide information on academic tracks and promotion procedures, help participants identify their academic strengths and potential weaknesses, and help participants adopt practical habits that help in preparing for academic promotion.

SUMMARY:

This workshop is a down-to-earth introduction to "strategies for success" for academic promotion for early career psychiatrists. Different academic tracks (e.g., traditional track, clinician educator track) and criteria for promotion will be explained. Timelines and procedures for academic promotion relevant to most institutions will be outlined. National data and trends in promotion will be presented. The workshop will focus primarily on 10 practical habits that may be adopted in preparing for academic promotion. Participants will identify their strengths and potential weaknesses and possible adaptive approaches to their weakness areas. This workshop will involve interactive learning exercises and Q-and-A formats and it will have a tone of warmth and collegiality. Up-to-date resource materials will be provided to all participants.

REFERENCES:

1. Kay J, Silberman EK, Pessar L: Handbook of Psychiatric Education and Faculty Development. Washington, D.C., American Psychiatric Press, 1999.
2. Roberts LW, Hilty D: Concise Guide for Early Career Academic Psychiatrists. Washington, D.C., American Psychiatric Press, (in preparation).

Issue Workshop 47
RESPONDING TO THE IMPACT OF SUICIDE ON CLINICIANS

Chairperson: Eric M. Plakun, M.D., *Department of Admissions, The Austen Riggs Center, 25 Main Street, P.O. Box 962, Stockbridge, MA 01262*
Participants: Jane G. Tillman, Ph.D., Edward R. Shapiro, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, participants should be able to enumerate psychotherapist responses to patient suicide and list practical recommendations for responding patient suicide from the personal, collegial, clinical, educational, administrative, and medico-legal perspectives.

SUMMARY:

It has been said that there are two kinds of psychiatrists—those who have had a patient commit suicide and those who will. Mental health clinicians often have less contact with death than clinicians from other environments. Nevertheless, each death by suicide of a psychiatric patient may have a more profound effect on psychiatric personnel than other deaths do on non-psychiatric colleagues because of powerful emotional responses to the act of suicide, and the empathic attunement and emotional availability that is part of mental health clinical work. This workshop offers results from a pilot study revealing eight thematic clinician responses to suicide: initial shock;

grief and sadness; changed relationships with colleagues; dissociation; grandiosity, shame, and humiliation; crises of faith in treatment; fear of litigation; and an effect on work with other patients. Recommendations derived from this and other studies are offered to guide individually impacted clinicians, colleagues, trainees, training directors, and administrators in responding to patient suicide in a way that anticipates and avoids professional isolation and disillusionment, maximizes learning, addresses the needs of bereaved family, and may reduce the risk of litigation. The workshop will include ample time for interactive discussion with participants about their own experiences with patient suicides.

REFERENCES:

1. Plakun EM: Principles in the psychotherapy of self-destructive borderline patients. Journal of Psychotherapy Practice and Research 1994; 3:138–148.
2. Powell J, Geddes J, Deeks J, et al.: Suicide in psychiatric hospital inpatients. British Journal of Psychiatry 2000; 176:266–272.

Issue Workshop 48
CANNABIS DEPENDENCE TREATMENT: WHERE WE ARE, WHERE WE ARE GOING
National Institute on Drug Abuse

Chairperson: Francis J. Vocci, Ph.D., *NIDA/NIH/HHS, 6001 Executive Boulevard, Room 4123, Bethesda, MD 20892-9551*
Participants: Carl Hart, Ph.D., Jack R. Cornelius, M.D., Frances R. Levin, M.D., Alan I. Green, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to recognize the signs and symptoms of cannabis dependence and withdrawal, the investigational pharmacological approaches, and abuse and complications in comorbid psychiatric populations.

SUMMARY:

After alcoholism, cannabis dependence is the most common substance abuse disorder in the United States. An underappreciated fact is that the lifetime prevalence of cannabis dependence is 9 percent of the population that uses cannabis. In 2002, 975,000 of the 3,300,000 people treated for an alcohol or substance abuse disorder were treated for cannabis dependence; the majority of them were adolescents. Thus, the practicing psychiatrist is likely to have cannabis-abusing patients when treating adolescents, alcohol dependence, depression, and schizophrenia. This workshop will have four presentations on cannabis dependence and withdrawal, treatment of cannabis dependence, investigational approaches using medications to treat the primary disorder or comorbid psychiatric disorders, and future directions in research. The current state of the science of cannabis dependence and withdrawal will be presented. Clinicians presenting will draw on both their research and practice experience to engage the audience in discussion of treatment of patients with the primary disorder and treatment of more complicated, comorbid cases. Presentations will take no more than one hour. Following the presentations, a discussion will be conducted. This workshop should be of interest to adolescent psychiatrists, addiction psychiatrists, practitioners of adult psychiatry, nurse practitioners, and psychiatric nurses.

REFERENCES:

1. Haney M, Hart C, et al: Marijuana withdrawal in humans: effects of oral THC or diralproex. Neuropsychopharmacology 2004; 29:158–70.
2. Cornelius JR, et al: Fluoxetine versus placebo for marijuana use in depressed alcoholics. Addictive Behaviors 1999; 24:111–4.

Issue Workshop 49
BOUNDARIES AND SUPERVISION: AVOIDING LEGAL RISKS AND DOING GOOD CLINICAL WORK

Chairperson: Werner Tschan, M.D., *Neuensteiner Strasse 7, Basel 4053, Switzerland*
Participants: Robert I. Simon, M.D., Linda M. Jorgenson, J.D., Gary R. Schoener, Psy.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to analyze boundaries from a risk management perspective, properly document supervision, understand vicarious vs. direct liability.

SUMMARY:

The last two decades were marked by many licensure board actions and civil suits in which boundary violations were alleged. In many "negligent supervision was claimed." The first panelist, a clinical and forensic psychiatrist, will examine what is known about the more common boundary violations that may form a "slippery slope" in terms of violating the standard of care for psychiatric treatment. The realities of clinical practice bring about situations in which there are gray areas as regards the maintenance of boundaries.

The second presenter, an attorney, will examine the role of consultation and supervision in examining proposed boundary crossings as well as documentation that will provide for both a good clinical record and risk-management protection. This will include a discussion of common supervisory failures and the types of things that emerge in legal cases as "negligent supervision." She will differentiate vicarious from direct liability.

The third presenter, a clinical and forensic psychiatrist from Europe, will discuss the issues and challenges in the arena of professional boundaries that have emerged in Europe. He will also discuss the role of supervision and consultation in preventing problems, in providing for early intervention in troubled situations, and as part of remediation for practitioners who have been disciplined.

As important as supervision is, there is rarely any formal training provided to psychiatrists and mental health professionals about how to do it effectively. The final presenter, a clinical psychologist, will examine some methods of teaching supervision skills to those who might be supervising clinicians. It is hoped that audience discussion will focus on both the handling of challenges to professional boundaries and the role of consultation and supervision as an aid to the trainee and the practitioner.

REFERENCES:

1. Lifson L, Simon R: Mental Health Practitioners and the Law. Cambridge, MA, Harvard University Press.
2. Gabbard G, Wilkinson S: Management of Countertransference With Borderline Patients. Washington, DC, American Psychiatric Press.

Issue Workshop 50
PSYCHIATRIC COMORBIDITIES IN HIV INFECTION
Collaborative Session With the National Institute of Mental Health

Chairperson: David Stoff, Ph.D., *National Institute of Mental Health, 6001 Executive Boulevard, Room 6210, Bethesda, MD 20892-9619*
Participants: Francine Cournos, M.D., Marshall Forstein, M.D., Stanley Rosenberg, Ph.D., Larry K. Brown, M.D., Ezra S. Susser, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this symposium, the participant should be able to identify the magnitude/scope of the problem of psychiatric

comorbidities (especially severe mental illness) in HIV disease, risk factors, clinical complications, and most promising forms of treatment and preventive interventions for co-occurring mental health-related disorders in HIV infection.

SUMMARY:

Psychiatric comorbidities in HIV infection are becoming more apparent as HIV-infected patients live longer due to the advent of efficacious antiretroviral therapies. Thus, the face of the epidemic has changed in the U.S. to a chronic, heterogenous disease in which "non-HIV" comorbid conditions impact on the nature, progression and treatment of HIV disease. This symposium will address one of the most common psychiatric comorbidities—severe mental illness (SMI)—that may be preexisting or secondary to HIV infection. The goal is to marshal the latest empirical research on co-occurrence of SMI (and other related psychiatric comorbidities), in the context of HIV infection, that will suggest treatments and preventive interventions to relieve the burden of the combined impact of these conditions. Francine Cournos will review the latest findings on the epidemiology and management of co-occurring HIV infection, mental illness, and substance use in the United States. Marshall Forstein will concentrate on the most challenging clinical psychiatric issues that arise in the course of treating patients infected with HIV (e.g., psychiatric comorbidity, treatment decision making about antiretrovirals, adherence, pain management, disease progression). Stanley Rosenberg will present data on the extraordinarily high prevalence of HCV among persons with SMI who are also HIV-infected and its associations with psychiatric and psychosocial factors (e.g., illness severity, drug abuse, poverty, homelessness, incarceration, minority status). Larry Brown will report on promising intervention strategies for reducing HIV-related risk behaviors in adolescents with psychiatric disorders. This symposium concludes with a discussion led by Ezra Susser who will facilitate participant-audience interaction to integrate the research on psychiatric comorbidities in HIV infection and suggest new directions for a research agenda on the topic.

REFERENCES:

1. Dausey DJ, Dasai RA: Psychiatric comorbidity and the prevalence of HIV infection in a sample of patients in treatment for substance abuse. Journal of Nervous and Mental Disease 2003; 191:10–17.
2. Douaihy AB, Jou RJ, Gorske T, Salloum IM: Triple diagnosis: dual diagnosis and HIV disease, part I. AIDS Read 2003; 13:331–341.

Issue Workshop 51
RENEWING INTEGRITY THROUGH FILM: AN ESSENTIAL VIRTUE OF PROFESSIONALISM

Chairperson: Francis G. Lu, M.D., *Department of Psychiatry, San Francisco General Hospital, 1001 Potrero Avenue, Suite 7M, San Francisco, CA 94110*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand how integrity is an essential virtue of professionalism and understand how films can be used to evoke the virtue of integrity.

SUMMARY:

Integrity is an essential virtue of professionalism in the fields of medicine, psychology, social work and nursing. The American Board of Psychiatry and Neurology core competencies reference includes integrity in its description of professionalism, one of the six core competencies. Erik Erikson wrote at the end of his life that he considered integrity the highest stage of human development. How can integrity be renewed in our professional lives as clinicians and teachers, when in the words of Blaise Pascal: "Truth's so darkened nowdays, and lies so established, that unless we love the truth we will never know it."? The great scholar of mythology Joseph Campbell has written: "The images of myth are reflections of the spiritual potentialities of every one of us. Through contemplating these, we evoke their power in our own lives." This workshop, based on the presenter's film seminar at Esalen Institute, will engage the audience in the experience of using the following films, like images of myth, to evoke the virtue of integrity: "To Kill a Mockingbird," "Rashomon," "Rules of the Game," "Paths of Glory," "Fog of War," "The Insider," "The King of Masks," "Roman Holiday."

REFERENCES:

1. C. Peterson, M. Seligman: Character Strengths and Virtues. New York, Oxford University Press, 2004.
2. American Board of Psychiatry and Neurology: Core Competencies for General Psychiatry, Deerfield, III, author, January, 2004.

Issue Workshop 52
THE LONG-TERM EFFECTS OF VIOLENCE IN SHAPING MINORITY COMMUNITIES

Co-Chairpersons: Napoleon B. Higgins, Jr., M.D., *412 Stockbridge Lane, Dickinson, TX 77539*
Aruna S. Rao, M.D., *Cambridge Health Alliance, 50 Craigie, Apartment 25, Summerville, MA 02143*
Participants: Jean-Marie E. Alves-Bradford, M.D., Eric R. Williams, M.D., Quinton E. Moss, M.D.

EDUCATIONAL OBJECTIVE:

To learn how violence effects interactions in minority communities; recognize unique perceptions and expressions of trauma in African-American, Latino, Asian, and refugee communities in the United States; and enhance outreach efforts to improve care for the minority patient.

SUMMARY:

The purpose of this talk is to present a novel minority perspective on issues regarding trauma. We will specifically focus on the views of African-American, Latino, Asian, and refugee communities in the United States. Currently, psychiatry is focusing on cross-cultural differences and disparities in treatment, assessment, and diagnosis in minority groups. What makes this talk unique is that it will concentrate on resiliency and coping mechanisms in minority communities and how those communities view trauma, communicate symptoms, and resist acceptance of mental illness. This talk will address obstacles in seeking treatment, such as cultural and language barriers, as well as difficulties in therapeutic alliance between the patient and professionals and how clinicians are viewed by the minority community. Many cultures deny that mental illness occurs in their population and often believe that it is a "white American majority" problem that does not affect them. By the end of this talk, the participant will know how to identify resilient factors within minority groups, how violence shapes minority communities, cultural barriers to treatment, and facilitate exchange between mental health professionals and the minority community. With this seminar we hope to advance intervention, education, and advocacy for minority populations.

REFERENCES:

1. Fullilove M, Heon V, Jimenez W, et al: Injury and anomie: effects of violence on an inner-city community. Am J Public Health 1998; 88:924–927
2. Ziggurats S, Klimidis S, Lewis N, Stuart G: Ethnic matching of clients and clinicians and use of mental health services by ethnic minority clients. Psychiatric Services 2003; 54:535–541.
3. Barbarin OA: Coping and resilience: exploring the inner lives of African-American children. Journal of Black Psychology 1993; 19:478–492.

Issue Workshop 53
THE MOVIES AND THE MIND

Chairperson: Willem C. Tuinebreijer, *GGD Amsterdam, Nieuwe Teertuinen 14A, Amsterdam 1013LV, Netherlands*
Participants: Rudolf A. Feijen, M.D., Bastiaan L. Oele, M.D., Josephine Caubel, M.D.

EDUCATIONAL OBJECTIVE:

The objective of this session is to increase awareness of the possibilities for using cinema to benefit both patients and psychiatrists. Film can be a vehicle for educating psychiatry, as well as a therapeutic tool. Portrayal of psychiatry in cinema shapes the patient's and his family's perceptions and expectations.

SUMMARY:

For a number of reasons, psychiatrists should go to the movies. Cinema, more so than other media, has a high narrative strength, emotional impact, and accessibility. First of all, films are of great value for those who teach and learn psychiatry. They can provide an enjoyable, intense, and varied body of case studies without clinical responsibility. What's more, the public's vision of madness and psychiatric treatment is influenced by what they see on the white screen. Discussing this with our patients can help us to improve the therapeutic relationship. Other possibilities of using film in psychiatric practice will be discussed, for instance as psychoeducational material or as a tool in psychodynamic therapies. Contemporary film fragments will be shown to illustrate these views. The audience will be invited to participate in an interactive discussion with the panelists.

REFERENCES:

1. Engstrom F: Movie Clips for Creative Mental Education. Library of ccc, nr 2003116258, 2004.
2. Gabbard GO: Psychiatry and the Cinema. Washington, DC, American Psychiatric Press Inc, 1999.

Issue Workshop 54
AMERICAN INDIAN TELEPSYCHIATRY: BRIDGING CULTURE AND DISTANCE

Chairperson: James H. Shore, M.D., *Department of Psychiatry, University of Colorado Health Sciences Center, AIANP, P.O. Box 6508, Mail Stop F800, Aurora, CO 80045*
Participants: Douglas K. Novins, M.D., Gilbert Jarvis, Daniel M. Savin, M.D.

EDUCATIONAL OBJECTIVE:

To 1) become familiar with models for telepsychiatric care in American Indian and Alaska Native communities; 2) understand the impact of telepsychiatry on the assessment, diagnosis, and provision of care for American Indian veterans and children; 3) recognize the importance of cultural issues in telepsychiatric work with these groups.

SUMMARY:

Over the past three years the University of Colorado Health Sciences Center's American Indian and Alaska Native Programs (AIANP) has run a series of telepsychiatry services that provide ongoing and consultative psychiatric care for American Indian and Alaska Native communities. These services include: 1) a series of weekly clinics focused on medication management, and ongoing groups/individual psychotherapy for veterans with PTSD; 2) consultative services for Indian children with serious mental health problems; 3) psychiatric and medical consultations to an Alaska nursing home with a high percentage of Alaska Native elders.

The presenters will include three AIANP psychiatrists who have been involved in these services and a tribal veteran who works as an outreach worker and community liaison in one of the PTSD clinics located on a rural reservation. The presenters will discuss their experiences in the implementation and administration of these services and models of service delivery. Aspects of telepsychiatric care to be discussed include assessment and diagnosis of Indian veterans and children, medication management, group/individual psychotherapy treatment of PTSD, cultural aspects of care, and incorporation of traditional healers into treatment. During audience discussion, videotaped examples of telehealth sessions will be shared.

REFERENCES:

1. Shore JH, Manson SM: The American Indian veteran and posttraumatic stress disorder: a telehealth assessment and formulation. Culture, Medicine, and Psychiatry 2004; 28:231–243.
2. Shore JH, Manson SM: Rural telepsychiatry: a developmental model. Psychiatric Services. In press.

Issue Workshop 55
CHRONIC FATIGUE SYNDROME AND GULF WAR ILLNESS: PATHOLOGY OR ABNORMAL ILLNESS BEHAVIOR?

Chairperson: Peter Manu, M.D., *Department of Psychiatry, Zucker Hillside Hospital, 75-59 263rd Street, Glen Oaks, NY 11004*

EDUCATIONAL OBJECTIVE:

At the conclusion of the symposium, the participants will become familiar with the evidence demonstrating that CFS and GWI reflects abnormal illness behavior rather than a somatic or psychiatric disorder.

SUMMARY:

Chronic fatigue syndrome (CFS) has become a common diagnosis that is often invoked as an explanation for a variety of somatic symptoms that lack demonstrable clinical findings, structural lesions, and laboratory abnormalities. The diagnosis is also frequently given to patients with the 1991 Gulf War Illness (GWI). The goal of the workshop is to examine the evidence and to use the participants' experience in order to answer the following questions: Is CFS/GWI a physical disorder? Is CFS/GWI a psychiatric disorder? Is CFS/GWI a pathological entity or a manifestation of abnormal illness behavior? The workshop will have three 30-minute segments. Each segment will include a 20-minute review of the evidence and a 10-minute interaction with the audience. The first segment will describe the current case definition of CFS and GWI and present the data regarding the role of infections, vaccinations, and immunologic dysfunction, toxic environmental exposures, hypocortisolism, and neurally mediated hypotension. The second segment will compare CFS/GWI with mood disorders and posttraumatic stress syndrome with regard to neuroanatomy and brain perfusion, serotonin metabolism, function of the hypothalamic-pituitary-adrenal axis, neuropsychological abnormalities, and response to antidepressants. The third segment will explore the illness behavior in CFS/GWI (abnormal personality traits, somatic attributions, maladaptive coping, role of support networks, and efficacy of cognitive therapy).

REFERENCES:

1. Manu P, Matthews DA: Chronic fatigue syndrome. In Functional Somatic Syndromes: Etiology, Diagnosis and Treatment, edited by Manu P, New York, Cambridge University Press, 1998, pp. 8–31.
2. Manu P: The Psychopathology of Functional Syndromes: Neurobiology and Illness Behavior in Chronic Fatigue Syndrome, Gulf War Illness, Fibromyalgia and Irritable Bowel Syndrome, New York, Haworth Press, 2004.

Issue Workshop 56
COMPUTER-ASSISTED CBT IN EDUCATION AND TREATMENT

Chairperson: Jesse H. Wright, M.D., *Department of Psychiatry, University of Louisville, Norton Psychiatric Clinic, Louisville, KY 40202*
Participant: Douglas Turkington, M.D.

EDUCATIONAL OBJECTIVE:

To explain rationale and indications for computer-assisted cognitive-behavior therapy (CBT), identify methods for using computer programs in CBT training, describe ways of integrating computer-assisted psychotherapy into clinical practice and education.

SUMMARY:

This workshop is intended for clinicians interested in using computer tools for psychotherapy as an adjunct to clinical practice or as a method of educating residents or other trainees in CBT. After a brief overview of the use of computers in treatment and education, two computer programs (Good Days Ahead: The Multimedia Program for Cognitive Therapy and Praxis) will be described and demonstrated. Good Days Ahead was developed primarily as a treatment method for depression but has also been used in training applications. Praxis was designed as a educational tool to assist clinicians in becoming proficient in CBT. Research demonstrating acceptance and efficacy of computer-assisted therapy will also be detailed. Workshop participants will discuss the different types of computer-assisted therapy and training with a focus on: (1) indications for using computer tools in clinical practice; (2) ethics of using therapeutic software; (3) integration of computer and human components of therapy and education; (4) methods of using computer tools for training in CBT; and (5) economic and managed care considerations. The presentation will include short didactic segments, demonstrations of multimedia computer programs, and discussion of issues in the implementation of software for CBT.

REFERENCES:

1. Wright JH, Wright A: Computer assisted psychotherapy. Journal of Psychotherapy Practice and Research 1997; 6:315–329.
2. Wright JH, et al: Development and initial testing of a multimedia program for computer-assisted cognitive therapy. American Journal of Psychotherapy 2002; 56:76–86.
3. Wright JH, Wright AS, Albano AM, et al.: Computer-assisted cognitive therapy for depression: maintaining efficacy while reducing therapist time. Am J of Psychiatry 2004; accepted for publication.

WEDNESDAY, MAY 25, 2005

Issue Workshop 57
IMPACT OF VIOLENCE ON PREGNANCY, BIRTH, AND PARENTHOOD: THE INTERFACE BETWEEN PSYCHIATRY AND OBSTETRICS

Chairperson: Johannes Bitzer, M.D., *Department of Obstetrics and Gynecology, University of Basel, Spitalstrasse 21, Basel 4031, Switzerland*
Participant: Werner Tschan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize obstetrical and gynecological patients exposed to violence, diagnose clinical symptoms in victims, and develop a therapeutic plan adapted to the medical and psychological needs of the woman.

SUMMARY:

The workshop provides an overview of impact of violence on women, in particular how it influences sexuality, pregnancy, birth, and postpartum outcome, as well as parenthood. One of the presenters illustrates the psychiatric approach, the knowledge we gain through treating affected persons, whereas the other presenter focuses on the perspective of the obstetrician and the intervention techniques used in Basel University's women's hospital. Case examples will be used to clarify the impact on the clinical course and to illustrate the results of therapeutic interventions.

In providing comprehensive prenatal and perinatal care, it is important to integrate the epidemiological findings on violence into the care of women and to discuss possible psychiatric intervention techniques from an interdisciplinary approach. Mental health issues in pregnancy are often neglected by obstetricians, just as the puerperal period is foreign to most psychiatrists. The workshop presents the cooperation model established at Basel University Women's Hospital. Participants will have an opportunity to discuss experiences of cooperation between psychiatry and obstetricians and other issues in women's health care.

REFERENCES:

1. Tschan W: The aftermath of sexual violence: impact on women sexuality and reproductive capacity. Swiss Archives of Neurology and Psychiatry.
2. Bitzer J: Basic knowledge of psychotraumatology for primary care providers. Therapeutische Umschau (in press).

Issue Workshop 58
CLINICAL DECISIONS: GUIDELINES, INDICATORS, AND ALGORITHMS

Co-Chairpersons: Rodrigo A. Munoz, M.D., *Department of Psychiatry, University of California San Diego, 3130 Fifth Avenue, San Diego, CA 92103*
Jack S. McIntyre, M.D., *Department of Psychiatry, Unity Health System, 81 Lake Avenue, 3rd Floor, Rochester, NY 14608*
Participants: Robert Popozian, Ph.D., Richard Smith, M.D., Madhukar Trivedi, M.D., Britton A. Hill, M.D.

EDUCATIONAL OBJECTIVE:

The audience will learn the principles for using current diagnostic and treatment tools in the daily care of psychiatric patients.

SUMMARY:

APA has been at the forefront in the effort to bring medical practices based on the best available evidence to the office of every psychiatrist. Starting with practice guidelines for the disorders commonly seen in most clinical practices, APA is rapidly developing tools that assure the diffusion and use of the best clinical decision making practices. The APA Task Force on Quality Indicators has established principles to develop markers for access, quality, outcomes, and satisfaction with care. While guidelines and indicators create the roads towards excellence, the clinician still faces diagnostic and therapeutic ambiguities and the need to make decisions in the midst of uncertainty. This workshop presents recent advances in the use of guidelines, quality indicators, and clinical algorhythms that may optimize the work of the clinician.

REFERENCES:

1. APA: Practice Guidelines for the Treatment of Psychiatric Disorders: 2002 Compendium, Wash. D.C, APA.
2. APA: Final Report: APA Task Force on Quality Indicators, 1999.

Issue Workshop 59
TREATMENT OF MENTAL ILLNESS IN U.S. JAILS AND PRISONS

Co-Chairpersons: Joseph R. Calabrese, M.D., *Department of Psychiatry, University Hospital Cleveland, 11400 Euclid Avenue, Suite 200, Cleveland, OH 44106*
Omar Elhaj, M.D., *Department of Psychiatry, University Hospital of Cleveland, 11400 Euclid Avenue, Suite 200, Cleveland, OH 44106*
Participants: Jeffrey L. Metzner, M.D., Timothy L. Thistlethwaite, M.D.

EDUCATIONAL OBJECTIVE:

To identify current unmet needs in addressing serious mental illnesses in the U.S. criminal justice system; realize practical treatment solutions in this setting; and review preliminary data from the Ottawa County Jail Mental Health Screening Project.

SUMMARY:

The evidence suggests that the management of serious mental illness in U.S. jails and prisons represents a tremendous unmet medical need and a significant financial burden on the society at large. The deinstitutionalization movement, starting in the 1980s, has displaced patients with serious mental illness from the health care system to the criminal justice system. Patients with undiagnosed, untreated serious mental illness are being housed in jails and prisons without adequate provision of care. Preliminary data from the Ottawa County Jail Screening Project suggests that charges, convictions, and time spent incarcerated for seriously mentally ill inmates are almost four times that of inmates without a serious mental illness. The aim of this workshop is to 1) increase the awareness of the implications of shifting the burden of care for the mentally ill to the criminal justice system, 2) present and discuss preliminary data from the Ottawa County Jail Project, and 3) present and discuss practical suggestions for treatment of inmates with serious mental illnesses. The workshop format is interactive and the speakers will each briefly present their respective segments, followed by a forum for questions and answers.

REFERENCES:

1. Metzner JL: Class action litigation in correctional psychiatry. J. Amer. Acad. Psychiatry and the Law 2002; 30:19–29.
2. Manderscheid RW, Gravesande A. Goldstrom ID: Growth of mental health services in state adult correctional facilities, 1988 to 2000. Psychiatr Serv 2004; 55:869–872.

Issue Workshop 60
IN FROM THE COLD: PERSPECTIVES ON SOCIAL SUPPORT IN PSYCHIATRY AND MEDICINE

Chairperson: Jacqueline Olds, M.D., *30 Hillside Avenue, Cambridge, MA 02140-3616*
Participants: David M. Spiegel, M.D., James S. Goodwin, M.D., Bruce S. McEwen, Ph.D., Richard S. Schwartz, M.D.

EDUCATIONAL OBJECTIVE:

To understand current research on the relationship between social support and health; incorporate that understanding into clinical practice.

SUMMARY:

Social support has been shown to be an important and independent determinant of overall health, with effects on mortality rates, an individual's response to stress, immune functions, and the incidence and course of a variety of specific illnesses. Attention to the state of a patient's social support network as an aspect of standard psychiatric care is, however, often minimal and sometimes nonexistent. This workshop brings together experts in several research areas related to social support and health (stress, cancer, and geriatrics) to summarize current knowledge in the field and then engage in a dialogue with clinician-educators and workshop participants about the relevance of their work to psychiatric practice. Particular attention will be paid to a surprising lack of research data concerning the effects of psychotherapy on social support. The workshop will be of interest to clinicians who wish to incorporate a better understanding of social support issues into their work with patients, as well as anyone seeking a summary of current research on the relationship between social support and health.

REFERENCES:

1. Spiegel D: A 43-year-old woman coping with cancer. JAMA 1999; 282:371–378.
2. Eschbach K, Marbides K, Patel K, Goodwin JS: Neighborhood and mortality among older Mexican Americans; is there a barrio advantage? Am. J. Public Health. In press.

Issue Workshop 61
RELIGIOUS AND SPIRITUAL ASSESSMENT IN CLINICAL PRACTICE

Co-Chairpersons: Francis G. Lu, M.D., *Department of Psychiatry, San Francisco General Hospital, 1001 Potrero Avenue, Suite 7M, San Francisco, CA 94110*
Christina M. Puchalski, M.D., *George Washington University, 2131 K Street, NW, Washington, DC 20037*
Participant: James L. Griffith, M.D.

EDUCATIONAL OBJECTIVE:

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 for the Psychiatric Evaluation of Adults and the DSM-IV Outline for Cultural Formulation, cultural issues including religion/spirituality should be incorporated in history taking, assessment, and treatment planning. Yet clinicians may be unfamiliar with methods of religion/spirituality assessments. This workshop will review cases that demonstrate methods of interviewing, assessment, and treatment planning. Participants will be invited to critique and comment on these cases and use them 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. Josephson AM., Peteet JR, Eds: Handbook of Spirituality and Worldview in Clinical Practice. Arlington, VA, American Psychiatric Publishing Inc., 2004.
2. Koenig HG: Spirituality in Patient Care: Why, How, When, and What. Philadelphia, Templeton Foundation Press, 2002.

Issue Workshop 62
ANGER MANAGEMENT: EVALUATION AND TREATMENT

Chairperson: Eva C. Ritvo, M.D., *Department of Psychiatry, University of Miami, 3026 North Bay Road, Miami Beach, FL 33140*
Participants: Larry J. Harmon, Ph.D., Gonzalo F. Quesada, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to understand the etiology and diagnosis of various types of anger,

evaluate angry behavior using clinical interview, mental status examination, collateral questionnaires, and psychological testing instruments, and review psychotherapeutic, educational, and medication interventions for anger management.

SUMMARY:

Rarely discussed and often suppressed, anger can have negative effects on nearly every part of life: work, health, legal, happiness, and of course, on social and romantic relationships. Dr. Harmon will define anger and identify the types of anger, for example, experience, expression, and hidden anger. The causes of anger many people experience in their daily lives will be addressed. Participants will learn how to evaluate angry patients by using various approaches such as clinical interview questions, mental status examination observations, collateral questionnaire findings, and psychological testing results. Specific questionnaires and tests will be identified. In addition, practical psychotherapeutic interventions will be described. For example, cognitive strategies,—physical de-escalation, delay techniques, interpersonal conflict resolution, and easily remembered language buffers. The workshop will also cover what types of anger would require intervention in conjunction with psychotherapy, such as psychiatric medication management. Dr. Quesada will explain which medications target specific diagnoses associated with anger, and medication side effects and benefits. Finally, participants will learn how to plan an "anger management" educational presentation for various groups.

REFERENCES:

1. Gibson D, Tulgan B: Managing Anger in the Workplace. Amherst, Mass., HRD Press, 2002.
2. Linehan MM: Cognitive-Behavioral Treatment of Borderline Personality Disorder. New York, NY, The Guilford Press, 1993.

Issue Workshop 63
DYNAMIC THERAPY WITH SELF-DESTRUCTIVE BORDERLINE PATIENTS

Co-Chairpersons: Eric M. Plakun, M.D., *Department of Admissions, The Austen Riggs Center, 25 Main Street, P.O. Box 962, Stockbridge, MA 01262*
Edward R. Shapiro, M.D., *Department of Admissions, Austen Riggs Center, 25 Main Street, P.O. Box 962, Stockbridge, MA 01262-0962*

EDUCATIONAL OBJECTIVE:

At the conclusion of this presentation, the participant should be able to enumerate principles in the dynamic psychotherapy of self-destructive borderline patients, implement newly acquired skills in establishing and maintaining a therapeutic alliance with such patients, and be familiar with the countertransference problems inherent in work with these patients.

SUMMARY:

Psychotherapy with self-destructive borderline patients is recognized as a formidable clinical challenge. Although much has been written about metapsychological issues in psychodynamic psychotherapy, little is available to help clinicians establish a viable therapeutic relationship with these patients. This workshop includes review of eight principles helpful in establishing and maintaining a therapeutic alliance in the psychodynamic psychotherapy of self-destructive borderline patients. The principles are: (1) differentiation of lethal from nonlethal self-destructive behavior; (2) inclusion of lethal self-destructive behavior in the initial therapeutic contract; (3) metabolism of the countertransference; (4) engagement of affect; (5) nonpunitive interpretation of the patient's aggression; (6) assignment of responsibility for the preservation of the treatment to the patient; (7) a search for the perceived injury from the therapist that may have precipitated the self-destructive behavior; and (8) provision of an opportunity for reparation. These principles are compared with Linehan's DBT and Kernberg's transference-focused psychotherapy. After the presentation, the remaining time will be used for an interactive discussion of case material. Although the workshop organizers will offer cases to initiate discussion, workshop participants will be encouraged to offer case examples from their own practices. The result should be a highly interactive opportunity to discuss this challenging and important clinical problem.

REFERENCES:

1. Plakun EM: Principles in the psychotherapy of self-destructive borderline patients. Journal of Psychotherapy Practice and Research 1994; 3:138–148.
2. Plakun EM: Making the alliance and taking the transference in work with suicidal borderline patients, Journal of Psychotherapy Practice and Research 2001; 10:269–276.

Issue Workshop 64
WHEN USUAL TREATMENTS FAIL: AUGMENTATION STRATEGIES FOR REFRACTORY SCHIZOPHRENIA

Chairperson: Jean-Pierre Lindenmayer, M.D., *Psychopharmacology Research Program, Manhattan Psychiatric Center, East 125th Street, Wards Island, NY 10035*
Participants: Joseph I. Friedman, M.D., Guochuan Tsai, M.D., Richard P. Brown, M.D., Peter F. Buckley, M.D.

EDUCATIONAL OBJECTIVE:

At the end of this workshop the participant will be familiar with the evidence of successful pharmacological treatment strategies for treatment-refractory schizophrenia.

SUMMARY:

Treatment resistance in schizophrenia is a problem of substantial proportions: While 30%–45% of patients with treatment-resistant schizophrenia respond to clozapine or at times to other atypical antipsychotics, the remaining 55%–70% respond partially or not at all. These patients represent a pharmacological treatment challenge and a public mental health problem as they utilize a high degree of mental health services. A number of augmentation strategies have been suggested for patients who have failed clozapine. However, there are few controlled studies in this area. Most studies include small numbers of patients with various definitions of partial response and are open label. In the absence of controlled data, most clinicians choose an augmentation strategy without a clear pharmacological rationale, but rather by targeting the prevailing residual symptoms or by a trial-and-error strategy. This workshop will address for the practicing physician evidence for the effectiveness of different pharmacological strategies in this group of patients, the development of an overall treatment strategy of sequential treatment trials with monitoring by objective measures, the therapeutic use of novel potential treatment mechanisms, and data from empirical treatment trials. Audience participation will be encouraged to contribute case material and successful treatment approaches in this patient population.

REFERENCES:

1. Volovka J, Czobor P, Sheitman B, et al: Clozapine, olanzapine, risperidone and haloperidol in patients with chronic schizophrenia and schizoaffective disorder. Am J Psychiatry, 2002; 159:255–62.
2. Rush AJ, Crismon ML, Kashner TM, et al: Texas Medication Algorithm Project, Phase 3 (TMAP-3): rationale and study design. J Clin Psychiatry 2003; 64:357–69.

Issue Workshop 65
REINVENTING CAREERS: TRANSITIONS AND LATER-LIFE STRATEGIES FOR PSYCHIATRISTS

Chairperson: Carolyn B. Robinowitz, M.D., *Department of Psychiatry, George Washington University, 5225 Connecticut Avenue, NW, Suite 514, Washington, DC 20015*
Participants: Joel Yager, M.D., Jerald Kay, M.D., Carol C. Nadelson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, participants will become knowledgeable about the aspects of late career development, strategies for remaining generative and stimulated, and opportunities and tools to prepare for career transitions.

SUMMARY:

It is never too soon to plan for growing older and how to balance work, family, and play. This session addresses later-career and later-life issues for psychiatrists. It considers how we reinvent ourselves and our careers as we grow and progress into the end of our work lives. What changes do we seek or avoid? How can we plan to stay stimulated and generative? How do we balance work, love, family, and play? The first half of the workshop consists of brief presentations by the panelists, all of whom have studied aspects of career and personal development, they will describe brief personal as well as clinical and theoretical vignettes, discuss balance and directions, as well as provide practical information on opportunities for satisfying career transitions. The second half will be interactive, encouraging questions and comments, and there will be ample opportunity for discussion and audience participation. While more specifically aimed at mid-to-late career paychiatrists, this workshop will also be of interest to early-to-mid career psychiatrists as they explore their own career directions and priorities.

REFERENCES:

1. Seeman M: Scaling Down. Am Journal Psychiatry 2003; 160:847–849.
2. Sher B: It's Only Too Late if You Don't Start Now: How to Create Your Second Life at Any Age. Delacorte Press, 1999.

Issue Workshop 66
PSYCHOTHERAPY TRAINING AND IMGS: THE INFLUENCE OF CULTURAL FACTORS

Chairperson: Nyapati Rao, M.D., *Department of Psychiatry, State University of New York, Downstate Medical Center, 450 Clarkson Avenue, Box 1203, Brooklyn, NY 11203*
Participants: Michael Garrett, M.D., Stephen M. Goldfinger, M.D., Damir Huremovic, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to understand how cultural factors influence the psychotherapy learning process of IMGs and develop more effective training strategies.

SUMMARY:

The ACGME has required that psychiatry residents must demonstrate competence in five types of psychotherapy (brief, supportive, psychodynamic, CBT, and combined therapies) to graduate from residency training, and the training programs have taken this mandate seriously. However, in this context, the residents' difficulties in learning psychotherapy might not have been adequately examined. For example, 45% of current psychiatry residents are international medical graduates (IMGs) who come from cultural backgrounds vastly different from those born and raised in the U.S. The theory and practice of psychotherapy is influenced by the values of the culture it emanates from, and these American cultural values (individual vs. group loyalty, gender roles, sexuality, etc) may engender conflict in IMGs and may affect their learning. In this workshop intended for educators, practitioners, and residents, a survey of residents in three training programs in Brooklyn, N.Y., regarding their attitudes towards various cultural values that impinge on psychotherapy training will be presented. Using this survey as a springboard, supervisory and training issues pertinent to psychotherapy education of IMGs will be discussed. The attendees will be encouraged to share their programmatic and individual experiences.

REFERENCES:

1. Mellman LA, Beresin E: Psychotherapy competencies: development and implementation. Academic Psychiatry 2003; 27:149–153.
2. Wen-Shing T, Strelzer J (Eds): Culture and Psychotherapy: A Guide to Clinical Practice. Washington DC, American Psychiatric Press, Inc., 2001.

Issue Workshop 67
CARDIOVASCULAR COMPLICATIONS OF PSYCHIATRIC TREATMENTS

Chairperson: Peter Manu, M.D., *Department of Psychiatry, Zucker Hillside Hospital, 75-59 263rd Street, Glen Oaks, NY 11004*

EDUCATIONAL OBJECTIVES:

The workshop will enable the participants to assess the risk and start the evaluation and treatment of orthostatic hypotension, Q-Tc interval prolongation, drug-induced cardiomyopathy, and cardiovascular complication of electroconvulsive therapy.

SUMMARY:

At least 50% of psychiatric patients have active medical disorders that are often underrecognized, misdiagnosed, or suboptimally treated. In a substantial proportion of cases the active medical problems of psychiatric patients are worsened or produced by psychotropic drugs or electroconvulsive therapy (ECT). The workshop will evaluate the spectrum of cardiovascular complications produced by psychotropic drugs and ECT in four 22-minute modules focusing on 1) orthostatic hypotension and syncope; 2) Q-Tc interval prolongation and *torsade de pointes;* 3) drug-induced myocarditis/cardiomyopathy; and 4) asystole, ventricular arrhythmias, and myocardial ischemia associated with ECT. Each module will address the presenting clinical features, strength of association with psychiatric treatment, risk of death, diagnostic work-up, and treatment of these iatrogenic complications.

REFERENCES:

1. Manu P, Suarez R, Barnett B (eds.): Handbook of Medicine in Psychiatry, American Psychiatric Publishing Inc. (in preparation).
2. Coulter DM, Bate A, Meyboom RH, et al: Antipsychotic drugs and heart muscle disorder in international pharmacovigilance: data mining study. BMJ 2001; 322:1207–1209.

Issue Workshop 68
THE MARKETING OF PSYCHIATRIC MEDICATIONS TO PATIENTS: WHERE DO WE STAND?

Chairperson: Patrick Ying, M.D., *Department of Psychiatry, New York University School of Medicine, 530 First Avenue, Suite 7D, New York, NY 10016*
Participant: Marshal Folstein, M.D.

EDUCATIONAL OBJECTIVES:

To understand the history of direct-to-consumer advertising of psychiatric medications and be familiar with the methods and issues relating to its current practice.

SUMMARY:

Direct-to-consumer advertising of pharmaceuticals has grown to be an over $2.5 billion enterprise. A significant portion of this advertising is devoted to psychiatric medications, as advertisements for antidepressants and other psychiatric medications are commonplace on prime-time television and in mainstream magazines. In this workshop, we will present a brief history of the evolution of this practice and then review examples of patient-oriented advertising including print ads, television commercials, celebrity endorsements, and less traditional forms of advertising such as Internet marketing and product placements in film and television. Following this will be a discussion in which participants will be encouraged to discuss their reactions to the material presented and their own clinical experiences with regard to the impact of these ads. Questions to be addressed include: How does this practice affect our patients? Is the marketing of psychiatric medications different than for other pharmaceuticals? Do these ads help with patient education and reducing stigma? Is the overall effect of these ads positive or negative? What should our response as a field and as clinicians be? Representatives of the pharmaceutical industry and patient advocacy groups will be encouraged to participate as well.

REFERENCES:

1. Gilbody S, Wilson P, Watt I: Direct-to-consumer advertising of psychotropics. an emerging and evolving form of pharmaceutical company influence. Br J Psychiatry 2004; 185:1–2.
2. Rosenthal MB, Berndt ER, Donohue JM, et al: Promotion of prescription drugs to consumers. N Engl J Med 2002; 346:498–505.

Issue Workshop 69
SELF-AWARENESS DEFICITS IN SCHIZOPHRENIA AND COCAINE ABUSE

Chairperson: Bernard D. Beitman, M.D., *Department of Psychiatry, University of Missouri, 1 Hospital Drive, Columbia, MO 65212*
Participants: Laura A. Flashman, Ph.D., George I. Viamontes, M.D.

EDUCATIONAL OBJECTIVE:

To outline the neurobiology of self-awareness and its deficits in order to help clinicians recognize the neural circuitry dysfunction, contributing to the often limited response to treatment of patients with schizophrenia and cocaine abuse.

SUMMARY:

Human brains evolve to predict responses to directed movement. Prediction errors, when expectations do not meet experiences, can be corrected through conscious examination of the relationship between motor programming and the environment. Without the ability to activate conscious self-reflection, a person cannot be responsible for self-change. Impaired awareness is of considerable clinical relevance in schizophrenia since it is associated with increased treatment noncompliance, reduced work performance, and impaired social skills. The causes are multifactorial. Using the neurological model of anosognosia often associated with right parietal lobe stroke, we will review studies using neuropsychological assessment and neuroimaging to investigate the neural basis of impaired self-awareness in schizophrenia. Impaired self-awareness in cocaine addiction is produced through a combination of high dopamine and high glutamate in the nucleus accumbens, which fixes attention on drug use and excludes other stimuli until drug use is consummated. Because the prefrontal cortices cannot inhibit the addiction-fired circuits, cocaine addicts are not able to process other inner experiences or the inner states of others. This workshop is intended for clinicians interested in the clinical application of the neurobiology of self-awareness. The audience is encouraged to present case examples as well as to comment and question after each presentation.

REFERENCES:

1. Beitman BD, Nair J (editors): Self-awareness Deficits: Defining and Treating Awareness Deficits in Psychiatric Patients. New York, W. W. Norton, 2004.
2. Flashman LA: Disorders of awareness in neuropsychiatric syndromes: an update. Current Psychiatry Reports 2002; 4:346–353.

Issue Workshop 70
RECOGNIZING AND MANAGING OPIOID-INDUCED HYPERALGESIA IN CHRONIC PAIN PATIENTS

Chairperson: Jon M. Streltzer, M.D., *Department of Psychiatry, University of Hawaii, 1356 Lusitana Street, 4th Floor, Honolulu, HI 96813-2421*
Participants: Carl R. Sullivan, M.D., A. Kenison Roy III, M.D.

EDUCATIONAL OBJECTIVE:

To understand the physiological response of the body to chronic opioid intake and to recognize and manage the consequences of such in the chronic pain patient.

SUMMARY:

Hyperalgesia can be a consequence of chronic opioid intake. This enhanced sensitivity to painful stimuli has been increasingly studied in recent years. Animal studies have elicited a number of physiological mechanisms involved; these involve descending pathways and the synthesis and release of dynorphin and several "anti-opioid" endogenous peptides. In humans, enhanced pain sensitivity has been demonstrated in methadone-maintenance patients to experimental pain. Furthermore, there is increasing evidence that pain is a clinical problem in methadone patients. Rather than being protected from acute pain and surgical pain, methadone patients need higher doses of additional opioid to control their pain. Chronic pain patients managed on a long-term basis with daily opioids also appear to exhibit this phenomenon. Psychological factors associated with chronic opioid intake serve to maintain the patient's desire for these medications despite the fact that their pain does not improve and their functionality often diminishes. Cases illustrating the phenomena of opioid-induced hyperalgesia and recommendations for treatment that include detoxification and transition to nonopioid pain medications will be presented. The audience will be encouraged to present cases, and treatment options will be suggested.

REFERENCES:

1. Ballantyne J, Mao J: Opioid therapy for chronic pain. NEJM 2003; 349:1943–53.
2. Streltzer J: Pain management in the opioid-dependent patient. Current Psychiatry Reports 2001; 3:489–496.

Issue Workshop 71
FAST TRACKING INTO CHILD PSYCHIATRY: WHO BENEFITS? WHO SUFFERS?

Co-Chairpersons: Kareem D. Ghalib, M.D., *Columbia University, 1051 Riverside Drive, Box 86, New York, NY 10032*
Lisa A. Mellman, M.D., *Columbia University 1051 Riverside Drive, New York, NY 10032*
Participants: Eugene V. Beresin, M.D., Jed G. Magen, D.O., David L. Kaye, M.D., Marc E. Dalton, M.D.

EDUCATIONAL OBJECTIVE:

At the workshop's conclusion, participants will be able to 1) describe models of adult and child and adolescent psychiatry training,

2) understand relative costs and benefits of "fast-tracking" versus "slow-tracking" into child and adolescent psychiatry fellowships, and 3) discuss the impact of residency training on workforce and access to care.

SUMMARY:

Workforce issues in child psychiatry have led many psychiatry training programs to shorten the adult training experience so that future child and adolescent psychiatrists can transfer into child training early. However, child and adolescent psychiatrists do not only treat children; most child and adolescent psychiatrists have large amounts of clinical contact with adults, both as parents of children and as adult patients. This workshop will address 1) models of adult and child and adolescent psychiatry training, 2) the financial and educational costs and benefits of fast-tracking and slow-tracking into child and adolescent psychiatry, 3) the fourth year of adult training, which is deleted in fast-tracking, 4) a survey of recent graduates of child and adolescent psychiatry fellowships, 5) the impact of each model on workforce and access to care. The intended audience of psychiatric educators, residents in adult and child and adolescent psychiatry, medical students, and psychiatric practitioners will participate in the discussion.

REFERENCES:

1. Beresin EV: Child and adolescent residency training: current issues and controversies. J American Academy of Child and Adolescent Psychiatry 1997; 36:1339–1348.
2. Kim WJ: Child and adolescent psychiatry workforce: a critical shortage and national challenge. Academic Psychiatry 2003; 27:277–282.

Issue Workshop 72
THE REACH OF MENTAL ILLNESS STIGMA
Collaborative Session With the National Institute of Mental Health

Chairperson: Bernice A. Pescosolido, Ph.D., *Department of Sociology, Indiana University, Ballatine Hall 744, Bloomington, IN 47405*
Participants: Patrick W. Corrigan, Psy.D., Cathy Sherbourne, Ph.D., Jo C. Phelan, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to demonstrate knowledge of current research on mental stigma, with particular focus on institutional stigma, and be familiar with some of the approaches used in stigma research.

SUMMARY:

The theme of the 1989 annual meeting of APA was "Overcoming Stigma" (Fink and Tasman 1992). Fifteen years have passed, and it is timely to ask, What progress has been made in overcoming stigma? To help us answer that question, Patrick Corrigan applies a sociological paradigm, structural or institutional discrimination, to examine all legislative bills relevant to mental health introduced in 2002 in the 50 states for their effect on liberties, protection from discrimination, and privacy; Cathy Sherbourne reports findings on individuals' concerns about disclosing mental health treatment to friends, employers, and insurers; and Jo Phelan discusses the "geneticization" of human behavior, one of the consequences of the genetics revolution, and how it might affect the stigma attached to mental illness. Bernice Pescosolido serves as moderator and discussant. Participants will have the opportunity to discuss the practice and policy implications of these and other recent stigma research findings and to suggest issues that should be addressed in future research. This workshop should be of interest to mental health practitioners and service providers and to mental health policy administrators. There are no requirements for participation.

REFERENCES:

1. Link BG, Phelan JC: Conceptualizing stigma. Annual Review of Sociology 2001; 27:363–385.
2. Corrigan PW, Penn DL: Lessons from social psychology on discrediting psychiatric stigma. Am Psychol 1999; 54:765–776.

Issue Workshop 73
BENEATH THE SWORD OF DAMOCLES: LIVING IN THE LIMBO OF REMISSION FROM CANCER

Chairperson: Fredric J. Van Rheenen, M.D., *Stanford University, 900 Welch Road, Suite 400, Palo Alto, CA 94304-1805*

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to recognize problems patients face when they are in remission from cancer, identify coping strategies patients employ in dealing with the limbo of remission, and employ helpful interventions in aiding the patient's coping with this situation.

SUMMARY:

This workshop is based on 20 years of my work as the psychiatric consultant to Stanford Medical Center's Oncology Division. I meet regularly with faculty, house officers, and patients with cancer. The workshop will start with defining the terms *Damocles* and *limbo.* Most patients who have been treated for cancer live feeling uncertain about their future. Certainly, any symptoms and all life decisions take on added meaning. We will discuss how the treatment of cancer, commonly unpleasant and frightening, is, on the other hand, characterized by activity, attention, structure, surveillance, and the support of family, the medical team, and fellow patients. In the the limbo period, all of the foregoing diminishes, and patients often feel abandoned and "on their own." There is a natural tendency for somatic overconcern and the fear of being a pest or hypochondriac. The workshop will discuss common coping strategies employed by patients and ways in which the medical team can help this coping process, including availability, psychosocial support, therapy, medication, and not to be overlooked, humor.

REFERENCES:

1. Parry C: Embracing uncertainty: an exploration of the experiences of childhood cancer survivors. Qual Health Res 2003; 13:227–46.
2. Zebrak B: Reflections of a cancer survivor/research scientist. Cancer 2003; 97:2707–2709.

Issue Workshop 74
BECOME A DELIRIUM DETECTIVE

Chairperson: Arthur M. Freeman III, M.D., *Department of Psychiatry, University of Tennessee, 135 North Pauline Street, 1st Floor, Memphis, TN 38105*
Participants: Kristin S. Beizai, M.D., Marie B. Tobin, M.D., Robert Kores, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, participants will be able to recognize the phenomenology of delirium, conduct a thorough assessment, and formulate a differential diagnosis. Participants will also be able to use a newly developed (by University of Tennessee) Delirium Assessment and Treatment Algorithm (UT-DATA).

SUMMARY:

Delirium occurs in about 15%–18% of patients on medical and surgical wards. Patients with delirium are known to have a higher morbidity and mortality. Yet it is frequently clinically missed, especially the hypoactive form. In addition, delirium can certainly be

encountered in the outpatient setting, most commonly with more subtle symptoms. This workshop is intended for psychiatrists and trainees who are interested in the interface of psychiatry and medicine. Consequently, no special background requirements of the attendees are necessary. Participants are encouraged to bring challenging cases for discussion.

A moderator and three discussants will use an interactive approach to educate the participants on the phenomenology, assessment, diagnosis, and treatment of delirium. Cases will be used to highlight salient points of each topic. Participants will be expected to apply their clinical "sleuthing" skills to direct the assessment and management of the cases presented. A newly developed delirium decision tree, the University of Tennessee Delirium Assessment and Treatment Algorithm (UT-DATA), will be presented, and attendees will be educated in its use. Participants can expect to leave the workshop with a novel method that allows them to become astute delirium detectives.

REFERENCES:

1. Rundell J, Wise M: Textbook of Consultation-Liaison Psychiatry. Washington, DC, American Psychiatric Press, 1996.
2. Trzepacz P: Update on the neuropathogenesis of delirium. Dement Geriatr Cogn Disord 1999; 10:330–334.

Issue Workshop 75
TREATMENT OF TOURETTE'S SYNDROME THROUGH THE LIFE CYCLE
National Tourette's Syndrome Association

Chairperson: Cathy L. Budman, M.D., *Department of Psychiatry, North Shore-LIJ Health System, 400 Community Drive, Manhasset, NY 11030*
Participants: John T. Walkup, M.D., Anthony L. Rostain, M.D.

EDUCATIONAL OBJECTIVE:

To recognize, diagnose, and treat tics and common psychiatric comorbidities like ADHD, OCD, and mood disorders in TS throughout the life cycle.

SUMMARY:

Tourette syndrome (TS) is a model neuropsychiatric disorder characterized by childhood onset of involuntary movements and vocalizations. Genetic and environmental factors influence its presentation and course. Attention deficit hyperactivity disorder (ADHD), obsessive compulsive disorder (OCD), and mood disorders are common psychiatric comorbidities among most TS populations, often causing greater, more persistent lifetime morbidity that the primary tic disorder. While tics tend to improve by young adulthood, associated psychiatric symptoms emerge and evolve during different developmental stages thereby posing special treatment challenges. Underrecognition of psychiatric comorbidities and concern about exacerbating underlying tics impede adequate treatment of debilitating symptoms otherwise effectively targeted by modern psychopharmacological and cognitive-behavioral interventions.

This workshop will highlight recent advances in the diagnosis and treatment of tics, ADHD, OCD, and affective disorders in patients with TS throughout the life cycle. Review of literature, rating scales, and actual cases by expert child and adult psychiatrists in the treatment of TS will enable participants to appreciate the significance of tics and of complex psychiatric comorbidity in TS in its interplay with neuropsychosocial development. Panel roundtable will facilitate exchange of informed clinical experience and interactive discussion.

This workshop is for psychiatrists treating movement and neurodevelopmental disorders in children and/or adults.

REFERENCES:

1. Leckman J, Peterson B, King R, et al: Phenomenology of tics and natural history of tic disorders. Advances in Neurology Tourette Syndrome 2001; 85:1–14.
2. Piacentini J, Chang S: Behavioral treatments for Tourette syndrome and tic disorders. Adv Neurol 2001; 85:319.
3. Budman C, Feirman L: The relationship of Tourette's syndrome with its psychiatric comorbidities: is there an overlap? Psych Ann 2001; 31:541–548.

Issue Workshop 76
ACCEPTANCE VERSUS CHANGE: DIALECTICS OF IMPLEMENTING DBT IN RESIDENCY TRAINING

Co-Chairpersons: Maribel Rivera, M.D., *Montefiore Medical Center, 111 East 210 Street, Klau 1, Bronx, NY, 10467*
Lisa Lyons, Ph.D., *179 Cedar Lane, Suite 8, Teaneck, NJ 07666*
Participants: Brad Foote, M.D., Kara L. McCunn, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session participants will recognize the empirical evidence supporting the use of DBT with parasuicidal patients with BPD. Participants will demonstrate knowledge of the basic theories and strategies in DBT. Participants will identify dialectics involved in the implementation of a DBT team in residency training programs.

SUMMARY:

Studies have shown high prevalence rates of borderline personality disorder (BPD) in the psychiatric population. BPD has been shown to be the personality disorder most associated with parasuicidal behavior and high utilization of inpatient psychiatric services, suggesting a need for better training of residents in empirically supported therapy modalities that target this patient population. DBT, originally developed by Marsha Linehan to treat chronically parasuicidal patients with BPD, is now a comprehensive multimodal treatment for multiproblem patient populations. Seven randomized control trials have demonstrated its efficacy. DBT combines basic cognitive-behavior therapy strategies with Eastern mindfulness practices working from a dialectical worldview that emphasizes the synthesis of opposites. The dialectical approach attempts to replace rigid, dichotomous thinking with more balanced thinking and acting, while trying to understand the multiple tensions that co-occur in therapy with parasuicidal patients with BPD. In this workshop we use a dialectical perspective to discuss the rewards and difficulties of implementing this treatment modality in residency training programs. Participants will be encouraged to discuss their own ideas, experiences with the treatment, and challenges to implementing DBT in their residency sites.

REFERENCES:

1. Linehan MM: Cognitive Behavioral Treatment for Borderline Personality Disorder. New York, Guilford Press, 1993.
2. Dimeff L, Linehan MM: Dialectical behavior therapy in a nutshell. The California Psychologist 2001; 34:10–13.

Issue Workshop 77
SEXUAL HISTORY: THE ART AND THE SCIENCE

Chairperson: Waguih W. Ishak, M.D., Cedars-*Sinai Medical Center, 8730 Alden Drive, W101, Los Angeles, CA 90048*
Participants: Shahrad R. Amiri, M.D., Danni Michaeli, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the workship the participant should be able to: recognize the importance of and the factors interfering with taking

an adequate sexual history and should be able to use this practical knowledge in the evaluation and treatment of their patients.

SUMMARY:

Sexual history is extremely valuable in learning about an important aspect of personal history, identifying sexual disorders, improving the quality of life of patients, addressing high-risk behavior, and treating sexual side effects of medications. Avoidance of discussing sexual issues is seen in clinical settings and is often related to both clinician's and patient's anxiety about the topic. The participants will acquire skills in taking an adequate sexual history and will learn ways to address the difficulties associated with the process. In addition, it is important for psychiatrists to identify the impact of current psychiatric and nonpsychiatric medications on sexual functioning. Thorough assessment of sexual disorders secondary to medical conditions will also be covered.

REFERENCES:

1. Risen CB: A guide to taking a sexual history. Psychiatr Clin North Am 1995; 18:39–53.
2. Andrist LC: Taking a sexual: history and educating clients about safe sex. Nurs Clin North Am 1988; 23:959–73.

WEDNESDAY, MAY 25, 2005

Issue Workshop 78

SLEEP DISORDERS IN PATIENTS WITH MEDICAL AND PSYCHIATRIC ILLNESS

Chairperson: Dimitri D. Markov, M.D., *Department of Psychiatry, Thomas Jefferson Medical College, 1020 Sansom Street, Suite 1652, Philadelphia, PA 19107-5004*
Participants: Karl Doghramji, M.D., Mary B. O'Malley, M.D.

EDUCATIONAL OBJECTIVE:

Faculty will discuss principles and practical issues involved in managing patients with sleep disorders, with emphasis on sleep disorders in the medically ill and in general psychiatric practice.

SUMMARY:

In recent years, there has been a great expansion of knowledge about sleep disorders, the importance of sleep, and the health consequences of chronic sleep deprivation. Much attention has been paid to the comorbidity between sleep disorders and psychiatric/medical illness. This knowledge, however, has not been fully implemented in clinical practice. Many physicians can recognize common sleep disorders. However, more needs to be done to educate physicians about diagnosing and treating sleep disorders in order to improve the physical and psychological health and the quality of life of their patients. In the setting of acute medical illness, the patient's sleep disorders are frequently overlooked. Untreated sleep disorders can complicate medical problems. During a psychiatric consultation, the psychiatrist can provide valuable input by diagnosing and addressing unrecognized sleep disorders.

REFERENCES:

1. Wise MS: Narcolepsy and other disorders of excessive sleepiness. Medical Clinics of North America 2004; 88:597–610.
2. Guilleminault C, Abad VC: Obstructive sleep apnea syndromes. Medical Clinics of North America 2004; 88:611–30.

Issue Workshop 79

FEMALE KNOCKOUTS: WOMEN PERPETRATORS AND VICTIMS OF PARTNER VIOLENCE

Chairperson: Susan J. Hatters-Friedman, M.D., *Department of Psychiatry, University Hospitals of Cleveland, 11100 Euclid Avenue, Hanna Pavilion, Cleveland, OH 44106*
Participants: Joy E. Stankowski, M.D., Renee M. Sorrentino, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, participants will better understand the scope of intimate partner violence against women with mental illness, intimate partner violence perpetrated by women, and stalking and partner murder committed by women. Participants will understand risk factors and appreciate the mental health professional's capacity to intervene or prevent.

SUMMARY:

Psychiatrists must actively consider the effects of intimate partner violence on women with severe mental illness in order to formulate accurate diagnoses and treatment plans that help alleviate a woman's danger at home. In our role as mental health care providers, we must recognize signs and symptoms of victimization. It is equally important to recognize women as perpetrators of violence. Demographic and diagnostic factors associated with women as perpetrators will be discussed.

In 1998 there were an estimated 3.2 million arrests of women and an annual average of 2.1 million violent female offenders. Although men commit the majority of stalking and partner murder, women commit these offenses as well. Women may kill their partners due to battered women's syndrome or for a variety of other reasons. Violent crimes committed by women, including stalking and partner murder, will be discussed in detail. Discussion will be focused upon the mental health professional's role in detection of risk factors and prevention.

REFERENCES:

1. Bergman B, Brismar B: Suicide attempts by battered wives. Acta Psychiatry Scandinavia 1991; 83:380–384.
2. Carlile JB: Spouse assault on mentally disordered wives. Canadian Journal of Psychiatry 1991; 36:265–269.

Issue Workshop 80

POLYPHARMACY: NEW ADVANCES IN SUPPORTING PSYCHIATRIC PRACTICE
Collaborative Session With the National Institute of Mental Health

Co-Chairpersons: Junius J. Gonzales, M.D., *Division of Services, NIH/National Institute of Mental Health, 6001 Executive Boulevard, Room 7146, MSC 9631, Bethesda, MD 20892-9631*
Graca Cardoso, M.D., *National Institute of Mental Health, 6001 Executive Boulevard, Bethesda, MD 20892*
Participants: Madhukar Trivedi, M.D., Robert L. Trestman, M.D.

EDUCATIONAL OBJECTIVE:

To understand complexities, from individual to financial, of polypharmacy; to recognize two state-of-the-art decision supports to improve practice.

SUMMARY:

Polypharmacy with psychotropic medications is a common and difficult practice when little scientific evidence is available. The use of multiple psychotropic drugs is particularly high among the more seriously ill patients. Some factors that may impact current polyphar-

macy are available services, psychopathology, and the available information on adverse drug effects. Polypharmacy carries risks of drug-drug interactions and toxicity at the patient level and also results in significant fiscal pressures. This workshop has two parts: first, to give a current update on prescribing practices and their implications; second, to describe two NIMH-funded efforts to advance the use of decision supports for psychiatric practice in two different settings—community mental health clinics and jails. The TMAP CDSS project will describe how the clinical, pharmacodynamic, and pharmacokinetic challenges that psychiatrists face can be overcome. Data will then be presented on psychotropic usage patterns in the Connecticut correctional system, responses of practitioners to traditional provider feedback, and a new research model adapting and introducing a decision-support protocol for the treatment of imprisoned bipolar disorder patients. The workshop participants will be asked for their experiences and needs for such systems as well as barriers and facilitators for implementation in their settings.

REFERENCES:

1. McCue RE, Waheed R, Urcuyo C: Polypharmacy in patients with schizophrenia. J Clin Psychiatry 2003; 64:984–9.
2. Trivedi M, Rush A, Crismon M, et al: Clinical results for patients with major depressive disorder in the Texas Medication Algorithm Project. Arch Gen Psychiatry 2004; 61:669–80.

Issue Workshop 81
PHILIP PULLMAN'S *THE GOLDEN COMPASS:* COMING OF AGE IN A FRACTURED WORLD

Chairperson: JoAnne Isbey, A.B.D., *University of Detroit Mercy, 112 Mapleton Road, Grosse Pointe Farm, MI 48236*
Participants: Theresa A. Yuschok, M.D., Eva M. Szigethy, M.D., Leah J. Dickstein, M.D., Cheryl Munday, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the workshop participants will be able to recognize contemporary archetypes in young adult literature, explore the clinical relevance of gender difference in contemporary narratives and how these gender differences resonate and represent the inner/outer reality of today's young people, and recognize the healing power of stories to promote the individuation process and character development of children.

The intended audience is child psychiatrists, child psychologists, mental health workers, and others interested in the lives of children in these turbulent times. Participants are urged to read The Golden Compass in preparation for the workshop.

SUMMARY:

The interactive, intergenerational workshop will explore the mythic and symbolic story world as a clinical narrative. The heroine, Lyra Belacqua, navigates the violent, chaotic trajectory of her cautionary tale, enduring abandonment, betrayal, and violence as she struggles to stay alive and true to her soul. Fated to affect the destiny of the universe and guided only by her beloved shape-changing daemon Pantalaimon and an ancient instrument, an alethiometer, that she must teach herself to read, Lyra must play her part without realizing what she is doing. Professor JoAnne Isbey will present an overview of the complex forces that challenge Lyra's courage and integrity. Leah Dickstein, M.D., will analyze cultural gender material that informs Lyra's development. Cheryl Munday, Ph.D. will analyze the violence and bullying that permeate Lyra's identity formation. Eva Szigethy, M.D., will identify and assess the protective and risk factors that mediate Lyra's path. Theresa Yuschok, M.D., together with the audience, will read excerpts that illustrate the mythic constructs of Lyra's individual everyday encounters that contain the symbols of her emergent heroic consciousness. As we review the story, we will search out analogues that metaphorically resonnate with the conditions of this world's children in 2005.

REFERENCES:

1. Pullman P: The Golden Compass: His Dark Materials, Book 1. New York, Alfred A. Knopf, 2002.
2. Freud A: Ego and the Mechanisms of Defense: The Writings of Anna Freud, Vol 2, Madison, Ct, International Universities Press, 1967.

Issue Workshop 82
THE DIFFICULT-TO-TREAT BULIMIA NERVOSA PATIENT

Chairperson: Waguih W. Ishak, M.D., *Cedars-Sinai Medical Center, 8730 Alden Drive, W101, Los Angeles, CA 90048*
Participants: Jennifer L. McLain, M.D., Antonia Ludwig-Noble, M.F.T., Marlene Clark

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand alternative treatment approaches to difficult patients with bulimia nervosa

SUMMARY:

Eating disorders cause immeasurable suffering for victims and families. In the U.S., there are an estimated seven million women, and one million men with eating disorders. 86% report onset of illness by the age of 20, 77% report duration from one to 15 years, and six percent of serious cases die due to complications. CBT remains the most validated treatment for bulimia nervosa, and many patients respond adequately. At the same time, there remains a percentage of patients who are treatment resistant and who do not adequately respond to treatment. Research has yet to adequately identify subgroups within the treatment resistant population. Effective interventions have yet to be matched to these potential subgroups. Individualization of treatment will be key in order to optimize the response. The workshop presenters will present cases of difficult to treat bulimia and some of the approaches used to ameliorate the outcome.

REFERENCES:

1. Sands S: Bulimia, dissociation, and empathy: a self-psychological view. In Psychodynamic Treatment of Anorexia Nervosa and Bulimia, edited by Johnson CL,. NY, Guilford Press, 1991, pp. 34–50.
2. Fairburn CG., Marcus MD, Wilson TG: Cognitive behavioral therapy for binge eating and bulimia nervosa: a comprehensive treatment manual. In Binge Eating: Nature Assessment and Treatment, edited by Fairburn CG, Wilson GT, New York, Guilford Press, 1993, pp. 361–404.

Issue Workshop 83
PSYCHOSOMATIC MEDICINE WITH A DEVELOPMENTAL TWIST: CHILD CONSULTATION/LIAISON FOR ADULT PSYCHIATRISTS

Chairperson: Maryland Pao, M.D., *National Institute of Mental Health, National Institutes of Health, 10 Center Drive, Building 10, Room 3N238, Bethesda, MD 20892-1276*
Participant: Susan B. Turkel, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be able to: 1) describe relevant differences in psychiatric consultation with medically ill children as compared with medically ill adults, 2)

recognize major milestones in normal development (cognitive, physical, emotional), 3) recognize normal adaptive responses to hospitalization in children and adolescents.

SUMMARY:

As medical technology advances and childhood mortality declines, the number of chronically ill children is dramatically increasing. An estimated 18% of children (more than 12 million) have a chronic physical, developmental, behavioral, or emotional condition requiring health services beyond that required by healthy children (Newacheck, 1998). With workforce shortages in child psychiatry (U.S. Surgeon General, 1999), many general psychiatrists will be asked to evaluate children and adolescents with concurrent medical problems. This workshop is designed to review normative developmental trajectories in children and adolescents with attention to how these can be derailed by medical illness and hospitalization. Presenters will review developmental theories of Piaget and Erikson as well as gross and fine motor, language, social, emotional, and physical milestones through adolescence. They will highlight aspects of history taking and the formulation of individualized treatment plans. Case vignettes will be used to illustrate key concepts.

A developmentally informed approach to psychosomatic medicine consults in a pediatric population will be presented. Facilitating coping and adjustment to illness in children and prevention of mental health problems may have serious implications for long-term mental health in children. Future research may provide information on who may be genetically vulnerable for poorer outcomes in adaptation to medical illness (Caspi, 2003).

REFERENCES:

1. Newacheck P, Strickland B, Shonkoff JP, et al: An epidemiologic profile of children with special health care needs. Pediatrics 1998; 102:117–123.
2. Surgeon General: Mental Health: A Report of the Surgeon General, 1999. http://www.surgeongeneral.gov/library/mentalhealth/home.html

Issue Workshop 84
VIRTUAL REALITY AND OTHER FORMS OF CYBERTHERAPY: AN EVIDENCE-BASED REVIEW

Chairperson: Jack Kuo, M.D., *Department of Psychiatry, Cedars-Sinai Medical Center, 8730 Alden Drive, W101, Los Angeles, CA 90048*
Participants: William Huang, M.D., Carson Reynolds, M.S., Jeffery Wilkins, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to demonstrate an understanding of the potential therapeutic benefits and possible risks of virtual reality and other forms of cybertherapy via an evidence-based analysis of both the scientific literature as well as the latest research presentations.

SUMMARY:

Method: A literature search of MEDLINE, PSYCHINFO, and Internet search engines performed from 1979 to 2004 and on-site review of presentations at national meetings including "Cybertherapy 2004".

Results: Early definitions of the term cybertherapy referred to online psychotherapy first via e-mail then later with instant messaging and telepsychiatry. Cybertherapy now involves a diverse array of modalities including virtual reality, cognitive augmentation, adaptive displays, and even videogames. Potential advantages over more traditional approaches include delivery and control of stimuli in an immersive environment and the subsequent capture and analysis of behavior in that environment, increased standardization and validation of methods for assessing complex behaviors, more ecologically valid assessment, real-time performance feedback, a detailed performance record for review and analysis, and a more effective means of utilizing both imbedded and procedural learning. The possible risks of modern cybertherapy include adverse effects to virtual experiences as well as ethical concerns.

Conclusions: Recent advances in cybertherapy may augment traditional therapeutic modalities and contribute to an enhanced understanding of emotional and cognitive development as well as provide an innovative, interactive means of educating, diagnosing, and treating patients.

REFERENCES:

1. Rizzo AA, Schultheis M, Kerns KA, Mateer C: Analysis of assets for virtual reality applications in neuropsychology. Neuropsychological Rehabilitation. In press.
2. Riva G, Alcaniz M, Anolli M, et al: The VEPSY updated project: virtual reality in clinical psychology, CyberPsychology and Behavior, 2001; 4:449–455.

Issue Workshop 85
THERAPEUTIC USE OF MOVIE CLIPS IN OUTPATIENT AND INPATIENT GROUP TREATMENT

Chairperson: Michael A. Kalm, M.D., *3191 South Valley Street #152 Salt Lake City, UT 84109*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to familiarize him/herself in using film clips and promoting group-therapy process in different treatment settings.

SUMMARY:

The presenter will first discuss the group therapy formed and maintained in treatment facilities and programs including but not limited to the Behavioral Health Unit of Millcreek Community Hospital, an affiliate of Lake Erie College of Osteopathic Medicine, Stairways Behavioral Health Outpatient Clinic, Behavioral Health Unit of St. Vincent Hospital, and St. Vincent Outpatient Clinic, all located in Erie, Pa. during last two years. He then will show movie clips and explain how they helped the group-therapy participants achieve their goals. At this point, the audience will be encouraged to participate through bringing up individual group experiences and potential usage of the film clips. Time permitting, the presenter will also discuss the exciting international list serve, members of which consist of U.S., Canadian, Mexican, and overseas behavioral health providers who use the commercial movies and/or film clips in their educational and therapeutic settings. The handouts will be distributed for the attendees to review the contemporary literature and research on the topic.

REFERENCES:

1. Kalm MA: The Healing Movie Book, Precious Images: The Healing Use of Cinema in Psychotherapy. Lulu Publications, 2004.
2. Wolz B: E-Motion Picture Magic: A Movie Lover's Guide to Healing and Transformation. Glenbridge Publishing Ltd., 2004.

Issue Workshop 86
INDIVIDUALS AND CONJOINT APPROACHES TO COUPLES THERAPY

Chairperson: Eva C. Ritvo, M.D., *Department of Psychiatry, University of Miami, 3026 North Bay Road, Miami Beach, FL 33140*
Participants: Michael C. Hughes, M.D., Jon A. Shaw, M.D.

EDUCATIONAL OBJECTIVE:

To describe conjoint and individual therapeutic approaches to each couples therapy, recognize theoretical and methodological considera-

tions for each approach and consider which couples are most appropriate for individual, conjoint, or a combination of individual and conjoint therapy.

SUMMARY:

It is estimated that a majority of adults who seek treatment have problems in their relationship with a significant other as a major concern. Nevertheless, couples therapy treatment of the couples relationship is made available for a small number of those with such relational concerns and is generally understood to be conjoint treatment of the couple, a procedure unfamiliar to most psychiatrists. This workshop shows how individual psychotherapy can be used to treat the relationship issues of couples through two approaches: treatment of each member of the dyad by separate therapists, who meet collaboratively (collaborative marital therapy), or treatment of one member of the dyad. The individual approach accesses intrapsychic and transferential issues, often allowing for longer-term treatment. The conjoint approach is also discussed, highlighting advantages for short-term approaches. Major issues of relational conflict are considered for each approach: intimacy and separateness, repetitive problematic interactions, partners' distorted perceptions of each other, and unshared secrets. Clinical examples will illustrate methodology and highlight similarities, advantages, and disadvantages for individual and conjoint treatment. Audience participation is emphasized. Such a comprehensive perspective allows for tailoring the treatment to the patients' needs and offers help for many more patients by enabling therapists, whose skills are in individual therapy, to adopt their approach to relational concerns.

REFERENCES:

1. Ritvo E, Glick I: Concise Guide to Marriage and Family Therapy. Washington, DC, American Psychiatric Publishing, Inc., 2002.
2. Sholevar GP (ed): Textbook of Family and Couples Therapy. Washington, DC, American Psychiatric Publishing, Inc., 2002.

Issue Workshop 87
RESIDENTS IN THE TRENCHES, BUT NOT OUT IN THE COLD: INTEGRATING SHELTER-BASED OUTPATIENT ROTATIONS WITH ONLINE EDUCATIONAL TOOLS
American Association of Community Psychiatrists

Chairperson: Stephen M. Goldfinger, M.D., *Department of Psychiatry, State University of New York, Downstate Medical Center, 450 Clarkson Avenue, Brooklyn, NY 11203*
Participants: Ellen Berkowitz, M.D., Eric Weitzner, M.D., Van Yu, M.D., Ramotse Saunders, M.D., Damir Huremovic, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to describe models of shelter-based residency training in working with homeless individuals and provide online assessment tools to monitor resident learning.

SUMMARY:

Training directors and community psychiatrists have struggled over how to integrate community-based clinical rotations with academic rigor and competency-based assessments. Many community placements are unstructured and rely on a notion of "place-them-and-they-will-learn." Some try to teach community psych from the classroom, void of the real-world exasperations and compromises so often faced. Few even attempt a quantitative evaluation of what the residents have learned. The State University of NY/Downstate Medical Center has, for the past seven years, had a mandatory clinical rotation during the PGY-3 year where all residents spend an afternoon a week providing group and individual assessments and treatment in one of Brooklyn's shelters for homeless and sometimes mentally ill consumers. A collaborative venture between The Project for Psychiatric Outreach to the Homeless and the dept. of psychiatry, the program had historically provided onsite supervision at the shelters, group discussions of shared experiences and problems (all), and offsite case supervision. However, both a didactic curriculum and standardized evaluations of residents' clinical competence had not been offered. In a highly innovative training model, these are currently being done online. A reading list is provided to all participants, and a senior faculty person provides both "live" and retrospective feedback to residents about their readings, experiences, and skills/attitudes/knowledge. In this workshop, the program's innovators and implementers and several of the residents currently working in these shelters will share their experiences and address the challenges and accomplishments of this project.

REFERENCES:

1. Susser E, Goldfinger SM, White A: Some clinical approaches to work with the homeless mentally ill. Community Mental Health Journal 1990; 26(5):468–480.
2. Cohen NL, McQuistion H, Albert G, et al: Training in community psychiatry: new opportunities. Psychiatric Quarterly 69:107–116 1998.

Issue Workshop 88
GRANDPARENTS AND GRANDCHILDREN: CHILD PSYCHIATRIC AND FAMILY PERSPECTIVES

Co-Chairpersons: G. Pirooz Sholevar, M.D., *Department of Psychiatry, Robert Wood Johnson Medical School, 222 Righters Mill Road, Narberth, PA 19072-1315*
Ellen Harris Sholevar, M.D., *Temple University, 222 Righters Mill Road, Narberth, PA 19072-1315*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to identify the many facets of being a grandparent, demonstrate intergenerational effects on grandparents, parents and grandchildren, identify cross-cultural variations in the grandparent-parent-grandchild roles.

SUMMARY:

The literature on grandparents, parents, and grandchildren is sparse from the points of view of normal adult development, intergenerational issues, and childhood development. The media and popular culture are populated with negative stereotypes of older people in general and grandparents in particular. In the United States there has been a dissolution of the extended family, and grandparents and grandchildren have limited interaction. At the same time, therapeutic jurisprudence has suffered a setback, and the grandparents' right to have contact with their grandchildren has been limited. Relationships with grandparents may have a beneficial effect on child/adolescent development and convey resilience on youth in difficult circumstances. These relationships may also be stressful to the parents' and grandchild's generation. Cross-cultural perspectives on interegenerational issues and grandparent-parent-grandchild relationships will be explored. This workshop will encourage the audience to explore the various facets of the grandparent-parent-grandchild relationship and to examine the effects of the intergenerational issues on all involved.

REFERENCES:

1. Mueller M, Elder GH: Family contingencies across the generations: grandparent-grandchild relationships in holistic perspective. J Marriage and the Family, 2003; 65:404–417.
2. Whitehead, M: Dylan's routes to literacy: the first three years with picture books. J. Early Childhood Literacy 2002; 2:269–289.

Issue Workshop 89
UNEXPLAINED MEDICAL SYMPTOMS IN A PEDIATRIC POPULATION

Chairperson: Rose Geist, M.D., *Department of Psychiatry, Hospital for Sick Children, 555 University Avenue, Toronto, ON M5G 1X8, Canada*
Participants: Gillian Kirsh, M.A., Rachel Gropper

EDUCATIONAL OBJECTIVE:

To recognize the spectrum and psychological underpinnings of pediatric CUP; to be familiar with the management of pediatric CUP involving a rehabilitative, family-oriented approach.

SUMMARY:

This interactive workshop focuses on a rehabilitative treatment model for pediatric chronic unexplained pain (CUP). Case studies will be used to discuss the principles and practice of a rehabilitative, family-oriented treatment program that focuses on enhancing patient functioning, rather than on the symptoms. The use of SSRIs in this population will be discussed. Pediatric CUP presents a diagnostic and management challenge to family doctors, pediatricians, and psychiatrists. Typically, families believe that the symptoms are due solely to an organic cause, despite lack of significant organic findings. They often resist considering suggestions that psychosocial factors may be contributing to the development or perpetuation of CUP (Livingston, Taylor, & Crawford, 1988; Costello, Edelbrock, Costello, et al., 1995). Consequently, health care utilization is increased (i.e., multiple diagnostic investigations, repeated emergency department visits, and prolonged hospital stays; Campo & Fritsch, 1994). Family physicians, paediatricians, and specialists in gastroenterology, rheumatology, endocrinology, and neurology are frequently consulted. The medical psychiatry program in the division of child psychiatry at the University of Toronto has developed an approach to management of these problems. The treatment includes a multidisciplinary team. The families are treatment allies who assist in enhancing patient functioning (sleep, school attendance, social interaction). Attention to the symptoms is actively discouraged. The family is taught coping strategies for enhanced functioning. Similar programs exist which are oriented to coping and function rather on the pain symptom itself (Bursch et al. 1998).

REFERENCES:

1. Bursch B, Wolco G, Zeltzer L: Clinical assessment and management of chronic pain and pain associated disability syndrome. Developmental and Behavioural Pediatrics 1998; 19:45–53.
2. Campo JV, Fritsch SL: Somatization in children and adolescents. Journal of the Am Academy of Child and Adolescent Psychiatry 1994; 33:1223–1235.

THURSDAY, MAY 26, 2005

Issue Workshop 90
USING AUDIOVISUAL TECHNOLOGY TO TEACH BEHAVIORAL SCIENCE

Chairperson: Jonathan S. Davine, M.D., *East Region Mental Health Services, 2757 King Street East, Hamilton, ON L8G 5E4, Canada*

EDUCATIONAL OBJECTIVE:

To develop techniques to use audiovisual technology to teach behavioral sciences; be exposed to a case-based, small group, longitudinal program for teaching behavioral sciences to family practice residents.

SUMMARY:

In this workshop, we describe the approach to the teaching of behavioral sciences to family medicine residents at McMaster University in Hamilton, Ontario. Instead of a block placement in the psychiatric unit, teaching takes place on a weekly half day devoted to behavioral sciences, for the entire duration of the two year residency. During the teaching time, a psychiatric consultant is present on site in the family medicine unit. The training is problem based, usually within small groups, utilizing cases that residents are seeing in their practice. Multidisciplinary teaching is emphasized.

The bulk of each half day consists of a review of cases the residents have been involved with, very often on videotape. We will discuss audiovisual medium as a teaching tool. We focus on giving feedback on the interview process in order to foster cohesive doctor-patient relationships and develop diagnostic acumen in a time efficient yet emphatic manner. We will look at ways in which learners can develop comfort levels to present themselves on tape in front of a small group.

A significant portion of the workshop will involve an experiential process in which the group will participate in a direct viewing of an audiovisual tape depicting the patient encounter. Many of the techniques used in giving feedback will be illustrated.

REFERENCES:

1. Walsh A, Davine J, Kates N: Teaching behavioural sciences to family medicine residents: integrating training into the family practice unit, Isr J Psychiatry Relat Scie 1998; 35:114–119.
2. Westburg J, Hilliard J: Teaching Creatively With Video. Springer Series on Medical Education, Springer Publishing Co., NY, 1994.

Issue Workshop 91
NEUTRALITY REVISITED: IS AUTONOMY WHAT WE MOST WANT?

Chairperson: John R. Peteet, M.D., *Department of Psychiatry, Brigham and Women's Hospital, 75 Francis Street, Boston, MA 02115*
Participants: Samuel B. Thielman, M.D., Allan M. Josephson, M.D., Leigh C. Bishop, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session the participant should be able to recognize how autonomy as a value influences neutrality as an ideal, and what alternatives its limitations suggest.

SUMMARY:

Autonomy generally trumps other values in psychiatric as well as in medical ethics. Rather than give advice, therapists help patients make decisions for themselves. Yet psychological autonomy takes time to develop; many patients want direction or even need control, and as feminists have reminded us, there is an important relational dimension of mental health. This workshop considers how our views of autonomy influence not only the myth but the ideal of therapeutic neutrality. Dr. Sam Thielman will briefly review the history of autonomy as a value in Western medicine. Dr. Leigh Bishop, a philosopher as well as a psychiatrist, will then consider where autonomy currently fits among the goals of medicine and the other forms of freedom with which it is sometimes confused. Finally Dr. Allan Josephson will discuss from his perspective as a child and adolescent psychiatrist the task of helping families to understand how promoting autonomy relates to healthy self assertion, narcissism, and consideration for others' needs. The workshop will emphasize audience discussion of clinical material illustrating the challenges that clinicians face at the limits of neutrality.

REFERENCES:

1. Schneider CE: The Practice of Autonomy: Patients, Doctors, and Medical Decisions. Oxford, England, Oxford University Press, 1998.

2. Peteet JR: Doing the Right Thing: An Approach to Moral Issues in Mental Health Treatment. Washington, D.C., American Psychiatric Publishing, 2004.

Issue Workshop 92
FIBROMYALGIA: CURRENT UNDERSTANDING AND FUTURE DIRECTIONS

Chairperson: Alan Z.A. Manevitz, M.D., *Payne Whitney New York Psychiatric Hospital, 60 Sutton Place South, Suite 1CN, New York, NY 10021*
Participant: James P. Halper, M.D.

EDUCATIONAL OBJECTIVE:

To learn to diagnose fibromyalgia, to learn approaches to current and future clinical treatment of fibromyalgia, and to understand the pathophysiology and new research of fibromyalgia.

SUMMARY:

Fibromyalgia syndrome (FMS) is a common, chronically painful, frequently disabling disorder of unknown origin. Epidemiologic data indicate that FMS affects at least 2% of the general population in the U.S. (approximately 5 million persons). Between 6% and 10% of all individuals in a medical physician's waiting room may have FMS. In addition to the pain-classification criteria, FMS patients report a variety of other clinical symptoms, including psychiatrically relevant anxiety, depression, headaches, and dysfunctional sleep. Fibromyalgia is associated with high rates of disability, increased health care utilization, more frequent psychiatric consultations, and a greater number of lifetime psychiatric diagnoses than for controls. More and more patients with this frustrating disorder present themselves or are referred to psychiatrists and/or even diagnosed for the first time by psychiatrists, and are treated with psychotropic medication. In the past there was a common perception that FMS was just a manifestation of depression. We now understand the prevalence of depression in FMS is about 40%. The pain associated with FMS appears to involve many physiologic components of nociception, so the earlier perception that patients were psychosomatic malingerers has been replaced by the recognition of neurophysiological abnormalities such as abnormal brain imaging and abnormal levels of CSF substance P. During the presentation, presenters and audience will share cases of psychiatric disorder and abnormal pain so the psychiatrist will be better able to recognize and diagnose FMS; learn up-to-date clinical approaches to treatment of this complex disorder; and learn about new research findings that indicate FMS is a primary CNS disorder and thus may be better treated by psychiatrists than rheumatologists.

REFERENCES:

1. Lautenschlager J: Present state of medication therapy in fibromyalgia syndrome. Scand J Rheumatol Suppl, 2000; 113:32–6.
2. Staud R, Domingo M: Evidence of abnormal pain processing in fibromyalgia syndrome. Pain Medicine 2001; 2:208–245.

Issue Workshop 93
SUBSTANCE ABUSE IN THE PRISON SETTING

Co-Chairpersons: Leo L. Gallofin, M.D., *Cedars-Sinai Medical Center, 8730 Alden Drive W101, Los Angeles, CA 90048*
Jeffery Wilkins, M.D., *180 Surfview Drive, Palisades, CA 90272*
Participants: Thomas J. Rosko, M.D., Janet A. Martin, M.D., Katherine G. Ruiz-Mellot, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to define the problem of substance abuse in correctional facilities, how substance abuse confounds diagnosis and treatment of inmates with mental illness, the health and economic impact of substance abuse, and current models for its prevention and treatment.

SUMMARY:

More than 2 million individuals, or 0.7% of the U.S. population, are incarcerated in county, state, and federal prisons. Within this population, approximately 10 percent to 15 percent of these individuals suffer from mental illnesses, and half of the mentally ill prison populations have comorbid substance abuse problems. Despite their imprisonment, inmates are still able to acquire and use substances of abuse or use prescribed medications in abusive ways. This workshop has three goals: 1) to present the means by which prisoners obtain substances of abuse and abusable prescription medications and its health consequences, 2) to discuss advancements made in linking academic and public health medicine with correctional health care systems, and 3) to present an algorithm for the prescribing of antipsychotics and other psychotropic medications in the context of fiscal and other logistical challenges to providing mental health care to inmates.

REFERENCES:

1. Conklin TJ: Self-reported health and prior health behaviors of newly admitted correctional inmates. American Journal of Public Health 2000; 90:1939–1941.
2. Raimer BG, Stobo JD: Health care delivery in the Texas prison system. JAMA 2004; 292:485–489.

Issue Workshop 94
ASSESSMENT OF CAPACITY: LAW, ALGORITHMS, AND VIDEOTAPE

Chairperson: Michael E. Wise, M.R.C., *CNWL NHS Trust, Becmht 13-15 Brondesbury, London NWGGHX, United Kingdom*
Participant: Julian Beezhold, M.R.C.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant will be able to recognize the principles of capacity and informed consent and their differences. He or she will be aware of different resources used in the assessment of capacity and new ideas for recording the information in more defendable formats.

SUMMARY:

The aim of the workshop is to help participants improve their ability to assess capacity and be aware of relevant tools for aiding decisions regarding capacity and consent. The workshop is aimed at psychiatrists of all levels. Research has shown that there is room for improving the knowledge of the principles of capacity at all levels of experience from trainee to board registered practitioner.

Initially participants will view a clinical dilemma and discuss whether capacity is present. A presentation will then inform participants of legal principles. A second dilemma will allow participants to determine their understanding of the principles. The second case will be used to demonstrate an algorithm, which has been used in multiple jurisdictions for the assessment of capacity. A third dilemma will illustrate the boundaries of tools and involve a group decision.

REFERENCES:

1. Williams R: Safeguards for Young Minds: Young People and Protective Legislation. 2nd Edition. Gaskell, London, 2004.
2. Informed consent: information or knowledge? Medicine & Law. 2003; 22:743–50.

Issue Workshop 95
AUTISM: PARENTS AS THERAPISTS

Co-Chairpersons: Gary Heffner, M.A., *East Central Regional Hospital, 3070 Skinner Mill Road, Augusta, GA 30909*
Joyce Cox, *East Central Regional Hospital, 100 Myrtle Boulevard, Gracewood, GA 30812*

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant will be able to give a brief description of what applied behavior analysis (ABA) is, how it can be used to treat autism, and the benefits of training parents to use ABA to treat their children with autism.

SUMMARY:

Applied behavior analysis is one of the most common methods used to treat autism. This workshop will introduce the participants to a program offered, at no cost, to Georgia parents of children with autism. The Judevine Autism Program at East Central Regional Hospital in Gracewood, Ga., trains parents to use applied behavior analysis methods to treat their children with autism in their own homes. The program is divided into two parts: a five-day workshop that teaches behavior modification principles, strategies to improve communication, and other treatment methods for autism; and a five-day hands-on training in which the parents observe their child being trained by an autism trainer. This is followed by the autism trainer coaching the parent as he or she trains the child. The workshop will present a synopsis and examples of the actual workshops for parents, show video examples of the training, and have a question-and-answer session.

REFERENCES:

1. Kozloff M: Reaching the Autistic Child. Cambridge, MA, Brookline Books, Inc.
2. Loraas OI: Teaching Developmentally Disabled Children: The Me Book, Austin, TX, Pro Ed Inc., 1981.

Issue Workshop 96
PENAL JUSTICE AND INJUSTICE

Chairperson: Rodrigo A. Munoz, M.D., *Department of Psychiatry, University of California San Diego, 3130 Fifth Avenue, San Diego, CA 92103*
Participants: Igor Koutsemok, M.D., David Deitch, Ph.D.
Gretchen Bergman

EDUCATIONAL OBJECTIVE:

To evaluate different strategies for the treatment of psychiatric patients in the penal system.

SUMMARY:

The large proportion of the mentally ill, including those addicted to drugs, who spend a part of their youth, often a large part of it, behind bars, have no guarantee of education, treatment, rehabilitation, or even an adequate program for re-entry into society. This workshop discusses a number of relevant issues: What is better: incarceration alone leads to a large rate of recidivism; treatment alone has rates of dropouts around 90%; combined programs show more effectiveness, but what should be the definition of treatment success? Who are the patients most likely to succeed? What do we learn from current research? This workshop follows another we held at the annual meeting last year and strives to highlight the problems, opportunities, and stresses of the mentally ill in the penal system.

REFERENCES:

1. Fazel F, Danesh J: Serious mental disorder in 23,000 prisoners: a systematic review of 62 surveys. The Lancet 2002; 359:545–50.
2. Arboleda-Florez J: Mental illness in jails and prisons. Curr Opin Psychiatry 1999; 12:677–82.

Issue Workshop 97
GUESS WHAT'S IN YOUR GENES? TALKING ABOUT GENETIC ILLNESS IN THE FAMILY

Chairperson: Arlette M. LeFebvre, M.D., *Department of Psychiatry, Hospital for Sick Children, 555 University Avenue, Toronto, ON M5G 1X8, Canada*

EDUCATIONAL OBJECTIVES:

At the end of this workshop participants will understand how to assess children's level of health cognition and readiness for disclosure and how to plan a progressive disclosure about genetically based medical illness in the family.

SUMMARY:

The increasing availability of predictive genetic testing for late-onset diseases means there is a growing need to understand such testing. We know something about the psychological consequences of knowing about genetic predisposition to illness for adults, but much less is known about how children, who are particularly vulnerable to emotional distress and damage to self-esteem given their cognitive and emotional immaturity, react to finding out about genetic predisposition to illness. In this interactive workshop, participants will hear about the risks and benefits of telling children about autosomal dominant, life-threatening illness they may have inherited from their parents. Participants will learn a systematic approach to assessing children's general understanding of health and illness (health cognition), their need/right to know, and a progressive disclosure of medical and genetic information based on each child's biological, psychological and social needs. Finally, assessment of competence to consent to testing and treatment in children will be discussed.

REFERENCES:

1. Mitchie S, Bobrow M, Marteau TM: Predictive genetic testing in children and adults: a study of emotional impact. J. Med. Genet. 2001; 38:519–526.
2. MacDonald D, Lessick M: Hereditary Cancers in children and ethical and psychosocial implications. Journal of Pediatric Nursing, 2000; 15:4.

Issue Workshop 98
BARIATRIC SURGERY: PSYCHIATRIC CONSIDERATIONS

Chairperson: Laura T. Safar, M.D., *Baystate Medical Center, 3300 Main Street, 3rd Floor, Springfield, MA 01199*
Participants: Brenda Temblador, Ph.D., Wenda Restall, L.C.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to 1) recognize the elements in the psychiatric evaluation that could pose a risk for poor outcome from bariatric surgery and describe a multidisciplinary plan to address them, 2) describe the possible psychological complications post-bariatric surgery and their treatment.

SUMMARY:

Today, 97 million Americans are overweight or obese. An estimated 5 to 10 million of those are considered morbidly obese. The demand for bariatric surgery has significantly increased across America. The controversy around bariatric surgery in the public opinion and medical literature involves also the field of psychiatry.

Purpose: To review different topics relevant to the interface between surgery and psychiatry, specifically applied to bariatric surgery.

Content: Psychiatric assessment for bariatric surgery; Pre-op and post-op psychiatric treatment; Post-op psychiatric complications; Programmatic issues: A multidisciplinary team approach to the surgical treatment of morbidly obese patients.

Methodology: Four power-point presentations, of maximum 15 min. each, on the four topics described above. The presentations will be based on our clinical experience combined with information from a literature review. Our program has been working on bariatric surgery since 1998, and we see approximately 300 to 400 new patients per year.

Conclusion: The participation of psychiatrists and mental health professionals in the multidisciplinary team that provides care to morbidly obese patients is essential to maximize positive outcomes and minimize complications.

REFERENCES:

1. Sogg S, Mori DL: The Boston interview for gastric bypass: determining the psychological suitability of surgical candidates. Obesity Surgery 2004; 14(3):370–80.
2. Clark MM, Balsiger BM: Psychosocial factors and 2-year outcome following bariatric surgery for weight loss. Obesity Surgery 2003; 13(5):739–45.

Issue Workshop 99
HITCHCOCK'S *PSYCHO:* MADNESS, MOTHERS, AND MURDER

Chairperson: Hillary Johnson, M.A., *British Association of Counseling and Psychotherapy, 22 Elmcroft Avenue, London NW11 ORR, United Kingdom*
Participant: Lawrence Ratna, M.D.

EDUCATIONAL OBJECTIVE:

To recognize the role of defense mechanisms in madness and art.

SUMMARY:

Using film clips and textual analysis as evidence, patterns of obsessive themes in Hitchcock's work will be delineated. These will be correlated with known events from his biography. The audience will be invited to examine the evidence. It will be argued that the subtexts driving the film "Psycho" suggest that they were personal in origin. Despite being dismissed in its times as "schlock horror," it has continued to retain its premier position in top-ten lists. The success of this film may be related to the prevalence of these psychological mechanisms in our culture. The response of the participants to the film will be invited as an index of this hypothesis. The relationships between Hitchcock's life and his work will be examined. It will be suggested that his artistic and personal failures following "Psycho" [e.g., two of his worst turkeys "Topaz" and "Torn Curtain"] were related to his failure to cope with the emergence of these pathologies. The clinical implications will be explored.

REFERENCES:

1. Spoto D.: The Dark Side of Genius: The Life of Alfred Hitchcock, Ballantine Books, New York, 1983.
2. Ratna L: The long term effects of sexual abuse. Int. J. Psychiat. in Clinical Practice 1998; 2: 83–96.

Issue Workshop 100
CARING FOR THE MEDICALLY ILL PSYCHOTIC PATIENT: CLINICAL, LEGAL, AND ETHICAL DILEMMAS

Chairperson: Robert C. Joseph, M.D., *Department of Psychiatry, The Cambridge Hospital, 1493 Cambridge Street, Cambridge, MA 02139*
Participants: Judith G. Edersheim, M.D., Duncan C. MacCourt, M.D., Elizabeth A. Davis, M.D.

EDUCATIONAL OBJECTIVE:

To identify patients at risk for ultimate extrusion from the medical/psychiatric system; be familiar with management strategies; understand appropriate roles of consultation service, medicine, and legal departments.

SUMMARY:

Caring for acutely psychotic patients with serious medical problems presents medical, psychiatric, and legal dilemmas interfering with appropriate and timely medical care. This workshop describes such hospitalized patients who suffer from life-threatening medical illnesses, refuse medical care, experience prolonged hospital stays, endure multiple transfers between medical and psychiatric units, and for whom guardianship is sought.

Generally unaddressed in the literature, these patients generate conflict among medical, psychiatric, and legal departments, resulting in feelings of abandonment among patients and physicians alike. The psychiatric team focuses on securing acute medical care, but the medical team focuses on the treatment-interfering behavior and determines that psychiatric care is the primary goal. As a result, the medical problem gets obscured. Ultimately these patients are passed back and forth between services and suffer poor outcomes, including premature ejection from the hospital.

We discuss the dilemmas of fluctuating risk and capacity assessments made in the context of unstable mental status exams and medical courses. We examine the failures of a predictable systemic response, which often indulges the fantasy that the legal process will fix the problem and results in an unpredictable situation without a coherent agenda. We suggest a framework for anticipating these issues, improving collaboration between services, and supporting the medical team's central role in caring for the patient.

REFERENCES:

1. Schwartz CE, et al: The medical psychiatrist as physician for the chronically mentally ill. General Hospital Psychiatry 1998; 20:52–61.
2. Katz J: The Silent World of Doctor and Patient. New York, The Free Press, 1984.

Issue Workshop 101
DETECTION OF MALINGERING

Chairperson: Alan R. Hirsch, M.D., *Department of Psychiatry, Rush University MC, 845 North Michigan Avenue, Suite 990W, Chicago, IL 60611-2201*
Participants: David E. Hartman, Ph.D. Roni L. Seltzberg, M.D., Carl M. Wahlstrom, Jr., M.D.

EDUCATIONAL OBJECTIVE:

To utilize techniques to help delineate malingering.

SUMMARY:

In forensic psychiatry, psychiatrists and mental health professionals routinely need to assess the mendacity of histories and to weigh their candor or disingenuousness during the physical examination. Yet psychiatrists are only 56% accurate in recognizing deception. This session is designed to teach different methods for detecting

both verbal and nonverbal cues of deception in the clinical setting. Through use of audience participation and videotapes of actual lying episodes, methods of determining lying will be demonstrated.

REFERENCES:

1. Hirsch AR, Wolf CJ.: Practical methods for detecting mendacity: a case study. J Am Acad Psychiat Law, 2001; 29:438–444.
2. Ekman P., O'Sullivan M, Friesen WV, Scherer KR: Face, voice and body in detecting deceit. J Nonverbal Behav 1991; 15:125–135.

Issue Workshop 102
ADHERENCE IN SCHIZOPHRENIA: ROLE OF ATTITUDE, FAMILY, AND ENVIRONMENT
Collaborative Session With the National Institute of Mental Health

Chairperson: Timothy Cuerdon, Ph.D., *National Institute of Mental Health, 6001 Executive Boulevard, MSC 9615, Bethesda, MD 20892*
Participants: Alex J. Kopelowicz, M.D., Peter J. Weiden, M.D., Dawn I. Velligan, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize and utilize the precepts of three explanatory models of adherence with their patients who have schizophrenia.

SUMMARY:

Medication nonadherence remains a major barrier to optimal treatment outcomes for patients with schizophrenia despite dramatic advances in psychopharmacology. One obstacle is the lack of accepted explanatory or predictive models of nonadherence to antipsychotic medication. This workshop will present and contrast three distinct models. The intrapsychic model focuses on patients' subjective beliefs; the interpersonal model looks at the influences of the patient's family and social network; and the environmental model evaluates the impact of manipulations that might cue or remind the patient.

The health belief model (HBM) is an intrapsychic model that emphasizes the role of beliefs and attitudes, and takes at face value the patient's statements regarding his or her willingness to take medication. The theory of planned behavior is an interpersonal model that understands adherence as being highly sensitive to subjective norms, such as significant others' attitudes about adherence, and a person's desire to comply with the wishes of these significant others.

The environmental model focuses on other reasons for poor adherence, including forgetfulness and failing to establish routines. Environmental supports such as signs, checklists, special pill containers, and electronic devices have been used successfully to bypass the neurocognitive deficits that are common in patients with schizophrenia.

REFERENCES:

1. Kopelowicz A, Zarate R, Gonzalez Smith V, et al: Disease management in Latinos with schizophrenia: a family-assisted, skills training approach. Schizophr Bull. 2003; 29:211–27.
2. Velligan DI, Prihoda TJ, Ritch JL, et al: A randomized single-blind pilot study of compensatory strategies in schizophrenia outpatients. Schizophr Bull. 2002; 28:283–92.

Issue Workshop 103
CONVERSION DISORDERS IN CHILDREN: DIAGNOSTIC AND CULTURAL CHALLENGES

Co-Chairpersons: Richard K. Harding, M.D., *Department of Psychiatry, University of South Carolina, 15 Medical Park, Suite 104A, Columbia, SC 29203*
Craig A. Stuck, M.D., *University of South Carolina, 15 Medical Park, Suite 103, Columbia, SC 29203*
Participants: John E. Bragg, Jr., M.D., Ishmeal Major, M.D.

EDUCATIONAL OBJECTIVE:

To be familiar with a range of presentations of conversions disorders in children and adolescents: be able to identify common psychiatric comorbidities; understand the implications of spirituality in the diagnosis and treatment of conversions disorders in children; and recognize the importance and difficulty of distinguishing conversion disorders from factitious disorders.

SUMMARY:

This workshop on pediatric conversion disorders will be organized around three case presentations. The first case highlights the challenge of diagnosing a conversion disorder when a preexisting medical condition (brain tumor) exists that could account for the symptoms and the implications for treatment of the patient. It also demonstrates the comorbidity with mood disorders and issues of family communication. The second case deals with the difficulty medical staff may have in recognizing conversion disorders and the challenge of differentiating them from another illness as specialists render conflicting opinions. It also illustrates the importance of considering factitious disorder early in the evaluation process and introduces the spectrum of pediatric self-induced illnesses. The third case of a school-age child with astasia-abasia and tremors illustrates the difficulties families face in obtaining treatment as some psychiatrists may not be familiar with conversion disorders. It also shows the challenges in finding culturally acceptable forms of treatment when the family concludes the most likely cause is "root," a practice of magic preserved by the Gullah culture. The workshop will be organized to permit questions and discussion after each case presentation. There are no background requirements.

REFERENCES:

1. Wyllie E, Glazer J, Benbadis S, et al: Psychiatric features of children and adolescents with pseudoseizures. Arch Pediatr Adolesc Med. 1999; 153:244–8.
2. Campo J, Fritz G: A management model for pediatric somatization. Psychosomatics 2001; 42:467–476.

Issue Workshop 104
DEVELOPING TARGETED INTERVENTIONS FOR AUTISTIC SPECTRUM DISORDERS
Collaborative Session With the National Institute of Mental Health

Chairperson: Ann Wagner, Ph.D., *National Institutes of Health, 6001 Executive Boulevard, Room 7149, Bethesda, MD 20892-9633*
Participants: Christopher J. McDougle, M.D., Connie Kasari, Ph.D., Robert T. Schultz, Ph.D., Nancy Minshew, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session participants should be able to (1) recognize that the social, communication, and reasoning deficits that define autism manifest in very different behaviors at different developmental and cognitive levels. The participant should furthermore appreciate that these differences impact choice of interventions; (2) identify two core deficits of ASD as menifest in young children, and describe interventions targeted to those deficits; (3) describe

fMRI evidence for social perceptual deficits in ASD and computerized intervention programs designed to teach persons with ASD how to better recognize faces and facial communications of social intent and affect; (4) list the symptom clusters associated with autism that are potentially responsive to pharmacological intervention.

SUMMARY:

This workshop will be an interactive discussion about the translation of research on symptom expression into targeted interventions for autistic spectrum disorders (ASD). The workshop will include four presentations: 1) review of core symptoms of autism and how their expression is modified by development and by severity of the disorder; 2) review of early predictors of deficits in language and social deficits in ASD, particularly joint attention and symbolic play skills. This presentation will include results of a randomized clinical trial targeting joint attention and symbolic play skills in 3 to 4 year old children with autism, and prediction to later language abilities; 3) review of fMRI and neuropsychological data showing deficits in face perception and deficiencies in underlying brain systems among persons with an autism spectrum disorder (ASD). This presentation will highlight an ongoing intervention study to train persons with ASD to become "face experts"; 4) review of pharmacological treatments targeted toward underlying neurobiological abnormalities associated with autism. Systematic drug studies focused on these symptom clusters will be reviewed, as will potential side effects and possible mechanisms of action. A discussion period will follow.

REFERENCES:

1. McDougle CJ, Posey DJ: Autistic and other pervasive developmental disorders. In Pediatric Psychopharmacology: Principles and Practice, edited by Martin A, Scahill L, Charney DS, Leckman JF. Oxford University Press, New York, 2003 pp. 563–579.
2. Volkmar FR, Lord C, Bailey A, et al: Autism and pervasive developmental disorders. Journal of Child Psychology and Psychiatry 2004; 45:135–170.

Issue Workshop 105
HELPING PATIENTS COPE WITH CANCER: HOW TO MAKE A DIFFERENCE

Chairperson: Alex J. Mitchell, M.D., *Liaison Psychiatry, Leicester Partnership Trust, Leicester General Hospital, Leicester LE4 5PW, United Kingdom*
Participants: Robert Zachariae, M.D., Manoj Kumar, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session participants should be aware of the common psychiatric complications of cancer. They should recognize how certain coping styles influence short-term and long-term outcome. They should know the advantages and disadvantages of specific treatment methods. They should have knowledge of the wider perspective in developing a comprehensive psycho-oncology service.

SUMMARY:

In patients recently diagnosed with cancer, distress is extremely common, affecting the majority of patients. The most commonly reported concerns are worries about recurrence, worries about dying, concerns about loss of function, and concerns about physical complications and pain. As time passes, although the rate of distress reduces, a substantial proportion continue to experience symptoms of depression, anxiety, or a mixture of the two. Other patients have intense anger or irritability. The predictors of persistent distress are not well understood, but evidence suggests that the coping style of the patient is an important mediator of quality of life. However, the picture is rarely simple, with some styles such as denial having both positive and negative associations depending on time since diagnosis. A number of studies show that psychological and psychiatric interventions can improve quality of life and that these can often be delivered by health professionals from varied backgrounds. Even in health systems with low resources, it is possible for patients and health lay people to deliver supportive psychosocial care.

REFERENCES:

1. M Sharpe, V Strong, K Allen, et al: Major depression in outpatients attending a regional cancer centre: screening and unmet treatment needs. British Journal of Cancer 2004; 90:2; 314.
2. Newell SA, Sanson-Fisher RW, Savolainen NJ: Systematic review of psychological therapies for cancer patients: overview and recommendations for future research. Journal National Cancer Institute 2002; 94:558–584.

Issue Workshop 106
CHALLENGES WHEN PSYCHIATRISTS SEEK TREATMENT FOR THEMSELVES
National Alliance for the Mentally Ill

Co-Chairpersons: Michael F. Myers, M.D., *2150 West Broadway, Suite 405, Vancouver, BC V6K4L9, Canada*
Leah J. Dickstein, M.D., *Department of Psychiatry, University of Louisville School of Medicine, 3006 Dunraven Drive, Louisville, KY 40202*
Participants: Raymond M. Reyes, M.D., Francine Cournos, M.D., Jack Drescher, M.D., Suzanne E. Vogel-Scibilia, M.D.

EDUCATIONAL OBJECTIVE:

To appreciate common themes in the assessment and treatment of psychiatrists who have suffered a mental illness.

SUMMARY:

This workshop continues a collaborative dialogue with the National Alliance for the Mentally Ill (NAMI) that began in 1999. Our goal is to facilitate timely and state-of-the-art care when psychiatrists become ill. Drs. Myers and Dickstein will give brief opening remarks followed by four 12-minute presentations. Dr. Raymond Reyes will discuss pharmacotherapy and psychotherapy issues when a psychiatrist suffers from a mood disorder. Dr. Francine Cournos will summarize common manifestations of the stigma surrounding mental illness in psychiatrists and how self-disclosure may counteract these forces. Dr. Jack Drescher will explain how, despite APA having removed homosexuality from DSM over 30 years ago, some gay and lesbian psychiatrists will avoid needed treatment because of the absence of "gay-friendly" treatment in their home community. Dr. Suzanne Vogel-Scibilia, who serves on the serves on the board of NAMI, will enlighten us with lessons learned through support, education, and advocacy that can improve the lives of psychiatrists living with a mental illness. The audience will participate in the 30-minute discussion period by posing questions, giving commentary, and sharing their own stories if they like.

REFERENCES:

1. Cournos F: City of One: A Memoir. New York, WW Norton & Company, 1999.
2. Myers MF, Dickstein LJ: Treating medical students and physicians. Directions in Psychiatry 2003; 23:277–290.

Issue Workshop 107
GOT PSYCH? INCREASING STUDENT INVOLVEMENT IN PSYCHIATRY

Chairperson: Paul D. Cox, M.D., *Department of Psychiatry, University of California, Davis, 2230 Stockton Boulevard, Sacramento, CA 95817*
Participants: Cyndi R. Murrer, B.S., Sherry A. Nykiel, B.A., Deborah J. Hales, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to plan and implement educational opportunities to nurture medical student awareness of and interest in psychiatry.

SUMMARY:

As psychiatric educators, we must address the shortage of psychiatrists and the stigma held by many non-psychiatric physicians in treating mental illness. Clerkships provide the principal exposure to clinical practice. Many schools use student interest groups and shadowing experiences to encourage earlier experiences in psychiatry. However, these do not involve direct patient care. This workshop will focus on supporting broad-based student involvement in face-to-face patient care, nurturing an active student community devoted to psychiatry.

Paul Cox, M.D., will provide an overview of approaches to increase student interest in psychiatry.

Cyndi Murrer, MSIV, and Sherry Nykiel, MSIV, will present the Student Initiative for Psychiatric Education and Services (SIPES). This framework provides students opportunities to participate in treatment. Students develop patient education material and provide screening in student-run clinics with senior students providing leadership and teaching junior students. At this stage of professional development, these experiences can be formative and encourage students to develop higher levels of self-efficacy in psychiatry, influencing their future practices, regardless of specialty. Deborah Hales, M.D., will discuss this and other faculty and student initiatives to increase awareness and interest in psychiatry to recruit new psychiatrists and advance the interface between psychiatry and other areas of medicine.

REFERENCES:

1. Sierles FS, Yager J, Weissman S: Recruitment of U.S. medical graduates into psychiatry: reasons for optimism, sources of concern. Academic Psychiatry 2003; 27:252–259.
2. Sierles FS, Dinwiddie SH, Patroi D, et al: Factors affecting medical student career choice of psychiatry from 1999 to 2001. Academic Psychiatry 2003; 27:260–268.

Issue Workshop 108
OUTCOMES AND THERAPEUTIC PROCESSES OF ACUTE PARTIAL HOSPITALIZATION

Chairperson: Paul B. Lieberman, M.D., *Department of Psychiatry and Human Behavior, Brown University School of Medicine, 593 Eddy Street, Providence, RI 02903*
Participant: Mark B. Elliot, M.D., Rendueles Villalba, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to recognize the important therapeutic role of partial hospitalization, appreciate its therapeutic methods, and understand modifications in techniques helpful for more severely ill patients.

SUMMARY:

This presentation will address three issues in partial hospital care that remain insufficiently explored: (1) its effectiveness, (2) its "mechanisms of action," and (3) its utility for severely ill patients. We will present data from two acute partial hospital programs covering more than 1,400 patients, and using several, distinct psychotherapy orientations (CBT, IPT, existential therapy). Outcome data indicate that significant improvements occur in multiple areas of functioning (anxiety and depression, hopelessness, resiliency) and that there are striking similarities in outcome across several types of treatment. The data further suggest that these changes are not due entirely to medication effects, but to psychosocial factors as well. This is shown by the magnitude and time course of improvement, changes in functioning comparing treatment days to weekend days, and larger trends in social processes occurring during treatment. Modifications in treatment to address the needs of more severely ill patients, often not well served in partial hospital settings, will be presented.

REFERENCES:

1. Hoge MA, Farrell SP, Munchel ME, Strauss JS: Therapeutic factors in partial hospitalization. Psychiatry 1988; 51:199–210.
2. Russell V, Mai F, Busby K, et al: Acute day hospitalization as an alternative to inpatient treatment. Can J Psychiatry 1996; 41:629–637.

Issue Workshop 109
THE DOUBLE-EDGED SWORD: MENTAL HEALTH CHALLENGES IN HIV AND HEPATITIS C
Society for Liaison Psychiatry

Chairperson: Maria L.A. Tiamson, M.D., *Department of Psychiatry, Veterans Administration Hudson Valley HCS, 16 Hudson Watch Drive, Ossining, NY 10562*
Participants: Kenneth Ashley, M.D., Silvia Hafliger, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participants will be able to recognize the psychiatric issues that complicate the treatment of HIV and HCV and demonstrate an understanding of the challenges psychiatrists face in the management of these patients

SUMMARY:

This workshop is a panel-audience interaction focusing on two infectious disease epidemics that have been increasingly recognized as major health and socioeconomic problems, not only in the United States but globally. An estimated 40 million people are infected with HIV worldwide. The face of the HIV/AIDS epidemic has changed. The role that mental health care providers play has also significantly grown as the epidemic continues. In the third decade of AIDS, the post-HAART (highly active antiretroviral therapy) era brings significant issues that make the management of these patients quite challenging. Hepatitis C infects an estimated 60 million-180 million people worldwide. Pegylated interferon and ribavirin therapy have emerged as possible cures but have potentially serious neuropsychiatric complications. Co-infection with HIV and HCV is common. In the United States, it is estimated that the prevalence of HCV in individuals with HIV ranges from 16% to 25%. In addition, HIV and HCV appear to influence each other, hence co-infection has become a focus of attention. Understanding the impact of HCV and HIV on the diagnosis and natural history of these viruses and their contribution to patient morbidity is essential in the management of HIV and HCV. Mental health care providers need to familiarize themselves with these issues so that they can better help HIV and HCV patients cope with these devastating diseases. The panel will share their experience in dealing with the management of these patients and demonstrate the importance of the role of the psychiatrist in the treatment of these patients.

REFERENCES:

1. Crone C, Geoffrey G: Comprehensive review of hepatitis C for psychiatrists: risks, screening, diagnosis, treatment, and inter-

feron-based therapy complications. Journal of Psychiatric Practice 2003; 9:93–100.
2. Tiamson M: Challenges in the management of the HIV patient in the third decade of AIDS. Psychiatric Quarterly, Kluwer Academic/Human Sciences Press 2002; 73:51–58.

Issue Workshop 110
EDUCATING PATIENTS AND FAMILIES ABOUT BPD
National Education Alliance for Borderline Personality Disorder in Collaboration with the National Institute of Mental Health

Chairperson: Richard G. Hersh, M.D., *Department of Psychiatry, Columbia University, 635 West 165th Street, New York, NY 10032*
Participants: Kenneth Silk, M.D., Dixianne Penney, Ph.D., Perry D. Hoffman, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should recognize 1) the benefits of open discussion with patients and families about the diagnosis and treatment of BPD, 2) the risks in ignoring or overlooking BPD when evidence of the disorder is present, and 3) resources available for patient and family education about BPD.

SUMMARY:

Clinicians may be reluctant to make a diagnosis of borderline personality disorder (BPD) or to share the diagnosis with patients and families even when appropriately made. Clinicians' behavior may be influenced by a variety of factors including: 1) questions about the validity of the BPD diagnosis, 2) fear that the BPD diagnosis is stigmatizing, 3) countertransferential reactions including sympathy or fear leading to a desire to make a more "benign" diagnosis. In this workshop we will examine the benefits of open discussion with patients and families about BPD and its prognosis and treatments. We will review the benefits of encouraging patient autonomy through proactive psychoeducation. We will also examine the risks associated with avoidance of the borderline diagnosis, including the potential for complications from treating borderline pathology exclusively as Axis I symptomatology, resulting in limited response to treatment. We will present information about multifamily groups and mentoring programs and will hear vignettes from NEA-BPD about efforts to provide support and lessen the burdens for family members living with individuals with BPD. Audience members will be encouraged to discuss their experiences communicating the borderline diagnosis and educating patients and families about the disorder.

REFERENCES:

1. Gunderson JG, Hoffman PD (eds): Borderline Personality Disorder Perspectives: From Professional to Family Member. Washington, DC, American Psychiatric Publishing, (in press).
2. LeQuesne ER, Hersh RG: Disclosure of a diagnosis of borderline personality disorder. Journal of Psychiatric Practice 2004; 10:170–176.

Issue Workshop 111
CASE CONSULTATION IN FORENSIC PSYCHIATRY: FACTITIOUS DISORDER WITH PSYCHOLOGICAL AND PHYSICAL SYMPTOMS

Chairperson: Jay Wung, M.D., *Cedar-Sinai Medical Center, 8730 Alden Drive W-101, Los Angeles, CA 90048*
Participants: Henry C. Weinstein, M.D., Marc D. Feldman, M.D., Renee M. Sorrentino, M.D.

EDUCATIONAL OBJECTIVE:

To understand the diagnostic criteria for somatoform and factitious disorders; recognize when malingering and factitious disorder is a consideration; understand the indications for forensic consultation; make a systematic assessment of somatoform disorders, factitious disorder, and malingering; and incorporate the diagnosis of factitious disorder and malingering in a treatment plan.

SUMMARY:

The primary diagnostic tool in psychiatry has always been speech—we rely on patients to report their symptoms accurately. However, there are times when we are confronted by patients whose reported symptoms do not correspond to physical observation. When a factitious disorder or malingering is suspected, we are often limited in our ability to diagnose them. After a review of the literature of the epidemiology and diagnosis of factitious disorders, we will discuss a case of suspected factitious disorder with both psychologic and somatic symptoms. The case involves a patient who was hospitalized psychiatrically with complaints of depression and an alleged suicide attempt. In addition, the patient had complaints of chronic pain related to rheumatoid arthritis, visual loss, weakness, and difficulty walking. During the course of her stay, the diagnosis of factitious disorder was eventually made.

While reviewing the case, consultation with the panel of forensic psychiatrists will be obtained, with the purpose of establishing the reason and goals of consultation and further recommendations for the diagnosis and treatment of this case, as well as the medicolegal ramifications. The panel will be open to opinions and questions from the audience throughout the presentation.

REFERENCES:

1. Krahn L: Patients who strive to be ill: factitious disorder with physical symptoms, Am J Psychiatry, 2003; 160:1163–8.
2. Feldman MD: Playing Sick? Untangling the Web of Munchausen Syndrome, Munchausen by Proxy, Malingering, and Factitious Disorder, New York, NY, Brunner-Routledge, 2004.

Issue Workshop 112
USING ADULT LEARNING PRINCIPLES IN RESIDENT PSYCHOTHERAPY EDUCATION

Chairperson: Kim A. Coon, Ed.D., *Department of Psychiatry, University of Oklahoma College of Medicine, T, 4502 East 41st Street, Tulsa, OK 74135*
Participant: Bryan K. Touchet, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participants should be able to recognize several adult learning principles and strategies, identify their personal learning strategy using the ATLAS instrument, and describe how the information-processing model may be used to conceptualize and enhance psychiatry residents' learning of psychotherapy.

SUMMARY:

Psychiatric resident psychotherapy training is widely implemented using a model that combines didactic curriculum with supervision of actual cases. The goal of this training is to transform the resident's theoretical knowledge into procedural skills while recognizing the importance of additional factors such as mentoring, internalization, socialization, modeling, and identification. How this method of training influences competency acquisition or outcomes is not well-studied. The ACGME requirement that residents be trained for demonstrable competency in psychotherapy challenges the psychiatric community to develop training models that define and produce such competency and that are linked to positive outcomes. Contributions from the adult-learning and cognitive sciences may provide a research base upon which to begin addressing this formidable task. This workshop will use adult-learning principles and strategies as they may be applied to psychotherapy training. Participants will discover their own learning strategy by self-administration of a validated tool,

the ATLAS. In addition, information-processing theory will be used to provide a learning framework to conceptualize psychotherapy learning. Elements of a sample curriculum will be presented. This workshop is targeted to psychiatrists and mental health professionals who are interested in resident psychotherapy training and curriculum development.

REFERENCES:

1. Glaser R: The reemergence of learning theory within instructional research. American Psychologist 1990; 45:29-39.
2. Frankford DM, Patterson MA, Konrad TR: Transforming practice organizations to foster lifeling learning and commitment to medical professionalism. Acad Med 2000;75:708-717.

Issue Workshop 113
CHALLENGES IN TEACHING CULTURAL ISSUES TO PSYCHIATRIC RESIDENTS: PERSPECTIVES FROM RESIDENTS AND FACULTY

Chairperson: Antonio E. Bullon, M.D., *Department of Psychiatry, Beth Israel Deaconess Medical Center 330 Brookline Avenue, Boston, MA 02115*
Participants: Francis G. Lu, M.D., Jennifer R. Lee, M.D., David J. Geltman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize the importance of integrating cultural psychiatry into the curriculum of a general psychiatric residency and will become familiar with approaches to teaching this material.

SUMMARY:

In today's world, teaching cross-cultural psychiatry has become an essential part of residency training. The purpose of this workshop is to discuss the successes and challenges of teaching "Culture and Psychiatry," a PGY-3 course in the Harvard-Longwood Adult Psychiatry Residency Program. We will include perspectives from faculty and residents, with commentary from a national expert on cross-cultural psychiatric education. We will pose the questions: What teaching methods are available to address this vast area, and what are the pros and cons of each? We will also discuss issues in curriculum design, such as how to avoid stereotyping and how to strike a balance between teaching a method or a clinical approach to cross-cultural encounters vs. imparting detailed information about a limited number of specific cultural groups. Residents will discuss questions including: What is the best way to stimulate interest in one's colleagues and in the residency program? How can residents nurture their interest in this field and develop careers in cross-cultural psychiatry? The discussion will conclude with an expert perspective from Dr. Francis Lu, who will provide an overview of national trends in the teaching of cultural psychiatry.

REFERENCES:

1. U.S. Department of Health and Human Services: Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2001.
2. Constantine MG: Developing competence in multicultural assessment: implications for counseling psychology training and practice. Counseling Psychologist 1998; 26:922–929.

THURSDAY, MAY 26, 2005

Issue Workshop 114
GROUP THERAPY OF SUBSTANCE ABUSE

Co-Chairpersons: David W. Brook, M.D., *Department of Psychiatry, New York University, 215 Lexington Avenue, 15th Floor, New York, NY 10016*
Henry I. Spitz, M.D., *Department of Psychiatry, Columbia University, 1011 Central Park West, New York, NY 10023-4204*

EDUCATIONAL OBJECTIVE:

To recognize the indications and contraindications for the group therapy of substance abuse, understand the many types of group therapies utilized for these patients' treatments; comprehend the theoretical and technical issues involved in the varieties of group therapy discussed, use the information learned in the workshop to treat the patients successfully.

SUMMARY:

Group therapeutic approaches to the treatment of substance abuse have been found to be clinically effective and cost-effective and are in widespread use. There are many kinds of group therapies in use, and group therapy is the treatment of choice for most substance abuse patients and for those with comorbid disorders. This workshop is aimed at clinicians with an interest in this topic and will focus on the needs and interests of the participants. It will offer participants a brief but comprehensive overview of the field, looking at the use of various kinds of group treatments used to bring about behavioral change in a variety of treatment settings. Group approaches to be included are self-help groups, interpersonal group therapy, cognitive therapy addiction groups, modified dynamic group therapy, phase models of treatment, relapse prevention group approaches, family groups, and groups in therapeutic communities. The use of individual treatment and medications in conjunction with groups will also be discussed. Both theoretical and technical aspects of group treatments will be included. Audience participation and interaction with the presenters will be encouraged through the sharing of experiences and the use of examples from clinical practice.

REFERENCES:

1. Brook DW, Spitz HI (Eds.): Group Therapy of Substance Abuse. New York, Haworth Medical Press, 2002.
2. Flores P: Group Psychotherapy With Addicted Populations: An Integration of Twelve-Step and Psychodynamic Theory. Binghamton, NY, The Haworth Press, 1997.

Issue Workshop 115
SCULPTING THE SCULPTURE: REDEFINING ETHICAL BOUNDARIES IN FACULTY-RESIDENT RELATIONSHIPS

Chairperson: Manisha R. Punwani, M.D., *Department of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, MA 01655*
Participants: Mahmoud A. Mohamed, M.D., Paul S. Appelbaum, M.D., Eugene V. Beresin, M.D., Laura W. Roberts, M.D.

EDUCATIONAL OBJECTIVE:

To better understand ethical and fiduciary responsibilities of faculty in training residents about the Ethical framework in the faculty-resident relationship and provide recommendations.

SUMMARY:

The purpose of this workshop is to explore the ethical complexities that underlie the faculty-resident relationships. We will identify vignettes emphasizing the experience of residents in psychiatry to reflect on some of the common schemas that underlie the ethical problems that can take place in faculty-resident relationships. These ethical problems result in a failure to address important issues that involve teaching, training, supervision, research, and publishing. Maintaining an ethical relationship creates a healthy training environment. This workshop will highlight the importance of incorporating education into the curriculum regarding ethical responsibilities and boundaries in the faculty-resident relationship. This education needs to ongoing and should be devoted to promoting an alliance between faculty and residents. This will in turn improve the quality of residents' training and facilitate their growth as supervisors and psychiatrists. The workshop will be presented by pioneers in the field of psychiatry discussing the various dimensions of faculty-resident relationships from an ethical standpoint, from a training standpoint, and from a research view point. Two residents will also be participating in this workshop. This workshop is meant for residents, medical students, training faculty members, training directors, and chairpersons.

REFERENCES:

1. Sinai J, Tuberus RG: Developing a training program to improve Supervisor-Resident relationship-step defining types of issues. Teach Learn Med. 2001 Spring; 13(2):80–5
2. Clarkes M: Measuring the quality of supervision and the training experience of Psychiatry. Aust NZI Psych 1999; 33(2):248–52

Issue Workshop 116
FELLOWSHIP TRAINING IN PSYCHOSOMATIC MEDICINE: WHAT TO EXPECT FROM ACCREDITED PROGRAMS IN A NEW SUBSPECIALTY

Chairperson: Philip A. Bialer, M.D., *Department of Psychiatry, Beth Israel Medical Center, First Avenue and 16th Street, 5F09, New York, NY 10003-2992*
Participants: James L. Levenson, M.D., Vassilios Latoussakis, M.D., Susan Lee, M.D., Mark J. Ehrenreich, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to recognize the components of an accredited fellowship in psychosomatic medicine as well as appreciate the experience of this training.

SUMMARY:

Psychosomatic medicine was officially recognized as a new subspecialty in 2003, and the requirements for fellowship training were published by the American Council on Graduate Medical Education (ACGME) in 2004. Seven programs were formally accredited in March 2004. The training directors of several of these programs will discuss the details of fellowship training in this new subspecialty, including the didactics, range of clinical work, and supervision. There will be additional descriptions of the liaison aspects of the training with the med/surg staff. Fellows from these programs will also discuss their personal experience by presenting examples of particularly interesting cases they have seen and special projects they have developed. An open discussion of the future of psychosomatic medicine and subspecialty training will be encouraged. Finally, the issues of advantages and disadvantages of an accredited training program and the recruitment of fellows and faculty will be addressed.

REFERENCES:

1. Kornfeld DS: Consultation-liaison psychiatry: contributions to medical practice. Am J Psychiatry 2002; 159:1964–1972.
2. Lipsitt DR: Consultation-liaison psychiatry and psychosomatic medicine: the company they keep. Psychosom Med 2001; 63:896–909.

Issue Workshop 117
WORLD VIEW AND SPIRITUALITY IN CLINICAL PRACTICE

Chairperson: Allan M. Josephson, M.D., *Department of Psychiatry, University of Louisville, 200 East Chestnut Street, Louisville, KY 40202-3869*
Participants: John R. Peteet, M.D., Mary Lynn Dell, M.D.

EDUCATIONAL OBJECTIVE:

To identify the role of the relvance of a patient's world view to clinical assessment and case formulation, recognize the potential influence of the therapist's world view on the clinical encounter, and appreciate the ethical challenges in dealing with these factors in clinical practice.

SUMMARY:

Psychiatry's greater openness to considering religious and spiritual factors in mental health has stimulated a number of practical questions: How much should clinicians support the use of religious practices that appear to be therapeutic? What are the best ways to recognize and deal with religion's negative effects? What is the role of a therapist's own belief system in approaching these questions? This workshop offers a framework for understanding the diagnostic and therapeutic implications of different systems of belief (world view and unique spiritual experiences).

These concepts, often seen as foreign to clinical practice, have recently been described (Josephson and Peteet, 2004) in a framework consistent with current diagnostic and therapeutic practice. Brief presentations will use clinical material to illustrate 1) the concept and the clinical significance of world view; 2) implications for both the patient's and the therapist's belief system for diagnosis and case formulation; 3) therapeutic implications of world view; 4) strategies for the eliciting and working with the patient's spiritual life, including involving clergy, and 5) ethical and clinical controversies in working at the interface between psychiatry and religion. Faculty will encourage participants to discuss examples from their own practices to help clarify the basis for their approach.

REFERENCES:

1. Josephson AM, Peteet JR: Handbook of Spirituality and World View in Clinical Practice. Washington, D.C., American Psychiatric Publishing Inc, 2004.
2. Peteet JR: Doing the Right Thing: An Approach to Moral Issues in Mental Health Treatment. Washington, D.C., American Psychiatric Publishing Inc, 2004.

Issue Workshop 118
WOMEN AS LEADERS: OPPORTUNITIES AND STRATEGIES FOR SUCCESS
American Association of Psychiatric Administrators

Chairperson: Jeanne L. Steiner, D.O., *Yale University, 34 Park Street, New Haven, CT 06519*
Participants: Page Burkholder, M.D., Mary Ellen Foti, M.D., Elisabeth J.S. Kunkel, M.D., June A. Powell, M.D., Rose Yu-Chin, M.D.

EDUCATIONAL OBJECTIVE:

At the completion of the workshop, participants will be able to identify common organizational dynamics and techniques for successful negotiation.

SUMMARY:

Although recent historical developments have been encouraging, as more women enter medicine and biases have weakened, many institutional and interpersonal obstacles remain for women in academic and organizational arenas. The purpose of this workshop, which is sponsored by the American Association of Psychiatric Administrators, is to highlight the issues that women in leadership positions face and to describe techniques and strategies to optimize the chances for success. Topics will include 1) organizational dynamics and gender, 2) the power of language, 3) skill sets needed for academic advancement, 4) the role of consultation, peer support, and mentoring, 5) how to get through it all—the importance of humor and support from others; and keeping the balance between work, relationships, and personal health.

Each of the presenters will describe her career path and speak for 10 minutes on a topic. A minimum of 30 minutes will be devoted to a discussion between panelists and the participants.

REFERENCES:

1. Yedidia MJ, Bickel J: Why aren't there more women leaders in academic medicine? the views of clinical department chairs. Academic Medicine 2001; 76:453–65.
2. Nadelson CC: Women in leadership roles: development and challenges. Adolescent Psychiatry 1987; 14:28–47.

Issue Workshop 119
BUILDING TRAUMA RESILIENCY: THE IMPACT OF MUSIC ON THE LIFE OF HOLOCAUST SURVIVORS

Chairperson: Andrei Novac, M.D., *Department of Psychiatry, University of California, 400 Newport Center Drive, Suite 309, Newport Beach, CA 92660-7604*
Participant: Bonita Jaros, Ph.D.

EDUCATIONAL OBJECTIVE:

To become familiar with consequences of severe traumatic stress, and with concepts like intergenerational trauma, cognitive bias, resiliency, and vulnerability, and understand the effects of music as a resiliency-building modality.

SUMMARY:

Over the past decade within the field of traumatic stress, numerous contributions have covered clinical, biological, and psychosocial aspects of traumatic events of recent history. Besides psychopathology such as PTSD, survivors of trauma are facing numerous life changes that have had limited coverage in the psychiatric literature: physical vulnerability to stress, particular family dynamics, intergenerational transmission of trauma, and patterns in both resiliency and vulnerability. The authors, a psychiatrist and a professor of linguistics who is also trained as an opera singer, will be covering the resiliency-building effect that music has had in the life of some Holocaust survivors. First, an overview of the neurobiology of the stress response and its relationship to trauma-specific cognitive and behavioral patterns will be described. Such manifestations are cognitive bias, paratraumatic behaviors, intergenerational transmission of trauma, and resiliency. Dr. Nahoum Jaros will present music from the Holocaust era and its suspected role in resiliency-building for certain survivors. Some examples from Dr. Nahoum Jaros' recent recording, and specific case studies, will be included. Finally, the role of resiliency-building modalities in future prevention of trauma-related pathology and its incorporation in the educational system will be presented. Extensive discussion with the audience will be encouraged.

REFERENCES:

1. Jaros BN: Sounds of survival and regeneration: a microstoria of the Holocaust, 1940–1945. Doctoral dissertation, Claremont Graduate University, 2005.
2. Novac A, Hudley C: Cognitive bias and aggressive behavior: neurobiological considerations. Aggressive Behavior (in press).

Issue Workshop 120
HOMELESSNESS, ADDICTION, AND SEVERE MENTAL ILLNESS IN PERSONS WITH HIV/AIDS

Co-Chairpersons: Mary Ann Cohen, M.D., *Mount Sinai Medical Center, 220 West 93rd Street, Suite 14A, New York, NY 10025-7413*
Jack M. Gorman, M.D., *Department of Psychiatry, Mount Sinai Medical Center, 1 Gustave Levy Place, Box 1230, New York, NY 10029*
Participants: Jeffrey Weiss, Ph.D., Julie D. Maggi, M.D., Rosalind G. Hoffman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop, the participant should be familiar with the barriers to care in persons who are homeless, HIV positive, substance dependent, and severely mentally ill and the role of psychosomatic medicine in homeless outreach and improvement of adherence to care.

SUMMARY:

Persons who are homeless, HIV positive, severely mentally ill, and actively using alcohol and other drugs are dying of nonadherence to medical care. Although an array of comprehensive medical, psychiatric, and social services may be available, persons who are embroiled in the epidemics of homelessness and AIDS may lack access to care even when it is readily available. Co-infections with hepatitis C and other sexually transmitted diseases further complicate care. The consultation-liaison psychiatrist can play a significant role in homeless outreach. We will describe our five-year program to integrate mental health services into a homeless outreach program. The homeless outreach team was developed to provide access to comprehensive medical care to homeless persons with HIV infection. The initial role of the consultation-liaison psychiatrist was to provide support and education for members of the homeless outreach team. The goal of the C-L psychiatry program was to help our patients adhere to HAART when indicated. During the first phase, the C-L psychiatrist provided educational seminars to introduce the team to psychiatric diagnostic criteria and to the use of appropriate therapeutic modalities. The team was also introduced to the mental health system as it is currently constituted with its advantages as well as its limitations for persons with serious mental illness and drug addiction. The homeless outreach team provided hands-on education for the psychiatrists about barriers to health care.

The community outreach program provided initial funding for an AIDS psychiatry fellowship. The psychiatry fellow accompanied the team on visits to the community during outreach efforts. At times, the only possible bridge to care was to first treat the mental illness, and then provide medical care. Illustrative patients will be presented, and the audience will be invited to present cases to the panel for an interactive discussion.

A random sample of 25 charts showed that clients with suspected or diagnosed severe mental illness who were not in consistent psychiatric care and utilized the services of the homeless outreach team more frequently than other clients. The consultation-liaison intervention focused on education and referral to appropriate mental health services. In a random sample of 272 patients seen for initial evaluation by the AIDS psychiatry team, 42 (15%) were homeless at the time of evaluation.

The results of an integrated medical-psychiatric approach will be presented to assess the impact of psychiatric care on adherence and immune function. The results of an assessment of the attitudes of members of the homeless outreach team will be discussed.

REFERENCES:

1. Susser E, Valencia E, Conover S: Prevalence of HIV infection among psychiatric patients in a New York City men's shelter. American Journal of Public Health. 1993; 83:568–70.
2. Blank MB, Mandell DS, Aiken L, Hadley TR: Co-occurrence of HIV and serious mental illness among Medicaid recipients. Psychiatric Services 2002; 53:868–873.

Issue Workshop 121
EFFECT OF MATERNAL DEPRESSION ON THE COGNITIVE AND EMOTIONAL DEVELOPMENT OF CHILDREN

Co-Chairpersons: Syed S. A. Naqvi, M.D., *Department of Psychiatry, Cedars-Sinai Hospital, 8730 Alden Drive, Los Angeles, CA 90048*
Heather Lin, M.D., *Adult Psychiatry, Cedars-Sinai Medical Center, 8730 Alden Drive, W101, Los Angeles, CA 90048*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand the impact of maternal depression on children's cognitive and emotional development.

SUMMARY:

Major depression is a common disorder, with a lifetime prevalence of around 15%. An almost universal observation is the nearly twofold prevalence of major depressive disorder in women, perhaps as high as 25% for women. Depression has a profound negative impact on a wide range of interpersonal relationships and behaviors. Multiple studies have shown the harmful effects of maternal depression on children's cognitive development and emotional development. By age 20, a child with an affectively ill parent has a 40% chance of experiencing an episode of depression, and that figure rises to 60% by age 25. These children not only inherit the genetic predisposition for depression, but also may be exposed to adverse environmental conditions that predict depressive outcomes such as parental marital discord, higher levels of interpersonal stress, and negative parent-child relationships. Due to the fact that children are exquisitely sensitive to interpersonal contacts, and mothers constitute a major proportion of the child's social environment, the importance of understanding the impact of maternal depression on children's growth and cognitive development cannot be underestimated.

REFERENCES:

1. Hay DF: Postpartum depression and cognitive development. In Postpartum Depression and Child Development, edited by Murray L, Cooper PJ, New York, Guilford Press, 1997, pp. 85–110.
2. Gotlib IH, Goodman SH: Children of parents with depression in Developmental Issues in the Clinical Treatment of Children, edited by Silverman WK, Ollendick TH, Needham Heights, MA, Allyn & Bacon, 1999, pp. 415–432.

Issue Workshop 122
KENDRA'S LAW BECOMES REALITY: MANDATING OUTPATIENT TREATMENT IN MANHATTAN

Chairperson: Andrew M. Kleiman, M.D., *Department of Psychiatry, New York University/Bellevue Hospital, 462 First Avenue, Room 21W30, New York City, NY 10016*
Participants: Michael Magera, M.D., Gary R. Collins, M.D., Jennifer Correale, J.D.

EDUCATIONAL OBJECTIVE:

To demonstrate an understanding of the Manhattan Assisted Outpatient Treatment Program, its history and implementation, legal, clinical, and ethic challenges, and its possible benefits to the severely mentally ill person in the community.

SUMMARY:

In November 1999, New York State enacted Kendra's Law, legislation that provides for court-ordered, assisted outpatient treatment (AOT) to ensure that individuals wit mental illness and a history of hospitalizations or violence secondary to noncompliance participate in and receive community-based services appropriate to their needs. Manhattan's AOT program is the largest in New York State and is based at Bellevue Hospital Center and the NYU School of Medicine. A careful examination of the history of outpatient commitment after national deinstitutionalization reveals the various goals of the current legislation. Specific clinical and legal criteria for Kendra's Law will be examined, as well as the 'real life' implementation of Kendra's Law in Manhattan. Outcomes and results of research will be discussed, as Manhattan provides a unique patient population. The possible benefits of Manhattan's AOT program will be explored, along with its particular challenges and ethical considerations and therapeutic jurisprudence. The discussion will then turn to the future of outpatient commitment in terms of legal, clinical, and ethical considerations.

REFERENCES:

1. Swanson JW, Swartz MS, Borum R, et al: Involuntary outpatient commitment and reduction of violent behavior in persons with severe mental illness. British Journal of Psychiatry 2000; 176, 324–331.
2. Kendra's Law: An Interim Report on the Status of Assisted Outpatient Treatment. New York State Office of Mental Health, January 1, 2003.

Issue Workshop 123
PRESENTEEISM AND ABSENTEEISM: UNDERRECOGNIZED AND UNDERTREATED AT WORK

Chairperson: Steven E. Pflanz, M.D., *Department of Psychiatry, McGuire Air Force Base, 4348 Prestwick Road, McGuire AFB, NJ 08641*

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand the impact of mental illness on worker productivity and to identify and treat psychiatric illness in working populations.

SUMMARY:

Presenteeism (reduced work performance on the job) and absenteeism among employees suffering from mental illness represent tremendous costs for industry. Decreased productivity in employees with depression has been estimated to cost employers $44 billion annually, of which 81% is accounted for by decreased productivity at work and 19% by absenteeism. Equally troubling, presenteeism due to mental illness is often unrecognized and untreated. Less than one-third of employees suffering from depression report receiving a prescription for an antidepressant medication in the previous 12 months, consistent with data showing that only 20%–30% of Americans with mental illness obtain adequate treatment each year. Mental illness is the second-leading cause of presenteeism and absenteeism, accounting for 29% of all lost productivity in workers. Total health care costs are 50% higher among workers with untreated or undertreated mental illness. Importantly, it has been repeatedly demonstrated that the overwhelming majority of workers with mental illness can regain normal work functioning with effective treatment. In this workshop, we will examine how psychiatrists can work with employers to successfully identify and treat employees suffering from psychiatric illness. The majority of the session will be devoted

to audience discussion of the role of the psychiatrist in treating mental illness in working populations.

REFERENCES:

1. Stewart WF, Ricci JA, Chee E, et al: Cost of lost productive work time among US workers with depression. JAMA 2003; 289:3135–3144.
2. Marlowe JF: Depression's surprising toll on worker productivity. Employee Benefits Journal 2002; 27:16–21.

Issue Workshop 124
TREATING PHYSICIANS IN A CULTURAL CONTEXT: SOME UNIQUE ISSUES

Co-Chairpersons: Michael F. Myers, M.D., *2150 West Broadway, Suite 405, Vancouver, BC V6K4L9, Canada*
Leah J. Dickstein, M.D., *Department of Psychiatry, University of Louisville School of Medicine, 3006 Dunraven Drive, Louisville, KY 40202*
Participants: Nyapati Rao, M.D., Renato D. Alarcon, M.D., Carmen T. Webb, M.D.

EDUCATIONAL OBJECTIVE:

To recognize important cultural issues when assessing and treating medical students, physicians, and their loved ones.

SUMMARY:

North American physicians constitute a huge mosaic of individuals who are diverse in race and ethnicity, country of birth and medical training, gender, faith, sexual orientation, and so forth. In this workshop, we will address some of the distinctive issues when physicians become our patients. Dr. Dickstein will speak about cross-cultural issues in the assessment and treatment of medical students and residents. Dr. Rao will address cultural issues in treating Indian physicians in individual psychodynamic psychotherapy. Dr. Alarcon will talk about a range of matters when treating physicians who are Hispanic. Dr. Webb will discuss issues in treatment of African-American physicians. Dr. Myers will describe the challenges of providing culturally competent couples' therapy with physicians. During the 30-minute discussion period, the audience will participate by posing questions, providing commentary, and sharing disguised clinical vignettes.

REFERENCES:

1. Dickstein LJ: Medical students and residents: issues and needs. In The Handbook of Physician Health. Edited by Goldman LS, Myers M, Dickstein LJ. American Medical Association, Chicago, IL, 2000, pp. 161–179.
2. Alarcon RD: Committee on Cultural Psychiatry, GAP. Cultural Assessment in Clinical Psychiatry. American Psychiatric Publishing Inc., Washington, DC, 2002.

Issue Workshop 125
COGNITIVE THERAPY FOR PSYCHOSIS FOR PSYCHIATRISTS: BASIC TECHNIQUE

Chairperson: Shanaya Rathod, M.D., *Mulfords Hill Centre, 37–39 Mulfords Hill, Tadley Hants RG26 3HX, United Kingdom*
Participants: Douglas Turkington, M.D., David G. Kingdon, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to understand which of their patients with schizophrenia may benefit from cognitive therapy; be able to incorporate evidence-based elements of cognitive therapy into their work with patients with schizophrenia.

SUMMARY:

Cognitive-behavior therapy (CBT) as an adjunctive therapy for persistent symptoms of schizophrenia is now supported by meta-analyses and 16 published randomized controlled trials. Unfortunately, few training schemes exist and, consequently, trained therapists are rarely available. Psychiatrists may need to consider if they can adapt their practice to incorporate elements of CBT successfully (Turkington & Kingdon, 2000). They can build on general psychiatric engagement, assessment and formulation skills with a particular focus on the first episode of psychosis and its antecedents. General understanding of cognitive therapy processes and ways of working can be adapted. Specific work on voices, visions, delusions, thought disorder, and negative symptoms can then be incorporated within the framework of identified clinical groups in clinic, community, and inpatient settings. CBT compliments medication management by assisting with understanding and improving compliance with treatment and also the delusional elaboration sometimes associated, or simply faulty assumptions about the function and purpose of medication. It is also valuable in eliciting risk issues through its ways of drawing out connections between thoughts, feelings, and actions, for example, in relation to passivity or command hallucinations. The workshop will use key strategies, case examples, and video interviews and allow opportunity for discussion.

REFERENCES:

1. Kingdon DG, Turkington D: A Casebook Guide to Cognitive Behaviour Therapy: Practice, Training and Implementation. Chichester, Wiley, 2002.
2. Kingdon DG, Turkington D: (due out 2004). Treatment Manual for Cognitive Behaviour Therapy of Schizophrenia and Psychotic Symptoms. Series Editor: Persons J, NY, Guilford.

Issue Workshop 126
FINDING EFFECTIVE ADOLESCENT DRUG TREATMENT: ASSESSMENT OF 144 LEADING PROGRAMS

Chairperson: Mathea Falco, *Drug Strategies, 2028 Green Street, San Francisco, CA 94123*
Participants: Robert Millman, M.D., A. Thomas McLellan, Ph.D., David Lewis, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be better able to assess the quality of individual adolescent drug programs and to evaluate, refer, and treat adolescents who are abusing or who are dependent on alcohol and drugs.

SUMMARY:

Adolescent drug treatment is critically important, yet very little research illuminates what works and what does not. Building on a recent nationwide study of adolescent drug programs, this workshop will explore critical elements of effective treatment and how they are applied in actual practice. Supported by a grant from the Robert Wood Johnson Foundation, Drug Strategies, a nonprofit research institute, recently conducted the first comprehensive study of adolescent alcohol and drug treatment in the United States. Guided by a distinguished panel of nationally recognized experts (three of whom are workshop speakers), Drug Strategies identified nine key elements of effective treatment and used these elements to assess the quality of 144 highly regarded treatment programs across the country. Most of these programs failed to address a number of the key elements. (The results of this research were published in the Archives of Pediatrics and Adolescent Medicine on September 8, 2004.) The workshop will discuss the findings of the nationwide program assess-

ment and the implications for adolescent treatment in this country. Through discussion of the critical elements of adolescent treatment, the workshop will also assist practitioners in evaluating, treating, and/or referring adolescents with substance abuse problems to appropriate programs. This is a unique opportunity for clinicians to take away essential current research that can have immediate beneficial impact in their treatment of adolescents.

REFERENCES:

1. Brannigan R, Schackman B, Falco M, Millman R: The quality of highly regarded adolescent substance abuse treatment programs: results of an in-depth national survey. Arch Pediatr Adolesc Med 2004; 158:904–909.
2. Winters KC: Treating adolescents with substance use disorders: an overview of practice issues and treatment outcome. Subst Abus 1999; 20:203–224.

Issue Workshop 127
THE MARRIAGE OF PSYCHIATRY AND MEDICINE IN INTEGRATED TREATMENT FOR ANOREXIA NERVOSA

Co-Chairpersons: George S. Nasra, M.D., *Department of Psychiatry, Unity Health System, 46 Prince Street, 3rd Floor, Rochester, NY 14607*
Mary Tantillo, Ph.D., *Unity Health System, 835 West Main Street, Rochester, NY 14611*
Participants: Manuel Matos, M.D., Sheri A. Faggiano, R.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of this workshop the participant will: (1) identify challenges and opportunities related to treating AN patients on a medical versus psychiatric inpatient unit; (2) describe common fears, frustrations, and hopes related to planning and implementing an intrgrated treatment approach; (3) identify strategies to manage tensions associated with developing an integrated approach; (4) describe essential elements of an integrated inpatient AN care map.

SUMMARY:

Decisions to hospitalize patients with anorexia nervosa (AN) on either a psychiatric or general medical unit depend on patients' presenting problems and the abilities of the staff to provide "whole person medicine." This workshop for medical and mental health professionals presents a model for how the Eating Disorders Program, Psychiatry/Consultation-Liaison Service, Medicine, and Nursing at Unity Health System collaborated to locate the care of severely ill AN patients on a medical inpatient unit within the system. Presenters will discuss the development of an integrated care map, a model for staff training and consultation, as well as opportunities and challenges involved in the delivery of patient care over the first two years of our collaboration. This workshop will address the various fears, frustrations, and hopes on the part of leadership and staff involved in the collaboration. The workshop will address how to successfully negotiate the tensions experienced when planning and implementing care for AN patients so these tensions do not obstruct the collegiality and mutuality required to grow and maintain a healthy marriage between psychiatry and medicine in the inpatient treatment of these patients. The workshop will end with a discussion between the audience and faculty.

REFERENCES:

1. Anderson, A. E., Bowers, W., & Evans, K. (1997). Inpatient treatment of Anorexia Nervosa. In D. M. Garner & P. E. Garfinkel (Eds.). Handbook of treatment for eating disorders (pp. 327–353), New York: Ghe Guilford Press.
2. Mehler, P. S. & Anderson, A. E. (1999). Eating Disorders: A guide to medical care and complications. Baltimore, MD: The Johns Hopkins University Press.
3. Zerbe, K. J. (1999). Women's mental health in primary care. Philadelphia, PA,: W. B. Saunders.

Issue Workshop 128
THE FUTURE OF PSYCHOSOMATIC MEDICINE IN THE U.S. AND ABROAD
World Psychiatric Association's Section of Psychiatry, Medicine, and Primary Care

Co-Chairpersons: Michelle B. Riba, M.D., *Department of Psychiatry, University of Michigan, 1500 East Medical Center Drive, Ann Arbor, MI 48109-0295*
Rodolfo D. Fahrer, M.D., *Department of Psychiatry, University of Buenos Aires, J. Salguero 2436, 8 Floor, Buenos Aires 1425, Argentina*
Participants: Allan Tasman, M.D., Pedro Ruiz, M.D., Don R. Lipsitt, M.D.

EDUCATIONAL OBJECTIVE:

To conceptualize the future of the field of psychosomatic medicine in the hospital setting, in medical continuing programs, and in primary care settings.

SUMMARY:

The denomination of psychosomatic medicine as a new specialty of psychiatry may cause a lot of controversies around the world. The significant contributions of consultation-liaison psychiatry to the practice of medicine and the education of its practitioners demonstrate its future opportunities and challenges. The current paradigm implies a training beyond that of the consultation-liaison psychiatrist or the specialist in psychosomatic medicine; assistance must be given not only to psychosomatic patients but also to patients with all kinds of psychiatric and cerebral/organic disorders. The idea of a new specialization based on the concept of "consultation and liaison psychiatry" is a reality and represents a unique opportunity to focus on the curriculum that will be required and discuss educational parameters (clinical rotation, type of supervision, core competencies, etc.). These issues will be addressed in this workshop, with a focus not only on the issues in the U.S., but abroad as well.

REFERENCES:

1. Gazzola LRA, Muskin PR: The Impact of Stress and the Objectives of Psychosocial interventions. In: eds. Schein LA, Bernard HS, Spitz HI, Muskin PR: Psychosocial Treatment of Medical Conditions. Brunner-Routlege, New York, pgs 373–406, 2003.
2. Fox BH. Premorbid psychological funcations as related to cancer incidence. Journal of Behavioral Medicine, 1, 45–452, 1978.

Issue Workshop 129
ADVANCES IN EARLY INTERVENTION IN THE PRODROMAL PHASE OF SCHIZOPHRENIA

Chairperson: Ian E. Alger, M.D., *New York Hospital, Cornell University, 500 East 77th Street, Suite 132, New York, NY 10162-0021*
Participants: Lewis A. Opler, M.D., Eric R. Marcus, M.D., Clarice J. Kestenbaum, M.D.

EDUCATIONAL OBJECTIVE:

The participants should be able to identify the prodromal signs of schizophrenia from phenomenological as well as behavioral antecedents of psychosis. They will recognize the importance of accurate diagnosis and early interventions for improving long-term outcomes.

SUMMARY:

Dr. Kestenbaum will discuss the positive prodromal symptoms of schizophrenic psychosis and compare them with the negative symptoms inherent in schizotypal individuals. Early intervention to prevent psychotic breakdown will be discussed. Clinical vignettes from several prodromal clinics will be presented. Dr. Marcus will discuss the following differential diagnosis—schizophrenic prodrome vs. disorganized learning disabilities vs. chronic depression vs. mania. Recognizing and identifying each condition and clarifying why they are often confused with schizophrenia will be a central focus. Dr. Alger will present a brief clinical video of a family therapy session with parents and their son, demonstrating the importance of helping families apply a normalizing approach to behaviors that might otherwise be unduly pathologized. Dr. Opler will summarize research showing better outcomes for persons with schizophrenia in developing countries, as compared with those in more developed countries. He will discuss the value of addressing specific sociocultural factors in our culture in order to protect vulnerable individuals from developing schizophrenia.

REFERENCES:

1. Marcus E: Psychosis and Near Psychosis, 2nd Ed. IUP 2003.
2. Miller TJ, McGlashan TH, Woods SW, et al: Symptom assessment in schizophrenic prodromal states. Psychiatric Quarterly 1999; 70:273–287.

ADVANCES IN PSYCHOSOMATIC MEDICINE

ADVANCES IN PSYCHOSOMATIC MEDICINE: PSYCHIATRIC CARE OF THE MEDICALLY ILL

Chairperson: James L. Levenson, M.D., *Medical College of Virginia, P.O. Box 980268, Richmond, VA 23298*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand key principles in the care of psychiatric illness in the medically ill, including diagnosis and treatment, as exemplified in heart disease, cancer, obstetrics and gynecology, transplantation, and psychopharmacology.

SUMMARY:

Psychosomatic medicine (PM), the newest formally approved psychiatric subspecialty, represents a scientific and clinical discipline at the interface of psychiatry and medicine. PM psychiatrists treat and study three groups of patients: those with comorbid psychiatric and general medical illnesses complicating each other's management, those with somatoform and functional disorders, and those with psychiatric disorders that are the direct consequence of a primary medical condition or its treatment. While PM subspecialists are needed for the more difficult, complex patients in locations difficult for a general psychiatrist to see, many general psychiatrists provide consultations in general hospitals. Most psychiatrists have patients who have both psychiatric and general medical illnesses.

The American Psychiatric Press Textbook of Psychosomatic Medicine is the first textbook designed for the new subspecialty. It is the official textbook of the Academy of Psychosomatic Medicine. In this symposium, four selected chapter authors, Drs. Shapiro, Massie, Stewart, and DiMartini (covering heart disease, cancer, obstetrics and gynecology, and transplantation) will review crucial issues for each area: (1) epidemiology, (2) clinical features, (3) diagnosis and assessment, (4) etiology, (5) differential diagnosis, and (6) treatment of psychiatric illness in the medically ill. A fifth chapter author, Dr. Robinson, will present a detailed review of psychopharmacology in the medically ill. The symposium will encourage audience participation during the Q & A period following the presentation.

REFERENCES:

1. Shapiro PA: Heart disease, in the American Psychiatric Press Textbook of Psychosomatic Medicine. Edited by Levenson JL. American Psychiatric Press, Inc., Washington, D.C., 2005; pp. 489–514.
2. Massie MJ, Greenberg DB: Oncology, in ibid, pp. 597–618.
3. Stotland NL, Stewart DE, Munce SE, Rolfe DE: Obstetrics and Gynecology, in ibid, pp. 847–876.
4. DiMartini AF, Dew, MA, Trzepacz PT: Organ transplantation, in ibid, pp. 775–806.
5. Robinson MJ, Owen JA: Psychopharmacology, in ibid, pp. 995–1052.

PSYCHIATRIC ASPECTS OF HEART DISEASE

Peter A. Shapiro, M.D., *Department of Psychiatry, Columbia University, 622 West 168th Street, Box 427, New York, NY 10032*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe the role of psychiatric factors in heart disease and describe and treat psychiatric problems of cardiac patients.

SUMMARY:

Because heart disease is so common, psychiatrists must be prepared to deal with issues of cardiovascular comorbidity in the care of their patients. The relationships between psychiatry and cardiovascular disease cut both ways; psychosocial factors affect the heart and vascular system, and cardiovascular disease affects mental wellbeing. Psychological states and traits contributing to risk for the development or exacerbation of heart disease include anxiety, anger, Type A behavior pattern, stress, sleep disorders and, especially, depression. Behavioral disorders such as overeating, smoking, and alcohol abuse also add to the risk of heart disease. Proposed mechanisms linking depression and coronary disease include autonomic, platelet and inflammatory effects, as well as health behaviors. Heart disease contributes to risk for numerous psychiatric problems, especially depression, anxiety, and cognitive disorders. Special populations such as patients with congenital heart disease, defibrillators, transplants, and left ventricular assist devices, have characteristic difficulties. In providing psychiatric treatment for patients with heart disease, one must consider the evidence for treatment safety and efficacy in the specific patient group in question, psychiatric and cardiac side effects of medications, drug-drug and cytochrome P450 interactions, and possible benefits for both the patient's mental health and general medical wellbeing.

REFERENCE:

1. Shapiro PA: Heart disease, in APPI Textbook of Psychosomatic Medicine. Edited by Levenson JL. Washington DC, APPI, 2004.

PSYCHIATRIC ASPECTS OF CANCER

Mary Jane Massie, M.D., *Department of Psychiatry, MSKCC Memorial Hospital, 1275 York Avenue, New York, NY 10021-6007*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to describe the common fears and practical problems of patients with cancer, to recognize the most common psychiatric disorders in patients with cancer, and to describe the psychiatric aspects of cancer treatment and the usefulness of psychiatric interventions.

SUMMARY:

Cancer is a major health problem in the United States and other developed nations. The death rate for many cancers (prostate, breast, colon, and rectum) is declining, but as our population ages we can expect to see a doubling of the number of people living with cancer from 1.3 million to 2.6 million between the years 2000 to 2050. Psychiatrists who work in many different settings will encounter people who have been newly diagnosed with cancer and are contemplating or undergoing treatment and those who are cured of cancer but suffer with disabling effects of the disease or treatment; fear cancer recurrence or death; and have questions about risk factors for cancer; patterns of inheritance, their future employability, interpersonal and sexual relationships, and family functioning. This presentation will provide an overview of the psychological factors in cancer risk and progression, the most frequently encountered psychiatric disorders (depression, anxiety, and delirium) in adult cancer patients; psychiatric issues in specific cancers; psychiatric aspects of cancer treatments; psychiatric interventions in cancer patients; survivor issues and cancer patients' use of complementary and alternative medicine treatments.

REFERENCE:

1. Massie MJ, Greenberg D. Oncology, in APPI Textbook of Psychosomatic Medicine. Edited by Levenson JL. Washington: American Psychiatric Press, 2005, pp 597–618.

PSYCHIATRIC ASPECTS OF OBSTETRICS AND GYNECOLOGY

Donna E. Stewart, M.D., *Department of Women's Health, University Health Network, 200 Elizabeth Street, Toronto, ON M5G 2N2, Canada*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize, diagnose, and treat psychopathological aspect of reproductive events, psychiatric aspects of ob-gyn disorders, and psychiatric conditions specific to women's reproductive health.

SUMMARY:

Obstetrics and gynecology (ob-gyn) is a specialty filled with intensely emotional clinical events ranging from the birth of a wanted baby, to the debilitating symptoms of chronic pelvic pain. Despite the emotional challenges of infertility, miscarriages, abortion and hysterectomy, most busy obstetricians and gynecologists have relatively little training, time, or interest in psychosocial or psychiatric problems.

The scope of psychosomatic medicine in the area of ob-gyn includes psychopathological aspects of normal reproductive events across the life cycle; psychiatric aspects of ob-gyn conditions, diseases and treatments; and psychiatric conditions specific to women's reproductive health.

Treatment of women patients requires an understanding of the anatomical and physiologic substrates of reproduction, its social contexts, and the nature of ob-gyn conditions, diseases, and treatments. Both psychiatrists and obstetricians-gynecologists need to have current knowledge of basic information and realities of practice for the other specialty to provide optimal care for women.

This presentation will update psychiatrists on the rapidly changing knowledge base for infertility, sterilization, abortion, premenstrual dysphoric disorder, psychiatric issues in pregnancy and postpartum, hysterectomy, chronic pelvic pain, menopause, and urinary incontinence.

REFERENCE:

1. Stotland NL, Stewart DE, Munce S, Rolfe D: Obstetrics and Gynecology, in the American Psychiatric Textbook of Psychosomatic Medicine. Edited by Levenson JL 2004; pp 847–876 APPI, Washington DC, 2004.

PSYCHIATRIC ASPECTS OF ORGAN TRANSPLANTATION

Andrea F. DiMartini, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 Ohara Street, Pittsburgh, PA 15213-1605*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participants should understand the psychosocial requirements for successful transplantation and the importance of these factors in the pre-transplant assessment. Participants should also know how various psychiatric disorders impact on post-transplant outcomes. Finally participants should be aware of specialized areas of emerging interest (i.e. living donation) and also to discuss neuropsychiatric side effects of immunosuppressive medications.

SUMMARY:

By the end of 2004 over 330,000 patients will have received a transplant in the U.S. a number projected to exceed 1/2 million within the next seven years. During 2004 over 90,000 patients waited for an organ. Thus, many psychiatrists will come in contact with transplant candidates or recipients and can benefit from the specialized knowledge needed to assess, diagnose, and care for these complex patients. The requirements for successful transplantation necessitate a somewhat different approach to psychiatric consultation. Patients need to be evaluated for their knowledge of their illness, transplantation awareness, compliance, and social support. Prevalence rates of psychiatric illness in transplant patients can exceed 50% and may impact both outcomes and compliance, further highlighting the need for psychiatric assessment and treatment. In liver transplantation, addictions are common and a thorough assessment of the candidate's addiction history, abstinence, and rehabilitation are essential. Adaptation to both the pre-transplant waiting period and post-transplant course are challenging. Patients may face chronic illness and a difficult post-operative recovery. Areas of special interest include hepatic encephalopathy, ventricular assist devices, and living organ donation. Finally, an understanding of the neuropsychiatric side effects of immunosuppressive medications can aid in the correct diagnosis and treatment of medication problems post-transplant.

REFERENCE:

1. DiMartini A, Dew MA, Trzepacz PT: Organ transplantation, in the American Psychiatric Press Textbook of Psychosomatic Medicine. Edited by Levenson J. pp. 775–803, in press.

PSYCHOPHARMACOLOGY IN THE MEDICALLY ILL

Michael J. Robinson, M.D., *Department of Neuroscience, Eli Lilly and Company, 12894 Brighton Circle, Carmel, IN 46032*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to discuss potential pharmacokinetic changes in medical/surgical populations, identify patterns of potential drug-drug interactions, discuss clinical recommendations for the use of psychotropic medications in specific medical/surgical populations

SUMMARY:

Psychopharmacologic interventions are an essential part of the management of the medically and surgically ill, with at least 35% of psychiatric consultations including recommendations for medication. Rapid developments in this psychopharmacology place severe demands on clinicians to remain current with new agents, new indications for established agents, and potential pharmacokinetic and pharmacodynamic interactions in a polypharmacy environment, which also includes herbal and non-herbal over-the-counter preparations. This review will include information on basic psychopharmacologic concepts including pharmacokinetic and pharmacodynamic considerations in the medically ill and general principles of potential drug-drug interactions. Some medically and surgically ill patients may not be able to take medication by mouth and therefore will require a parenteral route of administration. We will review these options for major drug classes. Finally, some of the issues discussed will be presented in more detail with clinical recommendations for psychotropic medication use in specific medical/surgical populations.

REFERENCE:

1. Robinson MJ, Owen J: Psychopharmacology, in Levenson JL (Editor). Textbook of Psychosomatic Medicine. APPI Press, Chapter 37:pp 995–1052, In Press

ADVANCES IN PSYCHOTHERAPY

NEUROBIOLOGICAL UNDERPINNINGS OF PSYCHOTHERAPY

Glen O. Gabbard, M.D., *Department of Psychiatry, Baylor College of Medicine, 6655 Travis, Suite 500, Houston, TX 77030*

EDUCATIONAL OBJECTIVES:

To demonstrate a working knowledge of how neurobiological research informs psychotherapy.

SUMMARY:

This symposium is designed for psychiatrists and other psychotherapists who are interested in how neuroscience research informs psychotherapy practice. It will provide an overview of relevant data helping us understand the neurobiological underpinnings of psychotherapy. The symposium begins with Dr. Beitman's discussion of how our knowledge of the brain constrains the theories of therapeutic action. Dr. Gabbard will then apply neural network theory and recent research on borderline personality disorder to probe the neurobiological basis for transference phenomena in psychotherapy. The third presentation, by Dr. Viamontes, defines the anatomical targets of psychotherapy as three thatamocorticostriatal loops and their associated pathways. Dr. Regina Patty will then explicate how the brain takes past experience and uses it to predict what is going to happen next, a neurobiological understanding of expectation. The fifth presentation, by Dr. Bart Blinder, shows how neuroimaging studies have been used to understand certain psychotherapeutic processes and their action in the brain. Dr. Helen Mayberg wraps up the symposium with a discussion of her research on how medication and psychotherapy affect the brain in different ways that are complementary to one another.

REFERENCES:

1. Westen D, Gabbard G: Developments in cognitive neuroscience: II. implications for theories of transference. Journal of the American Psychoanalytic Association 50:99–134, 2002.
2. Goldapple K, Segal Z, Garson C, Lau M, Bieling P, Kennedy S, Mayberg H: Modulation of cortical-limbic pathways in major depression: treatment specific effects of Cognitive Behavioral Therapy. Arch Gen Psych 2004; 61:34–41.
3. Beitman BD, Nair J (editors): Self-Awareness Deficits: Defining and Treating Awareness Deficits in Psychiatric Patients. New York, W. W. Norton, 2004.
4. Blinder BJ: Psychodynamic Neurobiology, in Beitman B, Blinder B, Riba M, Thase M, Safer D: Integrating Psychotherapy and Pharmacotherapy: Dissolving the Mind-Brain Barrier. Norton, 2003. pp 161–180.

MAPPING BASIC PSYCHOTHERAPEUTIC PROCESSES ONTO THE BRAIN

Bernard D. Beitman, M.D. *Department of Psychiatry, University of Missouri, 1 Hospital Drive, Columbia, MO 65212*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: define basic psychotherapeutic processes to be mapped onto the brain.

SUMMARY:

The brain constrains psychotherapy theorizing. Models of psychotherapeutic change must now conform to the patterns by which the brain organizes memory, emotion, behavior and interpersonal relationships. This presentation will review the basic processes that define psychotherapy in ways that can be mapped onto the brain.

Psychotherapy may be divided into four stages each of which has a goal: engagement, pattern search, change, and termination. Change generally has three substages: giving up the old pattern(s), beginning the new pattern(s), and maintaining them. In addition psychotherapists activate their own and their patient's self-awareness, imagine futures with their patients, and encounter resistance, transference and countertransference. The circuits that subsume these processes and the principles by which they operate are very likely to help inform psychotherapeutic models of change.

Successful psychotherapy does not "dissolve" undesirable patterns (e.g., maladaptive interpersonal responses) but instead helps to create modifications or alternative circuits to prevent their full blown expression. Thalamo-cortical-striatal loops appear to be involved as well as hippocampus, amygdala, anterior cingulate and prefrontal cortex. Knowing how new cell creation in the dentate gyrus contributes to desired changes is likely to help sharpen psychotherapeutic principles, strategies, and techniques.

REFERENCE:

1. Beitman BD, Nair J (editors): Self-awareness Deficits: Defining and Treating Awareness Deficits in Psychiatric Patients. New York: W. W. Norton, 2004.

A NEUROBIOLOGICAL UNDERSTANDING OF TRANSFERENCE

Glen O. Gabbard, M.D., *Department of Psychiatry, Baylor College of Medicine, 6655 Travis, Suite 500, Houston, TX 77030*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to demonstrate a refined understanding of transference based on neuroscience data.

SUMMARY:

Neuroscience research has deepened our understanding of the phenomenon of transference. Neural network theory has taught us that representations are created by forming, strengthening, or pruning connections between neurons. These representations are multiple and help dispel the myth of "the transference" in clinical work. There are multiple transferences that come into play in varying degrees in every case of psychotherapy. Similarly, real characteristics of the analyst play a major role in which representations are activated in any specific dyad of therapist and patient. Two distinct memory systems come into play in the creation of transference—both implicit declarative and implicit procedural elements can be found in the components of transference in the clinical setting. Research findings using functional neuroimaging with borderline patients also suggest neuroanatomical correlates of transference. Borderline patients demonstrate a combination of hyperactivity of the amygdala and weakening of prefrontal inhibitory controls. Finally, neuroscience research leads us to a more precise understanding of the therapeutic action of dynamic psychotherapy and the fate of transferences.

REFERENCE:

1. Westen D, Gabbard G: Developments in Cognitive Neuroscience: II. Implications for Theories of Transference. Journal of the American Psychoanalytic Association 2002; 50:99–134.

NEURAL CIRCUITS IN PSYCHOTHERAPY

George I. Viamontes, M.D., *United Behavioral Health, 12125 Woodcrest Executive, St. Louis, MO 63141*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize the neural targets of psychotherapy and be able

to apply the theoretical model presented to achieve an enhanced understanding of actual clinical cases.

SUMMARY:

Psychotherapy is a verbal technique for correcting deficits in neural information processing that cause maladaptive behavior. A model will be presented that defines the anatomical targets of psychotherapy as three thalamocorticostriatal loops and their associated pathways: (1) the anterior cingulate circuit (ACC), which controls motivation and the salience of internal and external signals; (2) the orbitofrontal circuit (OFC), which mediates social appropriateness, empathy, object-affect associations, mood regulation, and neurovegetative processes; (3) the dorsolateral prefrontal circuit (DPC), which facilitates executive function, including problem-solving, remote memory activation, self-direction, motor responses, and use of words to direct behavior. Thalamocorticostriatal loops are efficient selectors that can focus brain processing on a particular set of stimuli while excluding others. The ACC and OFC have strong reciprocal connections with the amygdala. The nucleus accumbens (the striatal component of the ACC) is driven by hippocampal inputs, and is an important gateway through which memories can influence behavior. The loops are interconnected at higher cortical levels. The words of psychotherapy enter neural circuitry through the DPC, whereas nonverbal exchanges enter through the ACC. Psychotherapy can change many aspects of signal processing, including pattern recognition, object-affect associations, motivational amplification, and the use of external principles to drive behavior. Practical aspects of this model will be illustrated through a case example of an executive who is in therapy because of ongoing problems with sexual harassment of subordinates.

REFERENCE:

1. Viamontes GI, Beitman BD, Viamontes CT, Viamontes JA: Neural Circuits for Self-Awareness: Evolutionary Origins and Implementation in the Human Brain. in: Nair, J., and Beitman, B., eds., Disorders of Self-Awareness. New York: W.W. Norton & Company. In press, 1995.

HOW THE BRAIN USES THE PAST TO PREDICT THE FUTURE: IMPLICATIONS FOR PSYCHOTHERAPY

Regina Pally, M.D., *Department of Psychiatry, University of California Los Angeles, 11980 San Vicente Boulevard, Suite 810 Los Angeles, CA 90049-6606*

EDUCATIONAL OBJECTIVES:

Participants will be able to (1) demonstrate knowledge of how the brain unconsciously predicts the future, organizes brain systems in accordance with predictions, and uses consciousness to correct prediction errors and (2) formulate psychodynamic interpretations and CBT interventions, based on this neuroscience paradigm, in treating repetitive maladaptive patterns of behavior.

SUMMARY:

Neuroscience data suggest that perceptions and responses begin even *before* events actually occur. As a result of evolutionary 'survival' pressures, the brain has evolved a number of mechanisms to enhance the speed and efficiency of responding to the environment. One such mechanism is the ability to unconsciously make predictions about what is most likely to occur *next*, based on the sensory context of what is occurring *now* and what has occurred in the *past*. These unconscious predictive mechanisms activate the perceptual and behavioral systems, so that they are ready 'ahead of time' and can more quickly react to events when they occur. For example, in the perceptual system, the sensory cortex is 'primed' in such a way, so that neurons will be more likely to detect the predicted sensory input. Consciousness plays a regulatory role, to monitor whether what was predicted actually occurred and to make corrections when necessary. Predictive mechanisms and the regulatory role of consciousness have implications for the understanding and psychotherapeutic treatment of patients who repeat maladaptive patterns of behavior. Unconscious predictions contribute to transference phenomena. The monitoring role of consciousness relates to the role of interpretation, insight, self-reflection and cognitive restructuring.

REFERENCE:

1. Freeman WJ: How Brains Make Up Their Minds. New York: Columbia University Press, 2000.

BRAIN IMAGING OF PSYCHOTHERAPY: CAPTURING MEANING AND CHANGE

Barton J. Blinder, M.D., *Department of Psychiatry, University of California, Irvine, 400 Newport Center Drive, Suite 706 Newport Beach, CA 92660-7608*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should become acquainted with the recent brain imaging studies of psychotherapy and comparisons of psychotherapy and pharmacotherapy, implications for diagnosis, clarification of psychotherapeutic technique and processes will be reviewed. Acquaintance with the design and outcome of studies correlating brain imaging and clinical outcome will be reviewed.

SUMMARY:

Advances in brain imaging now permit studies designed to assess affective, cognitive, and relational experiences of patients in a number of psychiatric diagnoses and the consequences of pharmacotherapeutic and psychotherapeutic treatments.

The central nervous system correlates of affective and behavioral changes during specific psychotherapeutic techniques (cognitive, psychodynamic, behavioral) for depression and anxiety can now be localized predominately in frontal lobe areas related to attachment and error correction (orbital frontal, dorsomedial-lateral) linked with medial temporal lobe structures (amygdule, hippocampus, cingulate) related to affective modulation and memory.

The clarification of how certain psychotherapeutic processes (interpretation, transference, insight, working through) and patient resistances (defenses, diminished awareness) operate in the central nervous system may be advanced through specifically designed challenge studies. Suggestions for modifications in psychotherapeutic technique for greater efficacy may result from brain imaging studies connected to clinical outcome.

REFERENCE:

1. Blinder BJ: Psychodynamic neurobiology in Beitman, B, Blinder, B, Riba, M, Thase, M, Safer, D: Integrating Psychotherapy and Pharmacotherapy: Dissolving the Mind-Brain Barrier: Norton, 2003: pp 161–180.

DIFFERENTIAL BRAIN EFFECTS OF MEDICATION AND PSYCHOTHERAPY

Helen S. Mayberg, M.D., *Department of Psychiatry, Emory University, 101 Woodruff Circle, WMRB Suite 4313, Atlanta, GA 30322*

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to recognize brain change patterns associated with response to different antidepressant treatments.

SUMMARY:

Requisite brain changes underlying antidepressant response and clinical remission are the object of intense study. Pre-clinical studies

of medications emphasize a bottom-up chain of events including aminergic reuptake inhibition and associated presynaptic autoregulatory desensitization, up- and down-regulation of multiple post-synaptic receptor sites, and receptor-mediated second messenger, and neurotrophic intracellular signaling effects in the brainstem, hippocampus, hypothalamus and their neocortical afferents. In contrast, theoretical models of cognitive behavioral therapy (CBT) action implicate 'top-down' mechanisms and primarily cortical targets, as the intervention focuses on modifying attention and memory functions involved in the mediation of depression-relevant explicit cognitions, affective bias and maladaptive information processing. We have identified differential brain changes measured with FDG PET associated with depression remission in patients treated with pharmacotherapy (SSRI) or CBT, respectively, consistent with preclinical and theoretical evidence of complementary but distinct modes of action. Furthermore, two brain subtypes have been characterized *prior* to treatment using these PET techniques that correlate with differential outcome to these two treatments. These types of imaging studies lay foundation for future studies of direct measures of brain functioning in the development of new algorithms for first-line clinical management of depressed patients.

REFERENCE:

1. Goldapple K, Segal Z, Garson C, Lau M, Bieling P, Kennedy S, Mayberg H: Modulation of cortical-limbic pathways in major depression: treatment specific effects of cognitive behavioral therapy. Arch Gen Psych 2004; 61:34–41.

ADVANCES IN RESEARCH

RESEARCH FRONTIERS: BRIDGING PSYCHIATRY AND MEDICINE

Chairperson: Herbert Pardes, M.D., *Co-Chairpersons:* Marian I. Butterfield, M.D., John F. Greden, M.D., *Participants:* Alexander H. Glassman, M.D., Andrew H. Miller, M.D., David J. Kupfer, M.D., J. Douglas Bremner, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session the participant will be able to (1) understand the importance of risk in research design and in the conduct of clinical research studies; (2) describe the relationship between major depression and ischemic heart disease and the safety and efficacy of antidepressant drugs post infarction; (3) describe how stress can influence disease expression in cancer patients and potential mechanisms by which inflammatory cytokines can enter the brain and alter neurotransmitter function, neuroendocrine function, and behavior in cancer patients; and (4) understand the practical applications of brain imaging to patients with mental and neurological disorders.

SUMMARY:

Numerous research advances in psychiatry research now narrow the divide between and medicine, psyche, and soma. This session for practicing clinicians and researchers alike will highlight several ways in which research is bridging the gap between psychiatry and medicine. For example, we know that stress clearly can impact on physical and mental health, but what are the mechanisms that underlie this impact? This group of research leaders will discuss the relationships between mental and physical illness and health. First, Dr. David Kipper, professor and chair of psychiatry at the University of Pittsburgh School of Medicine and director of research at Western Psychiatric Institute and Clinic, will begin the session by addressing the importance of risk research in the design and conduct of clinical intervention studies. Dr. Kipper will revisit the goal of "clinical significance" in psychiatric research outcomes and discuss the need for a greater emphasis on types of outcomes and how best to achieve them. Dr. Alexander Glassman, professor of clinical psychopharmacology at Columbia University, will present on treating depression after a heart attack. Dr. Glassman will review the relationship between major depression and ischemic heart disease and summarize the safety and efficacy of antidepressants in individuals post myocardial infarction. Dr. Andrew Miller, professor of psychiatry at Emory will review the bi-directional interactions between the nervous system and the immune system, and how this interaction may play a significant role in the development and progression of cancer. He will also discuss how inflammatory signaling pathways influence cancer expression and the potential underlying mechanisms. Dr. J Douglas Bremner, associate professor of psychiatry and radiology at Emory will discuss the practical applications of brain imaging to patients with mental and neurological disorders. He will review how brain imaging, specifically PET and MRI, can yield practical information about mental and neurological disorders. He will conclude with a review of imaging research findings and current state of the field.

REFERENCES:

1. Kraemer HC, Kadzin AE, Offord DR, Kessler RC, Jensen P.S., and Kupfer D.J., Coming to terms with the terms of risk. Arch. Gen. Psychiatry 1997; 54:337-343.
2. Swenson JR, O'Connor CM, Barton D, Van Zyle LT, et al: Sertraline Antidepressant Heart Attack Randomized Trial (SADHART) Group: influence of depression and effect of treatment with Sertraline on quality of life after hospitalization for acute coronary syndrome. Am J Cardiol 2004; 15:93(8):1080.
3. Capuron L, Miller AH: Cytokines and psychopathology, lessons from interferon alpha. Biological Psychiatry 2004; 56(11):819-24.
4. Bremner JD: Brain Imaging Handbook. WW Norton, New York, 2005.

CLINICAL CASE CONFERENCES

1. HOUSE CALL: TREADING ON PRIVACY IN PUBLIC PSYCHIATRY

Jeffrey Akaka, M.D., *PO Box 11780, Honolulu, HI 96828-0780,* Edward F. Foulks, M.D., Leslie H. Gise, M.D., Susan Stabinsky, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant will be able to (1) be familiar with the influence of psychodynamics on clinical judgment; (2) discuss the role of HIPPA regulations on decisions involving privacy and confidentiality; and (3) formulate a treatment approach to phobic anxiety and depression in the community setting.

SUMMARY:

Community services in many cities include mobile outreach teams, but it is rare that a non-mobile team psychiatrist makes a house call to a patient in active treatment. When it does occur, it raises a number of important questions about the paychiatrist's reasoning and rationale in arriving at such a decision. The clinical concerns promptingconsideration of a house call can be at odds with the patient's stated wish for privacy. They can also be at odds with the psychiatrist's own wish to preserve the working alliance as well as spare the patient from having to face the consequences of inquisitive neighbors. The case presented is of a man in long-standing treatment for depression and anxiety, with a stated preference for privacy. His absence from the clinic, despite being precedented without incident and despite the current era of HIPPA regulations, nevertheless led the treatment team to consider making a house call. The presentation and discussion of this case's unexpected results will include the particular demands of working in community psychiatry settings, as well as the global application of the treatment principles and privacy considerations involved.

REFERENCES:

1. Gutheil TG, Gabbard GO: Misuses and misunderstanding of boundary theory in clinical and regulatory setting. Am J Psychaitry 1998; 155(3):409-414.
2. United States Department of Health and Human Services, Privacy of Health Information–HIPPA, Revised 4/3/03, www.hhs.gov/ocr/hipaa/privacy.html.

2. CONSULTATION/LIAISON CASEBOOK CHALLENGE: STRATEGIES AND LIMITATIONS IN ESTABLISHING COMPETENCY

Elisabeth J.S. Kunkel, M.D., *Department of Psychiatry, Thomas Jefferson Medical College, 1020 Sansom Street, 1652 Thompson Building, Philadelphia, PA 19107,* Angel Angelov, M.D., Larissa Chism, M.D., Dimitri D. Markov, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant will be able to (1) learn the need for flexibility and multiple strategies in facilitation successful resolution of refusal of vital medical treatment; and (2) understand the intervention and limitations of civil courts regarding competency to choose or refuse treatment.

SUMMARY:

Psychiatry was consulted to see a middle-aged man with severe chronic mental and physical illness. His doctors had recommended an amputation, made necessary by complications of his diabetes and osteomyelitis. The consultation was difficult inthis case, as the patient was acutely psychotic and had an unclear history of treatment with antipsychotic medications. The consultation-liaison psychiatry team called into question the patient's competency for medical decision making. The panel will discuss psychopharmacological treatment strategies, the challenges faced within the mental health court system regarding the involuntary commitment of medically ill patients, the nuances between capacity determination and involuntary commitment, the interactions with the primary medical/surgical team, and the problems formulating an appropriate psychiatric and medical aftercare plan.

REFERENCES:

1. Silver M: Reflections on determining competency. Bioethics 2002; 16(5): 455-68.
2. Winick BJ: The side effects of incompetency labeling and the implications for mental health law. Psychology, Public Policy and Law 1995; 1(1):6-42.
3. Appelbaum PS: Rethinking the conduct in psychiatric research. Archives of General Psychiatry 1997; 54(2): 117-120.
4. Grisso T, Appelbaum PS: Assessing Competence to Consent to Treatment. New York, Oxford University Press, 1998.

3. CROSSING THE LINE: DETERMINING YOUR PATIENT IS TOO DANGEROUS TO DRIVE

Carl B. Greiner, M.D., *Department of Psychiatry, Nebraska Medical Center, P.O. Box 985582, Omaha, NE 68198-5575,* Laura W. Roberts, M.D., Steven Wengel, M.D., Nicole Wolfe, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant will be able to (1) understand criteria for "impaired driving"; (2) appreciate the taxonomy of driving behavior; and (3) recognize legal pitfalls in both reporting and not reporting impaired driving.

SUMMARY:

Impaired driving is a national concern. As psychiatrists, we examine patients who may have severe cognitive and emotional impairments that limit patient's ability to drive. This presentation will provide taxonomy of driving behavior.

Psychiatrists need to be alert to balanncing federal requirements for privacy (HIPAA) and the need to disclose dangerous behavior. The case conference will examine "road rage," substance abuse, and cognitive impairments as examples of potential driving impairment. Clinical issues, as well as forensic, and ethical perspectives will be privided.

REFERENCES:

1. Weiner BA, Wettstein RM: Legal Issues in Mental Health Care. New York, Plenum Press, 1993.
2. Leon J, Nahl D: Dealing with the stress and pressure in the vehicle, in Rothe PJ (ed) Driving Lessons—Exploring Systems That Make Traffic Safer. Edmonton, University of Alberta Press, 2002.
3. Impaired Driving. National Center for Injury Prevention and Control. http://www.cde.gov/ncipc/factsheets/driving. htm.

4. COMMANDED TO KILL: APPROACHING THE TREATMENT OF A MURDEROUS GRANDMOTHER

June A. Powell, M.D., *401 Waldron Street, P.O. Box 2519, Corinth, MS 38835-2519,* Patrice A. Harris, M.D., Nada L. Stotland, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant will be able to (1) create a differential diagnosis and treatment plan for delusional, suicidal and homicidal ideation in an elderly patient; (2) appreciate the complexities of appropriate disposition when delusional thinking

is a factor during commission of a felony; and (3) formulate strategies for helping treatment team members to function in the face of negative feelings

SUMMARY:

In this case of an elderly woman who presented after a suicide attempt, a compounding piece of history surfaces: 20 years beforehand, the woman had killed family members while under the delusion that she was helping them. How and when should this knowledge be brought into the design of individual treatment? Are similar symptoms at play now, and what is the differential diagnosis? The attending psychiatrist explores the clinical circumstances of the murders, and a forensic psychiatrist will elaborate on the disposition at the time. There will also be an exploration of the role of trauma, and discussion of the reactions and countertransferences engendered in family members and various treatment team members and their management.

REFERENCES:

1. Fenichel O: World-destruction fantasies, in: The Psychoanalytic Theory of Neurosis. New York: WW Norton & Co., 1945, 417-418.
2. Fenichel, Otto: The Psychoanalytic Theory of Neurosis, W.W. Norton & Company, 1966; "Obsessions and Compulsions"—being commanded, p. 269; "Suicide", pp. 40-401; "Schizophrenia"—world-destruction fantasies, pp. 417-418, schizophrenic thinking, pp. 431-432, hallucinations, pp. 425, 427.
3. Freud, Anna; The Ego and the Mechanisms of Defense, International Universities Press, Inc., 1966; "Transference", pp. 16-27.
4. Spinelli MG (ed): Infanticide: Psychosocial and Legal Perspectives on Mothers Who Kill. Arlington, VA: Aerican Psychiatric Publishing, Inc., 2004.

CONTINUOUS CLINICAL CASE CONFERENCES

1. CONTROL WHAT YOU CAN: SUCCESSFUL TREATMENT OF TEENAGERS IN CHRONIC PAIN: PARTS 1 AND 2

Eva M. Szigethy, M.D., *Department of Psychiatry, Boston Children's Hospital, 300 Longwood Avenue, Boston, MA 02115-5724,* eva.szitethy@childrens.harvard.edu, John Campo, M.D., David DeMaso, M.D., Eyal Shemesh, M.D.,

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant will be able to (1) be familiar with the etiology of abdominal pain in adolescents; (2) formulate the complex condition of comorbid chronic pain and psychiatric disorder in order to arrive at a comprehensive treatment plan; (3) understand treatment considerations of psychotherapy, psychopharmacology, and such social components as school and parental involvement, for adolescents with chronic pain and psychiatric comorbidities; (4) learn how developmental factors impact on treatment planning and preventive work in adolescents with chronic physical illness.

SUMMARY:

A case of an adolescent female with both physical and functional components of abdominal pain as well as comorbid depression, anxiety, and bulimia will be presented. Discussants will focus on presenting the etiology of abdominal pain and associated psychiatric comorbidities, and how to formulate such a complex case in order to inform a comprehensive treatment plan. Risk, protective, and developmental factors in coping with a chronic physical illness durig adilescence will be discussed.

During the second session, discussion of this case will be expanded into presentation of a biopsychosocial treatment plan, focusing on cognitive-behavioral therapy, pharmacotherapy, and intensive family work in her treatment and prevention of relapse,. Information on working with the school system and preparing such complex youth for transition into adulthood will also be covered.

REFERENCES:

1. Campo JV, Bridge J, Ehmann M, Altman S, Lucas A, Birmaher G, DiLorenzo C, Iyengar S, Brent DA: Recurrent abdominal pain, anxiety, and depression in priamry care. Pediatrics 2004; 113: 817-824.
2. King RA: Pediatric inflammatory bowel disease. Child Adolesc Pediatric Clin N Am 2003; 12:537-550.
3. Szigethy E, Whitton SW, Levy-Warren A, DeMaso DR, Weisz J, Beardslee WR: Cognitive-behavioral therapy for sepression in adolescents with inflammatory bowel disease: a Pilot Study. J Am Acad Child Adolesc Psychiatry 2004; 43: 1469-1477.
4. Campo JV, Perep J, Lucas A, Bridge J, Ehmenn M, Kalas C, Monk, Axelson D, Birmaher B, Ryan N, DiLorenzo C, Brent DA: Citalopram treatment of pediatric recurrent abdominal pain and comorbid Internalizing disorders: an exploratory study. J Am Acad Child Adolesc Psychiatry 2004; 43(10): 1234-42.

2. WEATHERING THE STORM: MANAGEMENT OF COMPLEX TRANSFERENCES: PARTS 1 AND 2

Beth J. Seelig, M.D., *Department of Psychiatry, Emory University Psychoanalytic Institute, 2004 Ridgewood Dr. NE, #300, Atlanta, GA 30322,* bseelig@emory.edu, Wendy Jacobson, Otto F. Kernberg, M.D., John M. Oldham, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant will be able to (1) recognize psychosomatic manifestations of transferences as they can occur during the course of psychodynamic treatment; (2) formulate a treatment strategy for the management of psychotic transference; (3) learn about the effectiveness of professional consultation for clinical impasse; (4) be familiar with technical interventions in several difficult clinical situations, particularly using transference and countertransference awareness and interpretation.

SUMMARY:

Over the course of two sessions, the case of a young woman who presented initially as having problems with love relationships, and who later in the treatment described multiple physical symptoms, will be discussed. During a long and stormy psychodynamic treatment, she developed various psychosomatic symptoms, which were eventually understood to represent complex transferences, and which often seemed to defy interpretation and resolution. At one point, professional consultation with one of the panel of discussants (Dr. Kernberg) was sought by the attending psychiatrist (Dr. Seelig) in order to manage a psychotic transference.

Clinical material demonstrating the unfolding of various transferences, particularly narcissistic and self-destructive elements, and how they played out in the awareness and management of countertransference, will be emphasized during the second part of the case conference.

REFERENCE:

1. Kernberg OF: Aggressivity, narcissism, and self-destructiveness in the psychotherapeutic relationship, in New Developments in the psychopathology and psychotherapy of Severe Personality Disorders. New Haven, Yale University Press, 2004.

DEBATE

RESOLVED: SECOND GENERATION ANTIPSYCHOTICS ARE UNIFORMLY SUPERIOR IN SAFETY AND EFFICACY TO FIRST GENERATION ANTIPSYCHOTICS

Moderator: Richard E. D'Alli, M.D.
Affirmative: Ira D. Glick, M.D., John M. Davis, M.D.
Negative: Rajiv Tandon, M.D., William T. Carpenter, Jr., M.D.

Abstract:

Of the 20 antipsychotic agents available in the U.S., 14 are labeled first-generation typical antipsychotics (FGAs) and six are considered second-generation atypical antipsychotics (SGAs) (there are nine SGAs among approximately 40 antipsychotics in the world). Supposedly because of their greater efficacy and better safety and tolerability profiles in comparison to FGAs, SGAs are rapidly becoming the standard of antipsychotic pharmacotherapy; eg., in the U.S., they comprise about 85% of all antipsychotics prescribed. Are all atypical antipsychotics really *more effective* than typical agents? Are SGAs uniformly safer and better tolerated than FGAs? Drs. Glick and Daveis will argue that while SGAs do not constitute a completely homogeneous grouping, they are uniformly more efficacious, safer, and better tolerated than FGAs. They will further suggest that SGAs should be utilized across the board and that the use of FGAs should be proscribed. Drs. Tandon and Carpenter will contend that while SGAs have some advantages over FGAs, they have some disadvantages as well and the argument that SGAs are uniformly more efficacious and safer than FGAs is a gross oversimplification. They will further note different SGAs have different benefits and shortcomings compared with different FGAs and the individual profiles of each agent need to be matched to the unique needs of each individual patient as decisions about antipsychotic therapy are made.

REFERENCES:

1. Carpenter WT Jr: Phase IV industry-sponsered trials are of little or no value. Psychot Dis 2001; 5: 2-4.
2. Davis JM, Chen N, Glick ID: A meta-analysis of the efficacy of second-generation antipsychotics. Arch Gen Psychiatry 2003; 60: 553-564.
3. Geddes J, Freemantle N, Harrison P, et al: Atypical antipsychotics in the treatment of schizophrenia: systematic overview and meta-regression analysis. BMJ 2000; 231: 1371-1376.
4. Tandon R, Nasrallah HA: Subjecting meta-analyses to closer scrutiny: little support for differential efficacy among second-generation antipsychotics. Arch Gen Psychiatry 2005; 61, in press.

FOCUS LIVE

1. MAJOR DEPRESSIVE DISORDER

Alan F. Schatzberg, M.D., *Department of Psychiatry, Stanford University, 401 Quarry Road, Stanford, CA 94305-5717,* Deborah J. Hales, M.D., Mark H. Rapaport, M.D.

EDUCATIONAL OBJECTIVES:

As a result of participation in this interactive workshop using Audience Response System technology, attendees will review aspects of current clinical knowledge and increase their understanding of current diagnosis and treatment of major depressive disorder. Participants will engage in a self-assessment activity designed to help them identify areas where they might benefit from more study.

SUMMARY:

In FOCUS Live! sessions, expert clinicians, who served as authors and guest editors of Focus, will lead lively multiple-choice question-based discussions. Participants will test their knowledge with an interactive audience response system, which instantly presents the audience responses as a histogram on the screen, allowing private comparison with other clinicians in the audience. Questions will cover existing knowledge about major depressive disorder important to practicing general psychiatrists, including diagnosis, treatment, and new developments.

Major depressive disorder is a chronic, debilitating medical condition that may cause profound impairment in a patient's life. Managing depression and depressive symptoms is a great challenge for the clinician. With effective treatment, a large majority of people improve significantly. The session features the opportunity for participants to test their knowledge on specific features of diagnosis, epidemiology, natural history and course of depression, and psychosocial and pharmacological treatments over the course of the illness. Attendees will have the opportunity to ask questions and to increase their knowledge of current treatment of major depression.

REFERENCES:

1. FOCUS: The Journal of Lifelong Learning in Psychiatry, Volume 3, Number 1, Major Depressive Disorder. Winter 2005 (in progress).
2. APA Practice Guideline on the Treatment of Patients with Major Depression, 2000, 2nd Edition.

2. PSYCHOSOMATIC MEDICINE: CONSULTATION-LIAISON PSYCHIATRY AND BEYOND

Jennifer G. Gotto, M.D., *Department of Psychiatry, Cedars Sinai Medical Center, 8700 Beverly Boulevard, #8631, Los Angeles, CA 90048,* Thomas N. Wise, M.D. *Department of Psychiary, University of South Florida, 3315 East Fletcher Avenue, MDC, Box 14, Tampa, FL 33613,* Deborah J. Hales, M.D., Mark H. Rapaport, M.D.

EDUCATIONAL OBJECTIVES:

As a result of participation in this interactive workshop using Audience Response System technology, attendees will review aspects of current clinical knowledge in the field of psychosomatic medicine: psychiatry in the medically ill. Participants will engage in a self-assessment activity designed to help them identify areas where they might benefit from more study.

SUMMARY:

In FOCUS LIVE! sessions, expert clinicians, who served as authors and guest editors of Focus, will lead lively multiple choice question-based discussions. Participants will test their knowledge with an interactive audience response system, which instantly presents the audience responses as a histogram on the screen, allowing private comparison to other clinicians in the audience. Questions will cover existing knowledge regarding disorders that are considered within the context of psychosomatic medicine.

The session focuses on topics in consultation liaison psychiatry and presents information that is important to practicing general psychiatrists, including diagnosis, treatment, and current information on topics such as capacity to consent to treatment, body dysmorphic disorder, HIVAIDS, recognition of delirium and possible causes. Attendees will have the opportunity to ask questions and to increase their knowledge of current treatments.

REFERENCES:

1. FOCUS: The Journal of Lifelong Learning in Psychiatry, Volume 3, Number 2, Psychosomatic Medicine. American Psychiatric Publishing. Spring 2005 (in progress).
2. Wise MD, Rundell JR: Textbook of Consultation-Liaison Psychiatry: Psychiatry in the Medically Ill. American Psychiatric Publishing, 2002.

3. CHILD AND ADOLESCENT PSYCHIATRY

David L. Kaye, M.D., *Division of Child & Adolescent Psychiatry, Children's Hospital, 219 Bryant Street, Buffalo, NY 14222-2006,* Eugene V. Beresin, M.D., *Massachusetts General Hospital, 55 Fruit Street, Bulfinch 449, Boston, MA 02114,* Deborah J. Hales, M.D., Mark Rapaport, M.D.

EDUCATIONAL OBJECTIVES:

As a result of participation in this interactive workshop using Audience Response System technology, attendees will review aspects of current clinical knowledge in the field of child and adolescent psychiatry. Participants will engage in a self-assessment activity designed to help them identify areas where they might benefit from more study.

SUMMARY:

In FOCUS LIVE! sessions, expert clinicians, who served as authors and guest editors of Focus, will lead lively multiple-choice question-based discussions. Participants will test their knowledge with an interactive audience response system, which instantly presents the audience responses as a histogram on the screen, allowing private comparison to other clinicians in the audience. Questions will cover existing knowledge regarding disorders of children and adolescents that may persist into adulthood.

The session focuses on information that is important to practicing general psychiatrists, including diagnosis, treatment, and new developments in the areas of adolescent suicide and mood disorders, disruptive behavior disorders, eating disorders, developmental disorders and anxiety disorders. The session features the opportunity for participants to test their knowledge on specific features of diagnosis, epidemiology, psychosocial, and pharmacological treatments over the course of disorders affecting children and adolescents. Attendees will have the opportunity to ask questions and to increase their knowledge of current treatment.

REFERENCES:

1. FOCUS: The Journal of Lifelong Learning in Psychiatry, Volume 2, Number 4, Child and Adolescent Psychiatry. American Psychiatric Publishing. Fall 2004.
2. Kaye DL, Montgomery M, Munson S: Child and adolescent mental health. Lippincott Williams and Wilkins, 2002.
3. Dulcan MK, Martini R, Lake MB: Concise Guide to Child and Adolescent Psychiatry, 3rd Edition, American Psychiatric Publishing, 2003.

FORUMS

1. RESEARCH PLANNING FOR DSM-V

Chairperson: Darrel A. Regier, M.D.
Participants: Wilson M. Compton III, Bruce Cuthbert, Ph.D., Michael B. First, M.D., William E. Narrow, M.D., Maritza Rubio-Stipec, Sc.D., Norman Sartorius, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate knowledge of the multiple activities undertaken to establish a research base for DSM-V

SUMMARY:

A major goal for the next edition of the DSM has been to take advantage of the multidisciplinary research advances in mental health since the publication of DSM-IV. Toward this end, APA has devoted an extended period of time for research planning in advance of DSM-V. This process has involved an assessment of the current state-of-the-science in relevant fields, an assessment of knowledge gaps, and the production of short- and long-term research agendas to stimulate new research to address these gaps. Three mechanisms have been established to accomplish these goals: a "white paper" process focusing on cross-cutting issues, an NIH-sponsored conference series addressing issues in specific diagnostic categories, and a publicly-accessible website to document comments and suggestions from all user groups. This forum will provide a summary of these efforts to date. Presentation topics include: the outcomes of three diagnostic-specific research conferences (personality disorders, substance-related disorders, stress- and fear circuitry-related disorders) and a research methods conference; recommendations from White Paper working groups on gender issues, aging, and infant/young child diagnosis; an overview of the DSM-V prelude website; and finally, international perspectives in the research planning process.

REFERENCES:

1. Kupfer DJ, First MB, Regier DA (editors): A Research Agenda for DSM-V, Washington DC, American Psychiatric Association, 2002
2. Phillips KA, First MB, Pincus HA (editors): Advancing DSM: Dilemmas in Psychiatric Diagnosis, Washington DC, American Psychiatric Association, 2003

2. SHOULD PSYCHIATRISTS AND OTHER MENTAL HEALTH PROFESSIONALS TAKE A LEAD IN TOBACCO DEPENDENCE TREATMENT?

Chairperson: Jill Williams, M.D.
Co-Chairperson: Douglas M. Ziedonis, M.D.
Participant: Nora D. Volkow, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the forum, the participant should be able to understand how they might have an increased role as a tobacco dependence treatment provider. Participants will participate in a discussion of how program and system changes can support tobacco dependence treatment in mental health settings.

SUMMARY:

Tobacco dependence remains the leading preventable cause of death in the United States and is specifically widespread among individuals with psychiatric disorders who, as a group, consume nearly half the cigarettes sold in the United States and die in large numbers from tobacco caused illnesses. In addition to increased morbidity and mortality, tobacco use dramatically affects the metabolism of numerous psychiatric medications, increases triggers to other substances, and is increasingly costly financially to patients. In 1996, the American Psychiatric Association (APA) released clinical practice guidelines for treating tobacco dependence that acknowledged the need for psychiatrists to address tobacco dependence in all the patients they treat, as well as in the smoker without a psychiatric disorder who has failed prior treatment and might benefit from more intensive psychosocial and medication treatments. Despite these recommendations, psychiatrists have continued to play only a small role in the treatment of tobacco dependence. Psychiatrists have a great opportunity to increase their role in the treatment of tobacco dependence, but need additional training and the commitment to focus on this clinical problem. There is a great need for psychiatrists and other clinicians treating psychiatric disorders to provide tobacco dependence treatment and this must become a core responsibility of our professions. New research and program developments will be discussed and there will be the opportunity for participants to also engage in a discussion and voice their own opinions on the issues raised in the forum.

REFERENCES:

1. APA Practice Guideline for the Treatment of Patients with Nicotine Dependence. APA Press 1996; 153(10): 1–30.
2. Williams JM, Ziedonis DM: Addressing Tobacco among individuals with a mental illness or an addiction. Addictive Behaviors 2004; 29(6):1059–1270.

3. GETTING INTO RESEARCH WITH AFRICAN-AMERICAN PATIENTS

Chairperson: Mindy J. Fullilove, M.D.
Participants: Ronald O. Valdesseri, M.D., Carl C. Bell, M.D., Benedict I. Truman, M.D., Vivian Pinn, M.D.

EDUCATIONAL OBJECTIVES:

The participants in this forum will be able to: (1) discuss the reasons for concern about the lack of African-American participation in research studies; (2) list the reasons for African-American alienation from the research endeavor; (3) propose methods for increasing African American participation in research studies and clinical trials.

SUMMARY:

African American are at increased risk of illness but are underrepresented in clinical and etiological research. Because mental illness is important for African-American patients as both a primary concern and a secondary factor predisposing to or complicating other illnesses, many professionals are concerned about this problem. In this forum, leading scientists from psychiatry and other disciplines will discuss key issues involved in encouraging African-American patients to participate in research. Past abuses of African-American patients, such as the Tuskegee syphilis study, have left a legacy of distrust. The current organization of research, which confines most of the decision making about research questions and methods to a technical elite, feeds old fears. Furthermore, the use of many research findings to pathologize the African-American population also increases distrust and resentment. The presenters in this forum will discuss the ways in which mental health professionals can create new relationships that will overcome existing distrust. The forum, by presenting a serious investigation of the problem, will enable participants to improve their own research and to contribute to solving the overall problem of getting African Americans into research.

REFERENCES:

1. Institute of Medicine, Unequal Treatment: Understanding Racial and Ethnic Disparities in Health Care, 2002.
2. Smith GC, Thomas SB, Williams MV, Moody-Ayers S: Attitudes and beliefs of Afro-Americans toward participation in medical research. Journal of General Internal Medicine 1991;14:537-546.

4. PSYCHIATRIC MANAGEMENT OF TREATMENT-RESISTANT SCHIZOPHRENIA

Chairperson: Jack S. McIntyre, M.D.
Co-Chairperson: Darrel A. Regier, M.D.
Participants: Jeffrey A. Lieberman, M.D., Alexander L. Miller, M.D., Mark Olfson, M.D., Peter J. Weiden, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand current best practices in providing psychopharmacologic and psychosocial treatment for patients with treatment-resistant schizophrenia.

SUMMARY:

The treatment of schizophrenia has changed dramatically with the development of new pharmacological treatments and evidence for effective psychosocial treatments. Six second-generation antipsychotics are now available. Despite recent advances and increasing treatment options, many patients with schizophrenia remain symptomatic despite treatment. This session presents practicing clinicians with the best, currently available empirical and expert consensus data highlighting the most promising psychopharmacologic and psychosocial interventions for treatment resistant schizophrenia. This session features the nation's leading experts on treatment-resistant schizophrenia including: (1) Dr. Alexander Miller who will discuss strategies for switching antipsychotics, prescribing clozapine and combination treatments, along with current empirical and expert consensus practice guideline recommendations for managing treatment resistant schizophrenia; (2) Dr. Jeffrey Lieberman will present relevant new findings with implications for psychopharmacologic management of treatment resistant schizophrenia from the NIMH-funded CATIE antipsychotic clinical effectiveness study, (3) Dr. Peter Weiden will present data on the evidence base for CBT in managing treatment-resistant schizophrenia, comparing effect sizes associated with CBT to successful antipsychotic "switch" studies; and (4) Dr. Mark Olfson will present data from a large national sample of psychiatrists characterizing these patients, the strategies practicing clinicians currently use to manage treatment-resistant schizophrenia and the reported outcomes of these efforts.

REFERENCES:

1. Volavka J, Czobor P. Sheitman B, Lindenmayer JP, Citrome L, McEvoy J, Cooper T, Chakos M, Lieberman JA: Clozapine, olanzapine, risperidone, and haloperidol in patients with chronic schizophrenia and schizoaffective disorder. American Journal of Psychiatry 2002; 159(2):255–262.
2. Pantelis C, Lambert TJ: Managing patients with "treatment-resistant" schizophrenia. Med J Australia 2003;178:62–66.

5. HOW PSYCHO-ONCOLOGY CAME TO BE

Chairperson: Philip R. Muskin, M.D.
Participant: Jimmie C. Holland, M.D.

EDUCATIONAL OBJECTIVE:

(1) The audience will learn the crucial impact of cultural attitudes about cancer and mental illness on the development of the field of psycho-oncology. (2) The audience will learn about the role of psychosomatic medicine and consultation-liaison psychiatry in the evolution of psycho-oncology. (3) The audience will learn the range of barriers that affected the genesis and progress of psycho-oncology.

SUMMARY:

The formal beginnings of psycho-oncology date to the mid 1970s when the stigma around cancer diminished to the point that the diagnosis could be revealed and patients could talk openly, for the first time, about their feelings at having cancer. However, a second stigma contributed to the late development of interest in the psychological dimensions of cancer: negative attitudes attached to mental illness and psychological problems, even in the context of medical illness. These historical underpinnings continue to color contemporary attitudes and beliefs about cancer and its psychiatric comorbidity and psychosocial problems.

Over the last quarter century, psycho-oncology became a subspecialty of oncology with its own body of knowledge contributing to cancer care. A significant base of literature, training programs, and a broad research agenda have evolved with applications at all points on the cancer continuum: behavioral research to change life style and habits and reduce cancer risk; study of psychological issues related to symptom control (anxiety, depression, delirium, pain fatigue) during active treatment; management of psychological sequelae in cancer survivors; and management of the psychological aspects of palliative and end of life care. Links between psychological and physiological domains of relevance to cancer risk and survival are being actively explored through psychoneuroimmunology.

Psycho-oncology has come of age as one of the youngest subspecialties of oncology; as one of the most clearly defined subspecialties of consultation liaison psychiatry; and as an example of the value of a broad multidisciplinary application of the behavioral and social sciences.

REFERENCES:

1. Holland JC: History of psycho-oncology: overcoming attitudinal and conceptual barriers. Psychosomatic Medicine 2002; 64:206-221.
2. Hewitt M., Herdman R., Holland JC (Eds.): Meeting Psychosocial Needs of Women with Breast Cancer. [Report of the National Cancer Policy Board/Institute of Medicine and National Research Council]. Washington, DC: The National Academies Press, 2002.

6. IDENTITY AS PSYCHIATRISTS: HERITAGE AND CREATIVITY IN THIS UNIQUE SPECIALTY

Chairpersons: Carlyle H. Chan, M.D., Charles Raison, M.D.
Participant: Thomas P. Beresford, M.D.

EDUCATIONAL OBJECTIVE:

Participants in this forum will (1) gain an understanding of the roots of modern psychiatry that inform practice today, and (2) acquire a view of the sources of creativity as part of psychiatry's unique identity.

SUMMARY:

The heritage of psychiatry reaches back into that of medicine itself. Psychiatry's intellectual core lies in its need for complex differential diagnosis that can guide specific treatment. This necessitates knowledge of (1) the schools of dynamic psychiatry, (2) modern objective/descriptive psychiatry, and (3) internal medicine and neurology as applied to disorders that mimic psychiatric states. Both our history and our identity as psychiatrists correspond to this most complex of clinical approaches. Each area provides unique clinical tools in use today, and each overlaps with the others, generating the creative impetus for innovations in psychiatric diagnosis and treatment. From our heritage as differential diagnosticians, the identity of the field and one's own professional identity manifest themselves. Other professions, for example, practice psychotherapy but have neither the diagnostic skills nor the biological treatment experience that good psychiatric training develops. Conversely, medical specialties that provide physical diagnosis are usually limited by their lack of access to both the dynamic and objective/descriptive approaches of psychiatry. As our specialty moves into the new century, its creativity will lie principally in the freedom of its dynamic, descriptive, and medical traditions to question and to inform each other. From this interaction our unique specialty will continue to evolve into one of the most complex of medical disciplines.

REFERENCES:
1. Havens LL: Approaches to the Mind: Movement of the Psychiatric Schools From Sects to Science. Cambridge, Harvard University Press, 1987.
2. Arciniegas DB, Beresford TP: Neuropsychiatry: an Introductory Approach. Cambridge, Cambridge University Press, 2001.

7. ABPN UPDATE: CERTIFICATION IN PSYCHIATRY AND ITS SUBSPECIALTIES

Chairperson: Stephen C. Scheiber, M.D.
Participants: Naleen N. Andrade, M.D., Michael H. Ebert, M.D., David A. Mrazek, M.D., Burton V. Reifler, M.D., Victor I. Reus, M.D., James H. Scully Jr., M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the requirements for certification by the ABPN in psychiatry and the subspecialties.

SUMMARY:

The purpose of this workshop is to present information on the requirements for certification by the ABPN in psychiatry and the subspecialties of addiction psychiatry, child and adolescent psychiatry, forensic psychiatry, geriatric psychiatry, and psychosomatic medicine, as well as clinical neurophysiology and pain medicine.

Application procedures, including training and licensure requirements, will be outlined. The content of the Part I (multiple choice), Part II (oral), subspecialty (multiple choice) examinations will be reviewed. As of 2005, all of the tests except for the Part II examination will be administered in a nationwide network of computer test centers, and the new test administration procedures will be delineated. Test-taking approaches for the multiple-choice examinations and the Part II examination will be discussed.

REFERENCES:

1. Shore JH, Scheiber SC (Eds.): Certification, recertification, and lifetime learning in psychiatry. Washington, DC: American Psychiatric Press, Inc., 1994.
2. Scheiber SC; Kramer TAM; Adamowski S (Eds.): Core competencies for psychiatric practice: what clinicians need to know. Washington, DC: American Psychiatric Press, 2003.

8. CULTURE, SPIRITUALITY, AND FOLK BELIEF

Chairperson: Edward F. Foulks, M.D.
Participants: Pedro Ruiz, M.D., Sherri M. Simpson, M.D.

EDUCATIONAL OBJECTIVE:

To review cross-cultured literature regarding the role of spirituality in healing and recovery.

SUMMARY:

The relationship between spirituality and clinical empathy has been well established in anthropological and historical studies as well as in folklore and classical literature. The archetype of the "wounded healer" is a commonly encountered phenomenon across cultures and across centuries of human history. Examples range from the story of the origins of the ancient Greek icon of modern medicine, Eskalapias, to the ethnographies of Siberian shaman healers and Kardecian spiritual healers of eastern Latin America. Wallace and others have traced patterns in the lives of healers which include: (1) a traumatic event or catastrophic illness during a crucial phase of life; (2) emotional trauma &/or the delirium resulting from this event leads to an altered state of consciousness; (3) during this state, the subject may have a transcendental experience, which may include such influences of holy spirits, God's prescence, a near-death/out of body vision, or an existential perspective of the self vis-à-vis the world, society, and the universe; (4) a recovery occurs, but the transcendental experience is not forgotten which eventuates in a spiritual/personal change in identity and life/spiritual perspective.

REFERENCES:

1. Puchalski C, Larson D, Lu F: Spirituality Courses in Psychiatry Residency Programs. Psychiatric Annals. 2000; 30:8.
2. Puchalski C: The Critical Need for Spirituality In Our Healthcare System. New Theology Review, 2001.

9. CDC MENTAL HEALTH AND ILLNESSES

Chairperson: Marc A. Safran, M.D.
Participants: Daniel P. Chapman, Ph.D., Alex Crosby, M.D. Barbara Lopes-Cardozo, M.D., Pamela G. Tucker, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participants will be able to: (1) understand the overall role of CDC in public health, (2) describe specific examples of work in the field of mental health, (3) discuss potential pros and cons of greater CDC involvement with mental health-related issues

SUMMARY:

The U.S. Centers for Disease Control and Prevention (CDC), headquartered in Atlanta, strives to promote health and prevent disease across the United States and around the world. Because CDC is not a mental health agency, and because other agencies within the Department of Health and Human Services have the lead in the federal government in addressing mental health, CDC has historically avoided initiating efforts in this arena. Yet, over time, noteworthy projects have evolved. The cross-center CDC Mental Health Work Group has advanced CDC's efforts in the field. This presentation will provide examples of CDC work in the field of mental health, including work related to wellness, suicide, infectious disease, and environmental exposures.

REFERENCES:

1. Safran MA, Waller RR: Mental health-related calls to the CDC National AIDS Hotline. AIDS Education and Prevention 1996; 8 (1): 37–43.
2. Holtz HA, Hanes C, Safran MA: Education about adult domestic violence in U.S. and Canadian medical schools, 1987–88. MMWR 1989; 38:17–19.

10. APA AND THE PHARMACEUTICAL INDUSTRY

Chairperson: David M. McDowell, M.D.
Participants: Richard Balon, M.D., Charles R. Goldman, M.D., Trevor R.P. Price, M.D., Anand Pandya, M.D., David B. Mallott, M.D., Stephen M. Goldfinger, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be able to describe the current policies and activities of the APA and the ACCME; members will have shared their thoughts about important future directions for the APA; and approaches on how best to shape and oversee the industry/organizational boundary will have taken place.

SUMMARY:

The interface between the pharmaceutical industry and medical/professional organizations has become an area of increasing scrutiny and controversy. From scholarly publications to tabloid media, attention is being focused on the nature, content, oversight, and potential abuse of industry involvement in research, academic departments, and medical societies. In response to leadership and member concerns

about these issues, in 1999 the APA established the Committee on Commercial Support.

The Committee on Commercial Support is charged with developing policies and procedures to ensure that the interface between the APA and commercial/industry supported educational activities reflect the highest ethical and educational standards. Direct tasks of the group include monitoring the content of industry-supported presentations at the annual meetings, developing guidelines and policies for improving the quality and balance of these presentations, and establishing sanctions for members and organizations in violation of APA policy. Although many policies involve interpretation of the guidelines of the ACCME, others are newly developed by APA, which is now a leader for policy making in this arena.

In this forum, members of the committee will briefly present an overview of our current activities and some of the more controversial issues and decisions we are facing. The bulk of the forum will be an open discussion among members and attendees on these issues, with hopes that valuable contributions which can be implemented for future meetings will emerge from the interchange.

REFERENCES:

1. Friedberg M, Saffran B, Stinson TJ, et al: Evaluation of conflict of interest in economic analyses of new drugs used in oncology. JAMA 1999; 282;1453—1457.
2. ACCME's Essential Areas, Elements, and Decision-Making Criteria Accreditation Council for Continuing Medical Education, pp 7–10, July 1999.

11. A STITCH IN TIME: PSYCHIATRIC AND MEDICAL COMORBIDITY IN AFRICAN AMERICANS ACROSS THE LIFE CYCLE

Chairperson: Annelle B. Primm, M.D.
Participants: F. M. Baker, M.D., Debbie Carter, M.D., Stephen McLeod-Bryant, M.D., Kenneth M. Rogers, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the forum, the participant should be able to (1) identify the most prevalent psychiatric and medical disorders and causes of death among the African-American age group cohorts among children, adolescents, adults, and older adults; (2) list the most common psychiatric and medical comorbidities among each African American age cohort; (3) understand the rationale for preventive and intervention strategies to maximize longevity, health and mental health status, level of functioning, and quality of life among African Americans

SUMMARY:

The Surgeon General's Report has identified mental health as a critical ingredient in overall health. This presentation will involve a review of the most common psychiatric disorders in African American age cohorts from childhood through older adulthood and their most common medical comorbidities, which account for the leading causes of death. Among these co-morbidities are HIV/AIDS, homicide, heart disease and stroke. Disparities in recognition, treatment, and outcome of these comorbidities will be addressed. Exploration of risk factors including genetic, socio-environmental, cultural and individual behavioral contributors will be discussed and potential opportunities for risk reduction and prevention and intervention strategies will be presented.

REFERENCES:

1. Baker FM, Bell CC: Issues in the psychiatric treatment of African Americans. Psychiatric Services 1999; 50(3) 362–8.
2. Baker FM: The Afro-American life cycle: success, failure and mental health. Journal of the National Medical Association, 1987; 79: 625–33.

LECTURES

SUNDAY, MAY 22, 2005

LECTURE 1
AAPL/APA'S MANFRED S. GUTTMACHER AWARD LECTURE
SUICIDE RISK ASSESMENT: EVIDENCE-BASED PSYCHIATRY

Robert I. Simon, M.D., *8008 Horseshoe Lane, Potomac, MD 20854-3831*

SUMMARY:

The purpose of systematic suicide risk assessment is to identify modifiable, treatable ridk and protective factors that inform the patient's overall treatment and management. No standard of care ixists for the prediction of suicide. Suicide is a rare event. Efforts to predict who will comit suicide lead to a large number of false positive and false negative predictions. Suicide is the result of multiple factors including diagnosis (psychiatric and medical), psychodynamic, genetic, familial, occupational, environmental, social,m cultural, existential, and chance factors. Stressful life events have a significant association with completed suicides.

Suicide ridk assessment is a core competency. It is an inductive process, reasoning from specific patient data to arrive at a clinical judgment. Suicide risk assessment based on current research identifies risk and protective factors that enable the clinician to make evidence-decisions. Professional organizations recognize the need for developing evidence-based clinical recommendations to be applied to the management of various diseases, including such behavioral states as suicide.

REFERENCE:

1. Simon RI: Assessing and Managing Suicide Risk: Guidelines for Clinically Based Risk Management, American Psychiatric Publishing, Inc., Arlington, Va, 2004.
2. American Psychiatric Association: Practice Guidelines for tha Assessment and Treatment of Patients With Suicidal Behaviors. Am J Psychiatry 2003; 160 (suppl): 1-60.

MONDAY, MAY 23, 2005

LECTURE 2
DISTINGUISHED PSYCHIATRIST LECTURE SERIES
HUMAN PSYCHIATRIC DISORDERS: GENETIC MODELS IN MICE

Eric R. Kandel, M.D., *Columbia University, 722 W 168th Street, New York, NY 10032-2603*

SUMMARY:

In the last two decades molecular genetics has transformed neurology. Diagnoses of neurological disorders are no longer based only on sign and symptoms, but also on tests for the dysfunction of specific genes, proteins, and nerve cell components as well as brain scans for disturbances of neural systems, Molecular genetics also has led to the discovery of (1) several newly defined molecular diseases caused by mutations in specific genes, such as the channelopathies, and (2) new mechanisms of pathogensis such as the trinucleotide-repeat and the prion disorders. To date, however, molecular biology has had only a modest impact on psychiatry. I propose to address this issue by illustrating that whereas neurology has long been based on the location of disease in the brain, there is not a comparable strong neuropathology of mental illness. In addition, tracing the genetic causes of mental illness is a much more difficult task than finding the gene for Huntington's disease. There is no single gene for schizophrenia or most other mental illnesses. Most psychiatric disorders have a combined multigenic and environmental basis. As a result of these limitations, psychiatry has not been able to benefit from animal models of mental illness. I will suggest that during the next few years things will change dramatically. The field is beginning to identify some genes involved in the major mental illnesses. We also are beginning to know something about the neural circuits affected by these diseases. As a result, we can now develop satisfactory animal models of components of these disorders. I will devote most of the lecture to describe attempts to develop mouse models of the cognitive deficits present in two major mental disorders: (1) anxiety disorders that have a component of learned fear, and (2) schizophrenia, focusing on the cognitive symptoms reflected in working memory deficit.

REFERENCES:

1. Shumyatsky GP, Tsvetkov E, Malleret G, Vronskaya S, et al: Identification of a signaling network in lateral nucleus of amygdala important for inhibiting memory specifically related to learned fear. Cell 2002; 111:905-918.

LECTURE 3
INTERNATIONAL PSYCHIATRIST LECTURE SERIES
TERRORISM AND DISASTER: POPULATION MENTAL HEALTH APPROACHES

Beverley Raphael, M.D., *Centre for Mental Health, NSW Health Department, 73 Miller Street, Locked Mail Bag 961, North Sydney NSW 2 2060, Australia*

SUMMARY:

The paper will consider the exposures and potential stressors associated with terrorism and disaster. It will present the available evidence of the mental health and other health impacts at a population level, and as they impact on individuals. Taking into account factors such as resilience, age, pre-existing vulnerabilities, and preparedness, it will examine exposures ranging from natural catastrophes, to disasters related to climate change and global warming. It will specifically discuss exposures related to terrorism in terms of biological, chemical, nuclear and explosive attacks as well as longer term impacts of unknown and ongoing threat. Potential for psychological preparation at population and individual levels will be discussed, for instance potential for programs in schools and workplaces. Models will be informed by capacity building utilising strengths based approaches.

Interventions in the event of large-scale incidents, mass violence, ''dirty'' bombs will also be discussed with implications for mental health and related service systems planning, with both population and individual strategies for response based on the best available current evidence.

REFERENCE:

1. Ursano RJ, Norwood AE, Fullerton CS: Bioterrorism, Psychological and Public Health Interventions. Cambridge University Press, Cambridge UK., 2004.

LECTURE 4
APA'S ADMINISTRATIVE PSYCHIATRY AWARD LECTURE
ADMINISTRATIVE ADVENTURES IN PUBLIC PSHCHIATRY: 1967-2005

Gabriel Koz, M.D., *306 Indian Springs Road, Williamsburg, VA 23185*

SUMMARY:

Take a guided administrative tour of often dramatic, frontline, and historic public psychiatry experiences. It began with a reluctant Fulbright Scholar to Harvard Medical School and a teaching fellow at Boston City Hospital in the early 60s. In 1967, Albert Einstein College of Medicine was given the largest "Kennedy CMC" grant to commence the South View Throg. Neck CMHC. Exciting heady tomes followed with Jack Wilder, M.D., T. Byron Kavasu, M.D., et al, poised to solve the nation's systems of psychiatric care delivery. In 1969 Einstein sent Dr. Gabriel Koz to be the eighth in six months, last gap Director of Psychiatry, at the embattled Lincoln Hospital in the South Bronx (aptly then called Fort Apache), hoping for failure before disaffiliating. Against many political Vietnam era war issues. Dr. Koz stayed seven years, working with colleagues, the community, and others to save the affiliation and the residency program. In 1977, Dr. Koz was chosen to unify three separate high-rise state hospitals on Wards Island in the East River of New York City, into a unified Manhattan Psychiatric Center with 1,500 beds and budget cuts. There followed five years of creative paychiatric and environmental innovations, one of which resulted in the largest sculpture garden in New York State on hospital grounds. In 1982, Mayor Koch decided to finally open the brand new moth-balled, Hyatt-built Woodhill Hospital (All That Jazz, Roy Scheider), by closing two other aging hospitals. For 18 years, Dr. Koz and his colleagues at the department of psychiatry, served the underserved of Greenmount, Bedford Stuyvesant, and Williamsburg Communities of Northern Brooklyn. In 1999, John Fevet, hospital director of Eastern State Hospital, the nation's first psychiatry hospital (1773), invited Dr. Koz to join his great staff as hospital medical director. Today the hospital is 500 beds (going down) and has achieved many great things, including building the nation's first psychiatric hospital labyrinth. Some lessons to take home from this lecture are that administrative psychiatry is an honorable profession, public psychiatry should be strengthened, and not weakened in the U.S., and public indoor and outdoor art can be therapeutically achieved in all psychiatric institutions.

REFERENCE:

1. White Coat, Clenched Fist: Fitz-Hugh Mullen, McMillan 1976.

LECTURE 5
FRONTIERS OF SCIENCE LECTURE SERIES STRESS AND THE MIND-BODY CONNECTION: LESSONS FROM NEUROENDOCRINOLOGY

Bruce S. McEwen, Ph.D., *Department of Neuroendocrinology, Rockefeller University, 1230 York Avenue, New York, NY 10021*

SUMMARY:

The mind involves the whole body and two-way communication between the brain and many systems of the body via neuroendocrine mechanisms. Stress is a condition of the mind and a factor in the expression of disease that differs among individuals, involving not just major life events but also the hassles of daily life that elevate activities of physiological systems so as to cause wear and tear, called "allostatic load". Allostatic load is the produce of genetic load, lifestyle, adult experiences and developmental events that set life-long patterns of behavior and physiological reactivity. This cumulative process will be illustrated for the role of the hippocampus, amygdala and prefrontal cortex in mood and anxiety disorders. Besides developmental influences associated with mother-infant interactions, the most potent experiences in adult life are those arising from competitive interactions between animals of the same species. Socioeconomic status (SES) in human society is also associated with gradients of mental disorders and other diseases. These gradients are likely to reflect the cumulative burden of coping with limited resources and negative life events as well as differences in life style, and the allostatic load that this burden places on the physiological systems involved in adaptation and coping.

Supported by NIH Grants and the MacArthur Foundation SES and Health Network.

REFERENCE:

1. McEwen B: Allostasis and allostatic load: Implications for neuropsychopharmacology. Neuropsychopharmacology 2000; 22: 108–124.

LECTURE 6
APA'S ALEXANDRA SYMONDS AWARD LECTURE EATING DISORDERS IN MIDDLE AND LATE LIFE: DIAGNOSIS AND TREATMENT OF A NEGLECTED PROBLEM

Kathryn J. Zerbe, M.D., *Center for Women's Health, Oregon Health Science University, 3181 SW Sam Jackson Park Road, Mail Cod OPO2, Portland OR 97201-3098*

SUMMARY:

Eating disorders are increasingly recognized by clinicians as occurring across the life span. This lecture reviews the current literature and clinically recognized phenomena of anorexia and bulimia nervosa and ED NOS and body image concerns that occur in middle and later life. The phenomenology, biopsychosocial etiology, and unique treatment needs of this population are highlighted. Body image concerns, abuse of non-prescribed substances, psychiatric comorbidity, compulsive exercise, and healthy eating and exercise habits are addressed as part of a comprehensive clinical evaluation and treatment program.

Emphasis is placed on the differntial diagnosis of weight loss and body image issues in the population between 35 and 90 years of age. Case examples are used to amplify pertinent treatment options. Issues that confront this population of patients such as cultural attitudes toward aging, biological bedrocks of weight control, existential and spiritual issues, and normative life transitions are outlines as part of a psychoeducational approach for patients. Dynamics of control, power, competition, lack of sense of oneself, envy of those who are younger, and perfectionism are aspects of the psychodynamic constellation that find expression in the continuum of eating disorders in later years and require psychotherapeutic intervention. The need for additional research and clinical reports to expand our understanding and intervention for this emerging clinical population is made apparent by the aging of the baby boomer generation who continue to struggle with a plethora of self and body image problems that interfere with quality of life and a healthy acceptance of aging and mortality.

REFERENCE:

1. Zerbe KJ: Eating disorders in middle and later life: a neglected problem. Primary Psychiatry 2003; 10:6, pages 80-82.

LECTURE 7
FRONTIERS OF SCIENCE LECTURE SERIES EPIGENETIC PROGRAMMING OF STRESS RESPONSES THROUGH VARIATIONS IN MATERNAL CARE: THE NURTURE OF NATURE

Michael Meaney, Ph.D., *Department of Neuroscience, Douglas Hospital Research Center, 6875 Lasalle Boulevard, Montreal, Quebec H4H1R3, Canada*

SUMMARY:

Maternal care alters the development of emotional, cognitive and endocrine responses to stress in the rat. The mechanisms for these effects included changes in the expression of genes in brain regions that regulate central corticotrophin-releasing factor (CRF) synthesis

and release from hypothalamic and amygdaloid nuclei. The adult offspring of mothers that exhibit increased pup linking/grooming and arched-back nursing (LG-ABN) show increased glucocorticiod receptor expression throughout the hippocampus. The differences in glucocorticoid receptor expression serve to regulate hypothalamic-pituitary-adrenal responses to stress via effects on hypothalamic CRF systems. Cross-fostering studies suggest that these effects are indeed directly related to variations in maternal care and may form the basis's for a non-genomic transmission of emotionality across generations. Recent studies focus on the mechanisms for these effects by examining DNA methylation within the promoter regions of the rat glucocorticoid receptor gene. These studies reveal sustained effects of maternal behavior on the cytosine methylation of the consensus binding sequences for specific transcription factors associated with chromatin remodeling and transcription factor binding. Studies targeting histone deacetylation suggest that methylation is indeed the mechanism underlying the sustained effects of early experience on glucocorticoid receptor gene expression.

REFERENCE:

1. Weaver ICG, Cervonii N, Chanpagne FA, et al: Epignetic programming by maternal behavior. Nature Neuroscience 7(8):1-8.
2. Agrawal, AA: Phenotypic plasticity in the interactions and evolution of species. Science 294, 321-326 (2001).
3. Rossiter, MC: Maternal Effects as Adaptations (edl. Fox, TA & Mousseau, CW) (Oxford University Press, London, 1999).
4. Levine, S: The notogeny of the hypothalamic-pituitary-adrenal axis. The influence of maternal factors. Ann. NY Acad Sci 746, 275-293 (1994).

LECTURE 8
APA'S GEORGE TARJAN AWARD LECTURE TEMPERAMENT, MOOD DISORDER, AND HUMAN NATURE

Hagop S. Akiskal, M.D., *Mood Center, University of California at San Diego, 50 La Jolla Village Drive, San Diego, CA 92161*

SUMMARY:

Temperament is an ancient concept of psychological medicine, denoting the optimum mixture of emotional traits or reactivity. Despite a rocky history during the past 100 years, it has undergone a renaissance lately. This presentation summarizes the author's collaborative research in 12 countries worldwide, leading to the psychometrically validated Temperament Evaluation of Memphis, Pisa, Paris, and San Diego (TEMPS). This research has revealed five factors: depressive, anxious, cyclothymic, irritable, and hyperthymic. The cyclothymic and the anxious types are putative endophenotypes for the bipolar spectrum. Clinically, a reversal from temperament (e.g. depressive) to its opposite episode (e.g. mania) seems to fashion mixed states. Furthermore, cyclothymia is a prospective predictor of bipolar II and possibly that of suicide in youth. Unlike personality disorders, which label what is negative about a person, temperaments encompass both liabilities and positive attributes. Among the latter are self-denial and dependability, worrying about one's kin, skepticism and critical attitudes, romanticism, risk-taking, novelty-seeking, and leadership skills. Interestingly, such qualities often emerge during the recovery period from clinical depression. Along with subaffective traits, these attributes are highly prevalent in clinically well populations. The foregoing data suggest that the temperamental foundations of affective disorders in their dilute forms are very much part of human nature. These considerations in turn have profound implications for psychotherapy, social psychology, the creative process, psychopharmacotherapy, genetics and evolutionary biology.

REFERENCE:

1. Akiskal HS: Mood disorders, in Sadock and Sadock (eds) Kaplan and Sadock's Comprehensive Psychiatry, 8th ed. Baltimore, Lippincott, Williams & Wilkins, 2004.
2. Akiskal KK, Akiskal HS: The theoretical underpinnings of affective temperaments: implications for evolutionary foundations of bipolar disorder and human nature. JAD 2005, in press.

LECTURE 9
WILLIAM C. MENNINGER MEMORIAL LECTURE I AM THE CENTRAL PARK JOGGER: A STORY OF HOPE AND POSSIBILITY

Trisha Meili, *55 Gurley Road, Stamford, CT 06902*

SUMMARY:

Shortly after 9:00 p.m. on April 19,, 1989, a young woman out for a run in New York's Central Park was savagely beaten, raped, and left for dead. Doctors despaired for her life and a horrified nation cried out in pain and outrage. Fourteen years later, Trisha Meili refealed her amazing story of survival and recovery in her best-selling memoir, *"I Am the Central Park Jogger: A Story of Hope and Possibility."* Trisha Meili will share how her journey of healing clearly linked the mind, body, and spirit and taught her to look at healing in a new way. She will offer lessons that allowed her to move beyond being a victim, reclaim her life, and become whole.

REFERENCE:

1. Meili T: I Am the Central Park Jogger: A Story of Hope and Possibility. New York, NY, Scribner, 2003.

TUESDAY, MAY 24, 2005

LECTURE 10
DISTINGUISHED PSYCHIATRIST LECTURE SERIES FROM GENES TO THERAPEUTICS: NEW APPROACHES TO SCHIZOPHRENIA

Robert Freedman, M.D., *Department of Psychiatry, University of Colorado, Campus Box C249-32, Denver, CO 80262*

SUMMARY:

New findings in molecular biology and neurobiology are being rapidly translated into new directions for the clinical therapeutics of schizophrenia. An example of this approach is the development of nicotinic agonists for the treatment of cognitive dysfunction in schizophrenia. The lecture will review the basic neurobiology of inhibitory mechanisms involved in the response of the brain to sensory stimuli and correlated genetic studies that have identified molecular abnormalities in the gene for alpha 7 nicotinic receptors. These receptors stimulate the activity of inhibitory interneurons. This basic science information has been translated into clinical research that has identified physiological abnormalities in persons with schizophrenia that are related to deficits in alpha 7 nicotinic receptors. While nicotine itself is abused heavily by psychotic patients, it is not a satisfactory therapeutic drug. Clozapine activates alpha 7 nicotinic receptors as well, but through an indirect mechanism. However, newly developed nicotinic agonists show promise for reducing neurocognitive deficits in schizophrenia.

REFERENCE:

1. Martin LF, Kem WR, Freedman R: Alpha-7 nicotinic receptor agonists: potential new candidates for the treatment of schizophrenia. Psychopharmacology 2004; 174:54–64.

LECTURE 11
APA'S KUN-PO SOO AWARD LECTURE
LEADERSHIP THROUGH EXAMPLE: MENTORSHIP AND NETWORKING

K. Patrick Okura, Ph.D. (posthumously), *6303 Friendship Court, Bethesda, MD 20817-3342*

SUMMARY:

K. Patrick Okura's life is a dynamic example of leadership through example. He served as the unofficial mayor of the Santa Anita Assembly Center (a Japanese American Internment Camp) in 1941, served as the National President for the Japanese American Citizen's League (JACL) from 1962-64, where he led the effort to join Martin Luther King, Jr., in his march on Washington, DC, in 1963, to the Director of the Okura Mental Health Foundation, in addition to other leadership positions in various agencies. His life story is chronicled in Victory without Swords: The Story of Pat and Lily Okura, Japanese American Citizens in 1941 America by Robert B. Kugel, Heritage Press, 2004.

lecture will be a collection of vignettes and reminiscences of M. Okura, from people that have worked with him, with a combination of video and personal tributes, as well as a discussion of how to be an effective advocate for Asian American Mental Health, and how to become an effective leader in academic psychiatry. Important points to be covered are the importance of personal relationships, taking advantage of opportunities for training (fellowships, seminars, degrees, research), understanding how policy is made and influenced, mentorship, networking, getting involved with professional and advocacy agencies, and the importance of personal mission.

REFERENCE:

1. Lu, FG, Lee, K, and Prathikanti, S: Minorities in academic psychiatry. Handbook of Psychiatric Education and Faculty Development, edited by Kay, J, Silberman, EK, and Pessar, L: APPI, 1999. Pp 109-123.

LECTURE 12
APA'S JUDD MARMOR AWARD LECTURE
PSYCHIATRY IN THE GENOMIC ERA

Thomas R. Insel, M.D., *Office of the Director, National Institute of Mental Health (NIMH), 6001 Executive Boulevard, Room 8235, MSC 9669, Bethesda, MD 20892*

SUMMARY:

During the past two decades, the biological sciences and most areas of medicine have been transformed by new technologies and fundamental new insights. The completion of the Human Genome Project provided a map of all of the genes of our species and the human haplotype map now provides a guide to individual variation of these genes. Along with genomics, neuroscience has become one of the most exciting areas of contemporary research. Recent discoveries have transformed our understanding of the brain, demonstrating how complex, often unconscious mental activity can be mapped in specific circuits within the brain. By any measure, the past two decades have been revolutionary for our understanding of the human genome and how the brain functions, two areas of science fundamental to psychiatry. In the next decade, can we expect equally revolutionary changes in the practice of psychiatry? This lecture will suggest three areas where psychiatry may be transformed in the future. First, the identification of specific genetic variations that confer susceptibility to mental disorders may provide the first molecular pathophysiology of these illnesses, yielding new targets for treatment. Second, neuroimaging may provide biomarkers and diagnostic tests for mental illness, replacing the diagnostic manual of "mental disorders" with a new manual based on the recognition of altered brain function. And third, we may begin to see the "personalization" of treatment in psychiatry, as science allows us to individualize care for mental as well as medical disorders. These goals, will require a shift in both research and training.

REFERENCE:

1. Insel TR, Fenton W: The future of psychiatry, in BJ Sadock and VA Sadock, Comprehensive Textbook of Psychiatry, 8th Edition. Lippincott Williams & Wilkins, Baltimore, in press.

LECTURE 13
FRONTIERS OF SCIENCE LECTURE SERIES
GENES, COGNITION, AND EMOTION

Daniel R. Weinberger, M.D., *Clinical Brain Disorders, National Institute of Mental Health, 10 Center Drive, Building 10, Room 4S-235, Bethesda, MD 20892-1379*

SUMMARY:

Genes for susceptibility to psychiatric disorders have been identified, based on the strategy of genetic association of allelic variants with psychiatric diagnosis. However, genes do not encode for psychopathology but for simple molecular variations in cells, which determine the developmental biology of neural systems. The challenge for the next generation of gene discovery in psychiatry will be characterizing at the level of brain systems the impact on brain development and function of susceptibility genes. This lecture will explore the emerging story based on studies in living subjects of the effects of three genes related to variation in normal human temperament and risk for psychiatric disorders. COMT affects prefrontal information processing and the extremes of the effects of the two functional alleles relates to risk for anxiety and psychosis, respectively. The SERT gene effects the development and function of the limbic circuitry of negative affect, and this effect predicts almost 30% of normal variation in anxious temperament. BDNF affects the plasticity of limbic and prefrontal cortical regions and interacts with SERT in the process. These results offer lessons in how genes inform us of the underlying biology of mental disorders.

REFERENCE:

1. Hariri AR, Mattay VS, Tessitore A, Kolachana B, Fera F, Goldman D, Egan MF, Weinberger DR: Serotonin transporter genetic variation and the response of the human amygdala. Science 2002; 297:400–403.

LECTURE 14
THE FEDERAL REGULATION OF BIOMEDICAL RESEARCH: A STUDY IN QUID PRO QUOS

Robert P. Charrow, Esq., *800 Connecticut Avenue, NW, Suite 500, Washington, DC 20036*

SUMMARY:

William Ruckelshaus, the former administrator of the Environmental Protection Agency, once observed that the relationship between law and science was more akin to "a shotgun wedding," born more of convenience than of love. Ruckelshaus' observation was based on the way in which executive branch officials, legislators, and courts use science to help shape public policy and to resolve disputes concerning those policies once implemented. That model has changed: science has gone from being the tool of government to being the target of government.

Starting in the 1980s, the impetus to regulate science—scientific integrity, protection of human subjects, conflicts of interest, access to raw data—grew as the amount of government spending on scientific research grew.

This presentation explores the impact of government regulation of science on the practice and funding of research by examining a variety of regulatory programs—tracing their origin, examining their

effectiveness, and assessing whether they are cost justified. While most regulatory programs have laudable goals—ensuring scientific integrity, minimizing conflicts, and protecting the safety of human subjects—it is less than clear that federal regulation is the best way of achieving those goals or even whether the direct and indirect costs of the federal regulatory bureaucracies can be justified.

REFERENCE:

1. Ruckelshaus WD: Science, risk, and public policy. Speech by U.S. Environmental Protection Agency Administrator to the National Academy of Sciences, Washington, DC, 1983.

LECTURE 15
APA/NIMH VESTERMARK PSYCHIATRY EDUCATOR AWARD LECTURE
THE FUTURE OF PSYCHIATRIC EDUCATION: SIX BRIDGES TO CROSS

Harold Alan Pincus, M.D., *Department of Psychiatry, University of Pittsburgh, 3811 O'Hara Street, Suite 230, Pittsburgh, PA 15213*

SUMMARY:

The furure of psychiatry is the future of psychiatric education (and vice versa). Psychiatry in the early 21st century is facing by frightening challenges and enormous opportunities (actually, in a metaphorically similar position to King Arthur and his Monty Python band of knights in the new hit Broadway musical Spamalot). In this case, however, instead of killer rabbits, a black knight and taunting Frenchmen, present day psychiatry is beset by a set of systematic barriers that inhibit its entry into the fast moving mainstream of modern medicine (including dealing with the multiple mixed metaphors in this abstract). In order to reach its "Holy Grail", in this case a new generation of psychiatrists who will be able to apply the best science to produce the best outcomes for their patients, psychiatric education must engage six critical tasks: (1) Implementin evidence-based medicine (for the field and on an individual level; (2) Creating the evidence base ("the Psychiatrist investigator as an endagered species"); (3) Enhancing doctor-patient communication; (4) Bridging with general medicine; (5) Owning substance abuse; and (6) Crossing the quality chasm.

REFERENCES:

1. Pardes H, Pincus HA: Challenges to academic psychiatry. Am J Psychiatry 140: 1117-1126, 1983.
2. Pincus HA: The future of behavioral health and primary care: drowning in the mainstream or left on the banks? Psychosomatics 44:1: 1-11, 2003.
3. Institute of Medicine Committee on Quality of Health in America (2001). Crossing the queality chasm: a new health system for the 21st century Washington ED: National Academies Press.

WEDNESDAY, MAY 25, 2005

LECTURE 16
APA'S OSKAR PFISTER AWARD LECTURE
THE CONFLICTING WORLDVIEWS OF SIGMUND FREUD AND OSKAR PFISTER: KEYS TO UNDERSTANDING PATIENTS

Armand M. Nicholi, Jr., M.D., *Harvard Medical School, 209 Musterfield Road, Concord, MA 01742-1648*

SUMMARY:

Whether we realize it or not, every patient and every clinician has a world view. Our world view is simply our philosopy of life. A few years after birth, we gradually begin to formulate our world view. Most of us make one of two basic philosophical assumptions: we, like Freud, view the universe, as a result of random events and life on this planet a matter of chance; or we, like Pfister, assume some intelligence beyond the universe who gives the universe order and life meaning. So every clinician, and every patient we treat, embraces some form of Freud's secular world view or Pfister's (100) spiritual world view.

Some historians of science such as Thomas Kuhn point out that even scientists' world view influences not only what they investigate but also how they interpret what they investigate.

The world view of our patients informs their personal, social and political lives. It influences how they perceive themselves—their identity, how they value others-their relationships, how they understand the reason for their existence—their purpose and what drives them-their motivation. Perhaps most important to our clinical work, the world view of our patients influence how they confront illness, suffering and death. Understanding the world view of our patients will tell us more about them than any other part of their personal history.

REFERENCES:

1. The Question of God: C. S. Lewis and Sigmund Freud Debate God, Love, Sex and the Meaning of Life by Armand M. Nicholi, Jr. M.D. Free Press (Simon & Schuster), 2003.
2. The Question of a Weltanschauung by Sigmund Freud in The Standard Edition of the Complete Psychological Works of Sigmund Freud Vol XXII p. 156.
3. Psychoanalysis and Faith: The Letters of Sigmund Freud and Oskar Pfister Basic Books, Inc, 1963.

LECTURE 17
FRONTIERS OF SCIENCE LECTURE SERIES
DEPRESSION AND HEART DISEASE: CAUSE, EFFECT, OR COINCIDENCE

Nancy Frasure-Smith, Ph.D., *Montreal Heart Institute, 5000 Belanger, Montreal, QUE H1T 1C8, Canada*

SUMMARY:

Depression is about three times more common in patients with coronary artery disease (CAD) than in the general community. There is also considerable evidence linking depression with poor prognosis in patients with established cardiac disease, and an increasing number of studies that suggest that depression may, in fact, lead to the development of CAD itself. However, the direction of causality, remains open to debate, and neither the American Heart Association nor the American College of Cardiology list depression among the major cardiac risk factors. This presentation will consider the evidence for and against depression as a cardiac risk factor, as well as the potential pathophysiological and behavioral mechanisms that may account for links between depression and cardiac disease. Results of recent trials of depression treatment in CAD patients will also be reviewed, with an emphasis on potential alternative treatment options.

REFERENCE:

1. Frasure-Smith N, Lespérance F: Depression and other psychological risks following myocardial infarction. Archives of General Psychiatry 2003; 60: 627–36.

LECTURE 18
DISTINGUISHED PSYCHIATRIST LECTURE SERIES
NEUROPSYCHIATRY AND THE FUTURE OF PSYCHIATRY AND NEUROLOGY

Stuart C. Yudofsky, M.D., *Department of Psychiatry, Baylor University School of Medicine, One Baylor Plaza, BCM 350, Houston, TX 77030*

SUMMARY:

The tragic history of the mis-conceptualization of people with dysfunctions of mood, perception, cognition, and behavior as being evil and dangerous will be reviewed in order to understand the roots of the pervasive stigmatization of people with these conditions. Pioneers of 18th century neuropsychiatry including Griesinger, Alzheimer, Pick, Kraeplin, Freud, Bleuler, and Meyer will be shown to have laid the foundations of modern-day, evidence-based psychiatry. Eric Kandel's call for a new intellectual framework for psychiatry will be presented in the context of specific examples of recent scientific breakthroughs to demonstrate how genetics, molecular biology, and neuroscience will radically re-shape the assessment and treatment of people who suffer from neurological and psychiatric disorders. A justification and framework fro the re-unification of neurology and psychiatry as the single specialty of neuropsychiatry will be advanced.

REFERENCE:

1. Martin JB: The integration of neurology, psychiatry, and neuroscience in the 21st century. Am J Psychiatry 2002; 159:695-704.

LECTURE 19
DISTINGUISHED PSYCHIATRIST LECTURE SERIES EVOLUTION: THE MISSING BASIC SCIENCE THAT BRINGS PSYCHIATRY COHERENCE AND DEEPER EMPATHY

Randolph M. Nesse, M.D., *Department of Psychiatry, University of Michigan, 426 Thompson Street, Room 5261, Ann Arbor, MI 48104*

SUMMARY:

Understanding how natural selection shaped human motivations and emotions is no abstract pursuit, but crucial basic knowledge that psychiatrists need in order to understand their individual patients. This lecture will explain the selective advantages of capacities for anxiety and depression, the situations in which they are useful, and the evolutionary reasons why their regulation is so often awry. It will also show how to conduct an Ecological Life Situation Assessment that shows how the motivational structure of an individual's life gives rise to current symptoms. In particular, building on work by Klinger and advances by Carver, Scheier, Little, and Emmons, changes in mood can be understood in terms of changes in ability to make progress towards individual life goals. This provides a way to explicate why certain life situations are stressful for certain individuals. An evolutionary approach also explains how frequency dependent selection on foraging and social strategies can maintain genetic variation that leaves many people vulnerable to mood and addiction disorders. Psychiatrists who understand these advantages and the evolutionary exigencies of social life can attain deeper empathy for why patients find it so hard to change their lives. This empathy is the key to more effective treatment.

REFERENCE:

1. Nesse RM: Natural selection and the elusiveness of happiness. Philosophical transactions of the Royal Society of London. Series B, Biological sciences 2004; 359 (1449): 1333–1347.

LECTURE 20
INTERNATIONAL PSYCHIATRIST LECTURE SERIES
THE 25TH ANNIVERSARY OF BULIMIA NERVOSA: A NEW DISORDER

Gerald F. M. Russell, M.D., *Priory Hospital Hayes Grove, Preston Road, Hayes Bromley, Kent BR2 7AS, England*

SUMMARY:

In the publication of my article in 1979, describing bulimia nervosa, three diagnostic criteria were identified: (1) episodes of overeating; (2) behaviours aimed at avoiding the fattening effects of food; and (3) a morbid fear of becoming fat.

The concept of bulimia nervosa consists of this triad making up a distinctive syndrome, one closely related to anorexia nervosa. The prognosis of bulimia nervosa is now thought to be less ominous than originally anticipated.

After 1980 it became clear that bulimia nervosa was relatively common. This caused some surprise as expressed by Stunkard in 1990: "Bulimia seems to have burst from the blue upon modern society and it has achieved widespread recognition in a very short period of time".

These has been a surprising reluctance to accept the fact that bulimia nervosa is a new disorder. Apart from the very few clinical descriptions in the pre-1979 literature, this conclusion is supported by three cohort studies. They have shown: (1) The lifetime risk of bulimia nervosa is significantly higher in persons born recently (1959 or later) compared with those born later (pre-1950); (2) The explanation for this cohort effect is that only in recent years were individuals exposed to specific adverse socio-cultural factors; and (3) These adverse factors can be located approximately to the late 1960's.

REFERENCE:

1. Russell GFM: Thoughts on the 25th anniversary of bulimia nervosa. European Eating Disorders Review 2004; 12, 139–152.

THURSDAY, MAY 26, 2005

LECTURE 21
DISTINGUISHED PSYCHIATRIST SERIES INSPIRING ETHICS: ETHICAL MILESTONES AND PREPARATION IN PSYCHIATRIC EDUCATION

Laura W. Roberts, M.D., *Department of Psychiatry, Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, WI 53226*

SUMMARY:

Our everyday live are filled with ethical meaning, ethical action and inaction, and ethically important decisions. This ethical richness is an essential strength of our professional work as physicians, and psychiatrists are especially well-positioned to constructively address ethically complex issues that arise in many settings. Nevertheless, in recent years, discussionns of ethical aspects of psychiatry have become a platform for controversy and polarization in our field. "Ethics" has become an uncomfortable word with many negative asociations. So how do we better define and express the aspirations of our field? How do we strengthen the ethical calling of our profession? In this talk, I suggest that attentionn to psychiatric ethics should enhance our field by inspiring ethical commitment, furthering our shared ethical understanding, and fostering innovation and creativity. I will outline the ethical comitments of psychiatry and present a foundation of ethical knowledge, skills, and values of our professional field. A systematic approach to ethical decisionmaking in clinical and research settings that is informed by conceptual and empiracally-derived knowledge will be offered. Key findings from the exciting new discipline of evidence-based ethics will be highlighted, and approaches to working with ethics issues—in teaching, in clinical care, in research, and in administration—in an effective manner will be illustrated.

REFERENCE:

1. Roberts LW, Dyer AR: Concise Guide to Ethics in Mental Health Care. American Psychiatric Press, Inc; Washington, DC, 2004.

MEDICAL UPDATES

1. GET SMART NATURALLY

Richard P. Brown, M.D., *Department of Psychiatry, Columbia University, 86 Sherry Lane, Kingston, NY 12401*

EDUCATIONAL OBJECTIVES:

Review efficacy, dosing, side effects, interactions, and contraindications on herbs, nutrients, foreign medicines, biofeedback, and yoga breathing (in children) to improve brain function.

SUMMARY:

We will review cognitive enhancement strategies for treatment of age-related cognitive decline, Alzheimer's, Parkinson's, post stroke, traumatic brain injury, ADD, and dyslexia. Models for their actions will be noted. These include omega-3 fatty acids, SAM-e, idebenone, pyritinol, galanthus, acetyl-L-carnitine, Huperzine-A, citicholine, vinpocetine, Rhodiola rosea, ginkgo, ginseng, Ayurvedic herbs, centrophenoxine, aniracetam, selegiline, phosphatidyl serine, alpha-lipoic acid, hydergine, B-vitamins, DHEA, biofeedback, meditation, and yoga breathing.

REFERENCES:

1. Brown RP, Gerbarg PG, Muskin PR: Alternative Treatments in Psychiatry, in Psychiatry Second Edition. Edited by Allen Tasman, et al., John Wiley and Sons, London, UK 2003.
2. Brown RP, Gerbarg PG, Graham B: The Rhodiola Revolution. Rodale Press 2004.
3. Arnold LE: Alternative treatments for adults with attention-deficit hyperactivity disorder (ADHD). Ann N Y Acad Sci. 2001; 931:310–41.

2. STRESS-INDUCED ANOVULATION: MIND OVER MATTER

Sara Berga, M.D., *Department of Gynecology and Obstetrics, Emory University, School of Medicine, 1639 Pierce Drive, 4208-WNB, Atlanta, GA 30322*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) explain how metabolic compromise and psychogenic challenge synergize to induce hypothalamic hypogonadism and anovulation; (2) identify how behaviors and attitudes can compromise fertility; and (3) be able to counsel patients about the benefits and limitations of pharmacologic versus nonpharmacologic strategies.

SUMMARY:

Behaviors that activate the hypothalamic-pituitary-adrenal (HPA) axis or suppress the hypothalamic-pituitary-thyroidal (HPT) axis can disrupt the hypothalamic-pituitary-gonadal (HPG) axis in women and men. Individuals with functional hypothalamic hypogonadism typically display a combination of behaviors that serve as psychogenic stressors and present metabolic challenges. Complete recovery of gonadal function depends upon restoration of the HPA and HPT axes. Hormone replacement strategies have limited benefit because they do not achieve these objectives and their use masks deficits that accrue form altered HPA and HPT function. Long-term deleterious consequences of stress-induced anovulation may include an increased risk of cardiovascular disease, osteoporosis, and dementia. Although fertility can be restored with exogenous administration of gonadotropins or pulsatile GnRH, fertility management alone will not permit recovery of the HPA and HPT axes. Failure to reverse the hormonal milieu induced by stress may increase the likelihood of poor obstetrical and fetal outcomes. In contrast, behavioral and psychological interventions that address problematic behaviors and attitudes have the potential to permit resumption of ovarian function along with recovery of the HPT and HPA axes. Full endocrine recovery offers better individual, maternal, and child health.

REFERENCES:

1. Berga SL, Daniels TL, Giles DE. Women with functional hypothalamic amenorrhea but not other forms of anovulation display amplified cortisol concentrations. Fertil Steril 1997;67:1024-1030.
2. Bera SL, Loucks-Daniels TL, Adler LJ, Chrousos GP, Cameron JL, Matthews KA, Marcus MD. Cerebrospinal fluid levels of corticotropin-releasing hormone in women with functional hypothalamic amenorrhea. Am J Obstet Gynecol 2000;182:776-784.

3. OKAY. INSIDE THEIR HEAD, BUT WHAT'S UNDER THEIR NOSE?

Claudia Miller, M.D., *Department of Family and Community Medicine, University of Texas Health Science Center, 7703 Floyd Curl Drive, MCS 222, San Antonio, TX 78229*

EDUCATIONAL OBJECTIVES:

At the conclusion of this talk, participants will be able to (1) describe the two-step mechanism of toxicant-induced loss of tolerance (TILT); (2) list five neuropsychological symptoms often associated chemical intolerance; (3) identify two environmental exposures commonly reposted as initiators for TILT, and (4) define "masking" and discuss ho it may keep patients and their physicians from recognizing environmental exposures that underlie illness.

SUMMARY:

The olfactory tract provides the most direct connection between our brains and the air we breathe. Recent research suggests that everyday, low-level chemical exposures may be causing a wide variety of psychiatric and other illnesses. Investigators from more than a dozen nations report that a subset of individuals who experience acute or chronic environmental exposures to chemicals experience myriad disturbing symptoms that may at first appear to be psychogenic. This talk will focus on an emerging disease mechanism that provides a physiologic explanation for these symptoms-a phenomenon know as "toxicant-inducted loss of tolerance" (TILT). TILT develops in two stages: (1) initiation, following an acute or chronic chemical exposure (chemical spill, indoor air pollutants, etc) and (2) subsequent triggering of symptoms by exposure to tiny amounts of previously tolerated, structurally unrelated substances, including inhalants (traffic exhaust, fragrances, pesticides), foods, drugs, caffeine and alcohol. Multi-system symptoms are typical, with fatigue and cognitive and affective symptoms predominating. Individual susceptibility and symptom expression vary, apparently on a genetic basis. Because individuals' symptoms overlap in time, patients and physicians will often overlook the possibility that triggering environmental exposures and underlining loss of tolerance may be at the root of their illness. Practitioners who are aware of and understand TILT will be able to include another potential etiology in their diagnostic armamentarium. In the future, hospitals will need to provide specially designed "clean" facilities called "environmental medical units" that will enable patients to avoid all symptom triggers, reach a clean baseline, and recover.

REFERENCES:

1. Ashford NA, Miller CS: Chemical Exposures: Low Levels and High Stakes. Second edition. New York, John Wiley and Sons, Inc., 1998.
2. Miller CS: Toxicant-induced loss of tolerance: mechanisms of action of addictive stimuli. Addiction 96(1):115-139.

4. A PRIMER OF GENETICS FOR PSYCHIATRY

Stephen Warren, Ph.D., *Department of Human Genetics, Emory University, School of Medicine, 1639 Pierce Drive, 4208-WNB Atlanta, GA 30322*

EDUCATIONAL OBJECTIVES:

Human genetics holds great hope in gaining mechanistic insight into psychiatric disease. This presentation will review contemporary approaches used to identify genomic regions and genes influencing psychiatric disorders. Emphasis will be placed on how to critically evaluate such studies, recognize common pitfalls, and how to judge levels of statistical significance.

SUMMARY:

The completion of the sequencing of the human genome promises the tools to understand the biological basis of complex diseases. Psychiatric diseases are among the most complex of diseases, and their genetic study is particularly challenging. This presentation will review common contemporary approaches used in genetic studies aimed at identifying genomic regions containing genes whose variation influences predisposition to psychiatric diseases. Both family-based and case/control methodologies will be reviewed along with a brief overview of the statistical tests used to judge significance. Emphasis will be placed on how to critically evaluate such studies and how to recognize issues in study design and analysis that can influence outcomes. The current state of genetic analyses of selected psychiatric diseases will be reviewed.

REFERENCES:

1. Freimer N, Sabatti C: The use of pedigree, sib-pair and association studies of common diseases for genetic mapping and epidemiology. Nature Genetics 2004; 36:1045–1051.
2. Neale BM, Sham PC: The future of association studies: Gene-based analysis and replication. American Journal of Human Genetics 2004; 75:353–362.

PRESIDENTIAL SYMPOSIA

1. ADVANCES IN PSYCHOSOMATIC MEDICINE

International College of Psychosomatic Medicine Collaborative Session with the National Institute of Mental Health

1. **A Model for Psychosomatic Medicine: Care in a U.S. Cancer Center**
   Michelle B. Riba, M.D.
2. **Ethical Issues in Psychosomatics**
   George Christodoulou, M.D.
3. **Recent Advances in Depression and Cardiovascular Disease Research**
   Constantine Lyketsos, M.D.
4. **Suffering: Another Frontier in Psychosomatic Medicine**
   Tom Sensky, M.B.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to understand the advantages of bio-psychosocial management of patients with cancer and learn about the association between depression and cardiovascular disease, the importance of suffering, and ethical issue in the practice of psychosomatic medicine.

SUMMARY:

This symposium deals with important issues in psychosomatic medicine, the roots of which (holism, psychogenesis) are ancient and can be traced back to the teachings of the ancient Greek physicians and philosophers. It is presented in collaboration with the International College of Psychosomatic Medicine.

Dr. Michelle Riba will discuss the advantages of biopsychosocial management of patients with cancer. Such management results in reduction of distress, improvement of quality of life and, in some cases, reduction of length of hospital stay.

Dr. Constantine Lyketsos will discuss the association between depression and cardiovascular disease (increased incidence, increased risk of dealth among post MI patients). He will present the initial data from a multi-ethnic study investigation of the association between depressive symptoms and subclinical cardiovascular disease.

Dr. Thomas Sensky will discuss the importance of suffering. He will present suffering in relation to its conceptualization (an appraised threat to the Self). Data on measurement of suffering will be discussed using a non-verbal measure of suffering—the Pictorial Representation of Illness and Self Measure (PRISM). He will discuss how suffering is handled clinically.

Dr. George Christodoulou will discuss the ethical issues regarding the practice of psychosomatic medicine as depicted in the existing ethical codes and the elements shared by many of these codes (attention to confidentiality, awareness of the limitations of the physician, exposure of incompetent colleagues and priority to the well-being of the patient).

Dr. Philip R. Muskin will be the discussant for the symposium.

REFERENCES:

1. Buchi S, Buddeberg C, Klaghofer R, Russi EW, Brandli O, Schlosser C, Stoll T, Villiger PM, Sensky T: Preliminary validation of PRISM (Pictorial Representation of illness and Self Measure—a brief method to assess suffering). Psychother Psychosom 2002; 71(6):333–341.
2. Holland JC: An unacknowledged gap in services compromises quality cancer care. Oncology News International 2004; 13:8:558–59.
3. The Works of Hippocrates, Transl.N.Duncas. Diachronic Publications, Athens, 1998.

2. ADDRESSING HEPATITIS C AND RELATED DISEASES IN PERSONS WITH SEVERE MENTAL ILLNESS

5. **Hepatitis C and Other Blood-Borne Infections in the Severely Mentally Ill**
   Stanley Rosenberg, Ph.D.
6. **Access to Medical Care for Persons with Severe Mental Illness, Hepatitis C and Related Disorders**
   Marvin S. Swartz, M.D.
7. **Gender Differences in HCV and Associated Risks With Severe Mental Illnesses**
   Marian I. Butterfield, M.D.
8. **A Public Approach to Blood-Borne Infection With Severe Mental Illness: The STIRR Intervention**
   Mary F. Brunette, M.D.
9. **Antiviral Treatment of Hepatitis C in Persons With Severe Mental Illnesses**
   Lisa A. Mistler, M.D.
10. **Integrating Care for Persons With Severe Mental Illness**
    Lisa B. Dixon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participant should be able to (1) recognize the public health burden of Hepatitis C; (2) identify barriers to care for persons with SMI; and (3) discuss treatment approaches to Hepatitis C.

SUMMARY:

Hepatitis C and related diseases are an urgent public health problem affecting persons with severe mental illness. This symposium will provide an overview of the illness burden of Hepatitis C, examine access to medical care for the illness, review gender differences in Hepatitis C infection, describe an intervention designed to lower Hepatitis risk, and review antiviral treatment approaches. The discuss will focus on approaches to integrating services for persons with severe mental illness.

REFERENCES:

1. Rosenberg SD, Goodman LA, Osher FC, et al: Prevalence of HIV, hepatitis B, and hepatitis C in people with severe mental illness. Am J of Public Health 2001; 91:31–37.
2. Butterfield MI, Bosworth HB, Meador KG, et al: Gender differences in hepatitis C infection and risks in persons with severe mental illness. Psychiatr Services 2003; 54:848–853.
3. Rosenberg SR, Brunette MF, Oxman TE, et al: The STIRR model of best practices for blood-borne diseases in clients with SMI. Psychiatr Services 2004; 55:660–664.
4. Brunette MF, Drake RE, Marsh BJ, et al: Blood-borne infections and persons with mental illness: Responding to blood-borne infections among persons with severe mental illness. Psychiatric Services 2003; 54:860–865.

3. TOWARD AN INTEGRATED SUBSPECIALTY OF PSYCHOSOMATIC MEDICINE

American Psychosomatic Society

11. **Acute Psychological Stress and Coronary Artery Disease**
    David S. Sheps, M.D.
12. **Biobehavioral Contributions to Cancer Risk and Disease Progression**
    Susan Lutgendorf, Ph.D.
13. **A Biopsychosocial Approach to Irritable Bowel Syndrome**
    Douglas A. Drossman, M.D.

14. **Positive and Negative Psychosocial Predictors of CD4 And Viral Load in HIV**
Gail Ironson, M.D.

15. **Depression and Diabetes: Epidemiology and Intervention**
Wayne J. Katon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants will better appreciate how biobehavioral variables can exacerbate and how mental health interventions can ameliorate the progression of physical disease.

SUMMARY:

In contrast to the traditional focus on mental health outcomes in C-L psychiatry, the new subspecialty of "psychosomatic medicine" can be more comprehensive by also including the influence of mental health interventions on medical outcomes. This approach, which is championed by the American Psychosomatic Society, will be illustrated in this symposium through the presentation of recent research findings and their clinical implications. Our first speaker will discuss the role of mental stress as an independent risk factor for coronary ischemia and clinical cardiac events. Our second speaker will address the physiological mechanisms by which stress, depression, and social support influence tumor progression in ovarian cancer. Our third speaker will discuss the pathophysiology of irritable bowel syndrome and the effects of psychopharmacologic and psychotherapeutic treatment. Our fourth speaker will show that in the context of antiretroviral treatment, psychosocial factors such as depression and optimism have opposite effects on disease progression in HIV. Our fifth speaker will discuss how depression complicates diabetes and the effects of antidepressant treatment. The discussant will emphasize the implications of these findings for clinical management and discuss how future research can help to establish this new, more inclusive, identity for the new subspecialty.

REFERENCES:

1. Lesperance F, Frasure-Smith N, Talajic M, Bourassa MG. Five-year risk of cardiac mortality in relation to initial severity and one-year changes in degression symptoms after myocardial infarction. Circulation 2002; 105:
2. Hofer MA. Relationships as regulators: a psychobiologic perspective on bereavement. Psychosom Med 1984:46:183-97.

4. MENTAL HEALTH AND SUB-SAHARAN AFRICA: A 21ST CENTURY PERSPECTIVE

World Psychiatric Association

16. **Uganda Region**
Florence Baingana, M.D.

17. **World Psychiatric Association's Efforts**
Ahmed M.F. Okasha, M.D.

18. **Kenya**
Frank G. Njenga, M.D.

19. **Eastern Africa**
Sylvia Kaaya, M.D.

20. **The World Health Organization's Efforts and Namibia**
Custodia Mandhlate, M.D.

EDUCATIONAL OBJECTIVES:

Participants will be able to fully identify programs and resources currently available in specific regions of Africa as well as what items are needed to propel mental health and psychiatry to the next level.

SUMMARY:

Due to the success of the first-ever APA-WPA Presidential Symposium in 2004, plans are currently under way to organize this event once again, at the 2005 APA Annual Meeting in Atlanta. It will focus on Sub-Saharan Africa and its mental health needs, and will be co-chaired by APA President Dr. Michele Riba, and Dr. Ahmed Okasha, the World Psychiatric Association's (WPA) President.

This presentation is timely as the World Health Organization (WHO) and WPA are both focusing their efforts on this region of the world. Areas that will be addressed include psychiatric and medical resources currently available and in need throughout the continent, including financial, human, and institutional, as well programs already in place (Jenkins, 2004).

Presidential Symposium presenters include Dr. Florence Baingana, from the World Bank who is currently based in Washington, D.C. and is familiar with the Uganda region as well as more global issues; Dr. Ahmed Okasha, who can represent the WPA's effort to address this issue; Dr. Frank Njenga of the Kenyan Psychiatric Society; and Dr. Sylvia Kaaya, based at the Muhimbili Medical Center's Department of Psychiatry in Tanzania.

REFERENCES:

1. Jenkins R, Gulbinat W, Manderscheid R, Baingana F, Whiteford H, Khandelwal S, Minoletti A, Mubbashar MH, Srinivasa Murthy R, Parameshvara Deva M, Lieh Mak F, Baba A, Townsend C, Harrison M, Mohit A: The mental health country profile: background, design and use of a systematic method of appraisal. Int Rev Psychiatry 2004; 16(1-2):31-47.

5. THE INTERFACE OF PSYCHIATRY AND MEDICINE: DISORDERS OF AFFECT, BEHAVIOR, AND COGNITION

Academy of Psychosomatic Medicine

21. **Psychiatric Aspects of Dementia**
Constantine Lyketsos, M.D.

22. **The Management of Depression and Comorbid Medical Illness**
Michael K. Popkin, M.D.

23. **Reproductive Mood Disorders: The Brain in Context**
David R. Rubinow, M.D.

24. **The Interface of Psychiatry and Medicine: Disorders Of Affect, Behavior, And Cognition**
Theodore A. Stern, M.D.

25. **Etiologies and Neuropathogenesis of Delirium: Management Implications**
Paula T. Trzepacz, M.D.

EDUCATIONAL OBJECTIVES:

To learn how to recognize and treat the manifestations of depression in comorbid medical illness; to understand the underpinnings of the psychiatric manifestations of disordered endocrine function related to the reproductive cycle; to understand the etiology, management, and treatment of delirium and its downstream complications; to learn how to diagnose and manage the neuropsychiatric manifestations of dementia; to learn how to assess and manage undue stress that results from serious medical illness.

SUMMARY:

Patients with problems at the intrface of pcychiatry and medicine fill general hospitals and outpatient clinics. Practitioners who practice at this interface need up-to-date knowledge, so that fimely diagnoses can be made and effective interventions initiated. The branch of Psychiatry that deals with medical and psychiatric illness, and the affective, behavioral, and cognitive manifestions of illness, is now a certified subspecialty, called Psychosomatic Medicine.

Presentations for this symposium were selected because they are representative of work conducted in the field. Moreover, since the content areas and conditions discussed in this symposium (e.g., depression, delirium, dementia, woen's issues, coping, and collaboratio with other health care providers) are prevalent, problematic, and relevant to psychiatric practitioners, speakers will emphasize strategies for successful management.

The manifestations, prevalence, etiology, epidemiology, course, and treatment of common conditions will be reviewed. The first presentation will be on the management of depression and co-morbid medical illness; it will be followed by one on the psychiatric symptoms associated with the reproductive cycle. Next there will be a talk on the etiology and management of acute confusional states and deilrium, and one on the psychiatric aspects of dementia.

Finally, we will conclude with a discourse on coping with serious medical illness. Selected references and comprehensive texts will be cited.

REFERENCES:

1. Stern TA, Fricchione GL, Cassem NH, Jellinek MS, Rosenbaum JF (editors): The Massachusetts General Hospital Handbook of General Hospital Psychiatry, 5/E. Philadelphia, Mosby/Elsevier, 2004.
2. Levenson JL (editor): Textbook of Psychosomatic Medicine. Washington, D.C., American Psychiatric Publishing, Inc, 2005.
3. Lyketsos CG, Lopez O, Jones B, Fitzpatrick AL, Breitner J, DeKosky S: Prevalence of neuropsychiatric symptoms in dementia and mild cognitive impairment: Results from the cardiovascular health study. JAMA. 2002; 288(12): 1475-1483.
4. Trzepacz PT: Is there a final common neural pathway in delirium? Focus on acetylcholine and dopamine. Semin Clin Neuropsychiatry. 2000; 5(2): 132-148.
5. Popkin MK, Andrews JE: Mood disorders secondary to systemic medical conditions. Semin Clin Neuropsychiatry. 1997; 2(4): 296-306.
6. Rubinow DR, Schmidt PJ, Roca CA: Hormone measures in reproductive endocrine-related mood disorders: Diagnostic issues. Psychopharmacol Bull. 1998; 34(3): 289-290.

6. HEART, MIND, AND SOUL: PSYCHIATRIC ISSUES IN CARDIAC HEALTH FOR AFRICAN AMERICANS

Association of Black Cardiologists

26. The Link Between Depression And Cardiovascular Disease
Richard Williams, M.D.

27. Racial Disparities: The Metabolic Breakdown
Randall Maxey, M.D.

28. Psychotropic Medication Use With The African-American Cardiology Patient
Curley L. Bonds, M.D.

29. Cultural Change: A Psychosocial Adjustment for the African-American Cardiology Patient
Annelle B. Primm, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, the participants will learn about aspects of African-American history and culture that affect health care behaviors in the context of cardiovascular diseases. Participants will be presented with information regarding very recent studies identifying medications uniquely beneficial to African-American patients including discussion of the challenges and controversies in proceeding with these treatments. Use of psychotropic medications in the cardiac patient will be reviewed.

SUMMARY:

Heart disease remains the number one causes of death in our society. African Americans are disproportionately represented in morbidity and mortality from these and related diseases. The Framingham Study reported long ago the importance of diet, exercise, early intervention and adherence to a treatment regimen as critical to survival. Clinicians face unique challenges in the African-American community where historic cultural practices diverge from these recommended behaviors. Due to a history of discrimination and unethical practices, African Americans harbor an appropriate wariness toward the medical profession that impedes efforts at health care maintenance and early intervention. Low fat, low sodium diets force a departure from the "soul foods" that traditionally are the center of comfort and celebration. Fear of addiction or dependence challenge providers who seek to convince patients to adhere to complicated regimens. Providers have also been challenged regarding choices for treatment of African Americans who did not always respond in the numbers and to the degree that majority populations may have. Only recently have studies been conducted that include and focus on African Americans in useful numbers. Recent discoveries have identified regimens uniquely beneficial to this special group. Psychiatry has an important role in this subspecialty area not only in advising regarding psycho-socio-cultural change but also in addressing the mental health aspects of anxiety and depression associated with these illnesses. Our expertise is also needed for advice on the safe and effective use of psychotropic medications in combination with cardiac treatment regimens.

REFERENCES:

1. Anne Taylor, M.D., Susan Ziesche, R.N., Clyde Yancy, M.D., et al Combination of Isosorbide Dinitrate and Hydralazine in Blacks with Heart Failure, NEJM, No. 20, Vol. 351:2049–2057, Nov. 11, 2004
2. Cacioppo JT, Hawkley LC: Social isolation and health, with an emphasis on underlying mechanisms. Perspect Biol Med 2003; 46:Suppl:539–552.
3. Taylor AL, Ziesche S, Yancey C, et al: Combination of isosorbide dinitrate and hydralazine in blacks with heart failure. N Engl J Med 2004;351:2049–57.
4. Hare JM: Nitro-redox balance in the cardiovascular system. N Engl J Med 2004;351:2112–2114.
5. Bloche MG: Race-based therapeutics. N Engl J Med 2004; 351:2035–2037.
6. Musselman DL, Evans DL, Nemeroff CB: The relationship of depression to cardiovascular disease: epidemiology, biology, and treatment. Arch Gen Psychiatry 1998;55(7):580–592.

RESEARCH ADVANCES IN MEDICINE

EXPLORING NEW FRONTIERS AND CLINICAL APPLICATIONS

Chairperson: Dr. Charles B. Nemeroff M.D., Ph.D.
Co-Chairperson: Marian I. Butterfield M.D., M.P.H.
Participants: Viola Vaccarino M.D., Ph.D., Elizabeth O. Ofili, M.P.H., David G. Harrison M.D., Lawrence S. Philips M.D., Cornelia M. Weyand, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, participants will have an enhanced understanding of (1) research advances in cardiovascular disease and factors that influence cardiovascular outcomes, including oxidative stress, depression and gender; (2) diabetes research advances and treatment implications; (3) the process of premature aging observed in rheumatoid arthritis and the potential role of "immunoscence" in this.

SUMMARY:

This session presents cutting edge research across several areas of medicine: cardiology, endocrinology, immunology, and rheumatology. Outstanding medical researchers will present scientific advances in these areas and related clinical implications. The first sessions will emphasize different areas of research in cardiovascular diseases. Dr. Viola Vaccarino, Associate Professor of Medicine and Cardiology at Emory, will discuss stress, depression, and the metabolic syndrome. Her research focus incardiovascular epidemiology and the role of gender and risk factors effecting prognosis and treatment. Dr. Elizabeth Ofili, an Associate Professor in Medicine and Cardiology at the Moorhouse School of edicine, will discuss research advances in cariovascular diseases. Her research focus is cardiac hypertrophy, myocardial ischemia, and heart failure. Dr. Daveid G. Harrison, Professor of Medicine and Director of Cardiology at Emory will discuss vascular diseases, oxidative stress, and depression. His research is on understanding how endothelial cells produce nitric oxide and how this is altered by a variety of common pathological conditions. Dr. Lawrence Phillips, Professor of Medicine and Director of the Division of Endocrinology and Metabolism at Emory, will present a research update on diabetes and implications for clinical care. He is a research pioneer in insulin-like growth factor regulation and gene transcription as well as systems and processes of care for improving the diabetes care. Corelia M. Weyand, MD, PhD is Director of the Lowance Center for Human immunology, professor of edicine and Immunolgy at Emory. She will discuss the process of immunosenescence and its relationship to premature aging in patients eith rheumatoid arthritis. Dr. Weyand is a leading researcher in defining disease mechanisms in chronic inflammatory syndromes, particularly, inflammatory blood vessel disease and rheumatoid arthritis.

REFERENCES:

1. Davis ME, Grumbach IM, Fukai T, Cutchins A, Harrison DG: Shear stress regulates endothelial nitric oxide synthase promoter activity through nuclear factor kappa-B binding. JBC. 2004; 279:163-8.
2. Ofili, EO, Cohen JD, St. Vrain JA, Pearson A, Martin TJ, Uy ND, Castello R, Labovitz AJ: Effect of treatment of isolated systolic hypertension on left ventricular mass. Journal of the American Medical Association 1998: 279(10):778-780.
3. Weyand CM, Goronzy JJ: Trends stem cell aging and autom= immunity in rheumatoid arthritis. Moi Med. 2004:10(9):426-33.
4. Williams SA, Kasi SV, Kruhoiz HM, Heiat A, Vaccarino V: Depression and risk of heart failure incidence among elderly: A prospective community-based study. Psychosomatic Medicine 2002: 64:6-12.
5. Zhu J-L, Pao C-I, Kaytor EN, Phillips LS: Involvement of Sp1 in the transcriptional regulation of the rat insulin-like growth factor-1 gene. Molec Cell Endo 2000: 164:205-218.

REVIEW OF PSYCHIATRY

SESSION I OF THE REVIEW OF PSYCHIATRY

SLEEP DISORDERS AND PSYCHIATRY

Section Editor: Daniel J. Buysse, M.D.

1. **Insomnia**
   Daniel J. Buysse, M.D., Anne Germain, Ph.D., Douglas E. Moul, M.D.
2. **Sleep Related Breathing Disorders**
   Patrick J. Strollo, M.D., Nilesh Dave, M.D.
3. **Restless Leg Syndrome and Parasomnias**
   John W. Winkelman, M.D., Lindsay Jonston, B.A.
4. **Circadian Rhythm Sleep Disorders**
   Phyllis C. Zee, M.D., Prasanth Manthena, Ph.D.

EDUCATIONAL OBJECTIVES:

Understand key concepts regarding the characteristics of sleep and its functions 2. Identify the most common sleep disorders in clinical practice and their symptoms 3. Recognize the important elements of clinical evaluation of sleep disorders 4. Discuss treatment approaches for the most common sleep disorders

SUMMARY:

Psychiatrists need to know about sleep and its disorders for several reasons. First, sleep is a fundamental biological process that regulates systemic physiology and central nervous system functions such as learning, cognition, and mood. Second, sleep disorders are widely prevalent and becoming more so. Third, sleep disorders often present with psychiatric symptoms, and psychiatric disorders often present with sleep symptoms. Finally, psychiatrists play a vital role in the recognition and treatment of sleep disorders. Psychiatrists' expertise in clinical psychopharmacology is often critical for treating patients with sleep disorders. This session will provide a brief overview of sleep and its functions, then address the most common sleep disorders of relevance to psychiatrists: insomnia, sleep disordered breathing, narcolepsy and other hypersomnias, Restless legs syndrome, parasomnias, and circadian rhythm sleep disorders. For each disorder, the faculty will discuss clinical epidemiology, new developments in etiology and pathogenesis, and essential elements of clinical evaluation. Finally, the treatment of each of these disorders will be discussed, including relevant behavioral, pharmacologic, and other interventions.

REFERENCES:

1. Kryger MH, Roth T, Dement W: Principles and Practice of Sleep Medicine, Fourth Edition. W.B. Saunders, in press.
2. Neylan TC, Reynolds CF, Kupfer DJ. Sleep Disorders: In Hales RE, Yudofsky SC, Talbott JA, editors. Textbook of Psychiatry. Washington, D.C.: American Psychiatric Press, Inc., 1994, p 833-855.
3. Perlis ML, Lichstein KL: Treating Sleep Disorders. Principles and Practice of Behavioral Sleep Medicine. Hoboken, New Jersey, John Wiley & Sons, Inc., 2003.
4. Reite M, Ruddy J, Nagel K: Evaluation and Management of Sleep Disorders. American Psychiatric Publishing, Inc., 2002.
5. Sleep Disorders and Psychiatry, Oldham JM Riba MB, (series editors). American Psychiatric Publishing Review of Psychiatry. Arlington, VA: American Psychiatric Publishing, Inc., in press.

SESSION II OF THE REVIEW OF PSYCHIATRY

PREGNANCY AND POSTPARTUM DEPRESSION

Section Editor: Lee S. Cohen, M.D.

5. **Course of Psychiatric Disorder During Pregnancy**
   Laura Fagiolo-Petrillo, M.D.
6. **Psychotropic Drug use During Pregnancy**
   Lee S. Cohen, M.D.
7. **Diagnosis and Treatment of Postpartum Mood Disorder**
   Ruta M. Nonacs, M.D.
8. **Uses of Psychotropics During Lactation**
   Adele C. Viguera, M.D., Ruta M. Nonacs, M.D.

EDUCATIONAL OBJECTIVES:

to describe the course of mood and anxiety disorders during pregnancy and the postpartum period; to highlight treatment strategies for patients suffering from depression during pregnancy and the peurperium; to describe the relative risks associated with prenatal exposure to psychotropics; and to review the available data regarding psychotropic drug use during lactation.

SUMMARY:

While the postpartum period has been described as a period of risk for psychiatric disorder, pregnancy has frequently been noted to be a time of emotional well-being for women providing "protection" against psychiatric illness. More recently, a growing number of studies describe new onset, persistence, or recurrence of psychiatric disorder during pregnancy. This symposium will review available information on course and treatment of mood and anxiety disorders during pregnancy and the postpartum period. Available reproductive safety data will be reviewed across the psychotropics and treatment strategies for use of these agents during pregnancy will be discussed for women suffering from unipolar depression, bipolar illness, and a spectrum of anxiety disorders. Treatment algorithms will also be presented for management of puerperal mood disturbance as will use of psychotropics when women wigh to breastfeed Given the morbidity associated with untreated psychiatric disorder, it is critical that clinicians be familiar with strategies which allow for effective treatment of special populations such as those women sho suffer from mood and anxiety disorders before, during, and after pregnancy.

REFERENCES:

1. Viguera AC, C.L., Baldessarini RJ, Nonacs R. (2002). "Managing pipolar diaorder during pregnancy: weighing the risks and benefits." Can J Psychiatry 47: 426-436.
2. Llewellyn, A. and Z. Stowe (1998). "Psychotropic medications in lactation." J Clin Psychiatry 59 (suppl 2): 41-52.
3. Cohen L.S., R. Nonacs, et al. (2004). "Diagnosis and treatment of depression during pregnancy. " CNS Spectr 9(3): 209-16.

SESSION III OF THE REVIEW OF PSYCHIATRY

BIPOLAR DISORDERS

Section Editors: Terence A. Ketter, M.D., Charles L. Bowden, M.D., Joseph R. Calabrese, M.D.

9. **Treatment of Acute Mania**
   Terence A. Ketter, M.D.
10. **Treatment of Acute Depression**
    Gary S. Sachs, M.D.
11. **Maintenance Treatment**
    Charles L. Bowden, M.D.
12. **Treatment of Rapid Cycling**
    Joseph R. Calabrese, M.D.

13. Treatment of Children and Adolescents

Kiki D. Chang, M.D.

EDUCATIONAL OBJECTIVES:

After attending this session, participants will be able to appreciate the emerging roles of new treatments for bipolar disorders with respect to the management of mania and depression, maintenance treatment and rapid cycling, and in special populations such as children and adolescents, and women.

SUMMARY:

New treatment options for bipolar disorder are emerging at an accelerating rate. In this session, we consider recent advances in treatments, including controlled trials involving two main categories of medications, newer anticonvulsants and newer antipsychotics, and adjunctive psychosocial interventions. Newer antipsychotics generally appear effective for acute mania. In contrast, newer anticonvulsants have diverse psychotropic profiles, and although not generally effective for acute mania (with the possible exception of oxcarbazepine), may have utility for other aspects of bipolar disorders (e.g. gabapentin for anxiety or pain; topiramate for obesity, bulimia, alcohol dependence, or migraine; and zonisamide for obesity). The newer antipsychotics olanzapine (combined with fluoxetine) and quetiapine (as monotherapy), and the newer anticonvulsant lamotrigine (as monotherapy) appear effective for acute bipolar depression. The anticonvulsants lamotrigine and divalproex, the newer antipsychotics olanzapine and aripiprazole, and adjunctive psychosocial interventions including psychoeducation, family-focused therapy, and cognitive behavioral therapy appear effective in delaying relapse in patients with bipolar disorders. The anticonvulsants lamotrigine and divalproex have some utility in rapid cycling bipolar disorder, but many patients are even resistant to combination therapies. Advances in the treatment of children and adolescents with bipolar disorders provide new insights into phenomenology and pharmacotherapy. Advances in the treatment of women with bipolar disorders reveal new insights into relationships between the reproductive cycle both mood and pharmacotherapy. Although clinical management of bipolar disorders remains challenging, recent advances are providing important new treatment options for patients with this illness.

REFERENCES:

1. Ketter TA, Wang PW, Nowakowska C, Marsh WK. New medication treatment options for bipolar disorders. Acta Psychiatr Scand 2004;110(Suppl 422):18–33.
2. Thase ME, Bhargava M, Sachs GS. Treatment of bipolar depression: current status, continued challenges, and the STEP–BD approach. Psychiatr Clin North Am 2003;26(2):495–518.
3. Bowden CL. Acute and Maintenance treatment with mood stabilizers. International Journal of Neuropsychopharmacology 2003;6:269–275.
4. Calabrese JR. Depression mood stabilisation: novel concepts and clinical management. Eur Neuropsychopharmacol 2004;14(Suppl 2):s200–7.

ROUNDTABLE

SAFETY AND EFFICACY OF SSRI ANTIDEPRESSANTS IN CHILDREN AND ADOLESCENTS: WHAT DO WE KNOW AND WHEN DID WE KNOW IT?

Moderator: Richard E. D'Alli, M.D.
Participants: Graham J. Emslie, M.D., John S. March, M.D., John T. Walkup, Benedetto Vitiello, M.D.

EDUCATIONAL OBJECTIVES:

1. After attending this Roundtable, the participant will understand the most effective, evidence-treatment of adolescent depression. 2. After attending this Roundtable, the participant will appreciate the scientific strategy to sort out the risk of suicidality associated with SSRI antidepressants.

SUMMARY:

Adolescent depression, with a point prevalence of 5% in the U.S., is a predictor of adult depression and a major risk factor in suicide, now the third leading cause of death in this age group behind accidents and homicide. New evidence now substantiates the effective treatment of adolescent depression using cognitive behavioral therapy in combination with an SSRI antidepressant (see second reference). However, this approach has been complicated by the nearly contemporaneous FDA announcement of its intent to include a "blank box" warning on all marketed antidepressants regarding their safety in patients below the age of 18. The result has been a public health debate, with significant implications for the appropriate care and illness education of patients. This roundtable brings together a number of key physician-investigators involved in this scientifically and politically turbulent area, who will discuss the current rationale in approaching the treatment of adolescent depression.

REFERENCES:

1. Vitiello, B and S. Swedo (2004) "Antidepressant Medications in Children" New Eng J of Med 350(15): 1489–91
2. TADS Team (2004) "Fluoxetine, Congnitive-Behavioral Therapy, and Their Combination for Adolescents with Drepression" JAMA 292(7): 807–820

SPECIAL SESSION

GLOBAL DISASTERS: PSYCHIATRIC MEDICINE AND PUBLIC CHALLENGES

The APA Council on Global Psychiatry and The WPA Conflict Management and Conflict Resolution Section

Rodrigo A. Mũnoz, M.D., *Department of Psychiatry, University of California at San Diego, 3130 Fifth Avenue, San Diego, CA 92103;* Eliot Sorel, M.D., *2121 K Street NW #800, Washington, D.C., 20037;* M. Parameshva Deva, M.D., (Malaysia), Srinivasi Murthy, M.D., (WHO), Lennart Levi, M.D., Ph. D., (Sweden), Frank G. Njenga, M.D. (Kenya), Mordechai Benyakar, M.D. (Argentina), Anthony T. Ng, M.D. (U.S.), Dori B. Reissman, M.D. (U.S.)

SUMMARY:

Major disasters, human-made (conflicts, chemical accidents, wars) and natural (earthquakes, floods, drought) have resulted in enormous death and destruction throughout the world over the centuries. The Indian Ocean tsunami that struck on a lazy Sunday morning in late December 2004 in South Asia and East Africa brought unprecedented and unimaginable tragedy and trauma. As of early February 2005 there were more than 170,000 dead and over 120,000 missing and presumed dead. This Special APA Sessio. Global Disasteres: Psychiatric Medicine and Public Health Challenges developed collaboratively with our Asian, African, and European colleagues is a modest response of solidarity to the terrible tragedy and trauma that afflicted South Asia, East Africa, and Northern Europe. It will provide the opportunity to share field experiences from the three regions; learn about the tsunami's public healt, medical, psychiatric, and mental health consequences; compare lessons learned and best practices in responding to such consequences; learn about systemic and systematic preventative measure anticipating future such events; enhance our global professional collaborative networks; and identify the current and future needs of the regions affected by the tsunami and how best contribute to the survivors' recovery and healing.

REFERENCES:

1. Saraceno, B., et al: WHO Recommendations for Mental Health in Aceh, January 25, 2005.
2. Norris FH: Psychosocial Consequences of Natural Disasters in Developing Countries—What Does Past Research Tell Us About the Potential Effects of the 2004 Tsunami? White River Junction, Vt.: National Center for PTSD, 2005.

This page intentionally left blank

SYLLABUS INDEX

C

D

E

F

G

H

I

M

T

This page intentionally left blank

NOTES